Australian Government

Australian Institute of Criminology

Trends & issues in crime and criminal justice

No. 660 January 2023

Abstract | Following substantial domestic and family violence (DFV) reforms in Australia in recent years, the identification of victim-survivors is increasingly embedded across service system responses. In contrast, while men using DFV often have diverse service system contact for co-occurring issues, their use of DFV is often not identified.

This mixed-methods study examines current screening and risk assessment practices for DFV perpetration in service systems that frequently encounter men who may be using DFV, including mental health, alcohol and other drug services, corrections and child protection services. Results show significant variation in screening and risk assessment practices and attitudes across service areas.

Domestic and family violence perpetrator screening and risk assessment in Queensland: Current practice and future opportunities

Silke Meyer, Nicola Helps and Kate Fitz-Gibbon

Introduction

Domestic and family violence (DFV) affects one in four women in Australia and is the leading preventable contributing factor to women's illness, disability and death (Australian Institute of Health and Welfare 2019). While not solely perpetrated by men against women, DFV remains highly gendered, with women and children over-represented as victims (Australian Institute of Health and Welfare 2019; World Health Organization 2021). This is especially the case at the high-risk end, with an average of one woman being killed by a male intimate partner every nine days in Australia (Australian Institute of Health and Welfare 2021).

The last eight years have seen unprecedented attention at the national and state levels focused on improving and reforming responses to DFV. Recent reviews including Victoria's Royal Commission into Family Violence (2016), the Special Taskforce on Domestic and Family Violence in Queensland's (2015) *Not now, not ever* report and the Council of Australian Governments (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. While significant attention has been paid to ensuring risk identification, assessment and management practices are in place for DFV victim-survivors, understanding of and responses to perpetrators of DFV remain limited and inconsistent. In particular, identifying DFV perpetrators and assessing and managing risk falls largely on police, courts and DFV specialist services, such as men's behaviour change programs (McEwan, Shea & Ogloff 2019; Storey et al. 2014). Screening and risk assessment for DFV used in other service areas remain primarily victim-centred (Messing & Thaller 2013; Penti, Timmons & Adams 2018; Todahl & Walters 2011), often rendering perpetrators invisible to the service system.

Research on men who use DFV highlights the complex intersecting issues these men often present with, including mental health problems, alcohol and other drug (AOD) misuse, risk associated with their role as a parent or other offending behaviour (Domestic and Family Violence Death Review and Advisory Board (DFVDRAB) 2021; Hester et al. 2015; Spangaro et al. 2017; Verbruggen et al. 2020). There is substantial co-occurrence between men's primary presenting issues in these service areas and their use of DFV (Gilchrist et al. 2019; Kraanen et al. 2013; Verbruggen et al. 2020). Health services, corrections and child protection services therefore present key opportunities to identify male perpetration of DFV and to assess and manage related risk. However, current international research evidence suggests that identification of and responses to perpetrators in these settings remains limited (Davis & Padilla-Medina 2021), with Australian evidence being scant (Tarzia et al. 2017).

Background

Emerging evidence on the screening of men for potential use of DFV reveals that men accessing service settings for other issues, such as health concerns, are willing to disclose their use of DFV when asked about it (Burge et al. 2005; Chang et al. 2011; Portnoy et al. 2020). Screening for perpetration of DFV may refer to a combination of practices, including the process of reviewing available information, and asking specific screening questions to identify the absence or presence of DFV (Davis & Padilla-Medina 2021) or to identify potential warning signs during intake conversations that may alert practitioners to the presence of DFV without the perpetrator client or patient explicitly disclosing it (Hegarty, Taft & Feder 2008; Portnoy et al. 2020). Risk assessment tools usually consist of a standardised set of questions, identifying the absence or presence of factors known to elevate the risk of revictimisation in the context of DFV. Some actuarial tools rely solely on quantifiable measures that generate a total score, indicating low, moderate or high risk, whereas others use a combination of standardised questions and professional judgement which requires drawing on other available information (Kebbell 2019; Messing & Thaller 2013).

There is emerging evidence regarding the predictive accuracy of existing screening tools (Davis & Padilla-Medina 2021; Kraanen et al. 2013. However, a scoping review by Davis and Padilla-Medina (2021) reveals the lack of evidence in relation to the administration of screening and risk assessment tools in the context of wider screening and risk assessment protocols and manuals, along with subsequent risk management. Further, research has identified varying degrees of predictive validity associated with the inconsistent administration of risk assessment tools (Kebbell 2019; Messing & Thaller 2013).

Support for the use of standardised questions and assessment tools as a standalone approach is mixed, with some studies supporting a combination of standard screening questions and DFV informed intake and assessment interview processes that rely on professional judgement (Davis & Padilla-Medina 2021; Hegarty, Taft & Feder 2008; Portnoy et al. 2020). Screening and risk assessment more broadly rely on professional judgement relating to information gathered during intake and assessment interviews, requiring frontline practitioners to have a high level of DFV specialist understanding (Aziz & El-Gazzar 2019; Bakon et al. 2020; Kimberg 2007). This is particularly so as it relates to perpetrator behaviour, including patterns of minimisation, denial, victim-blaming and systems abuse (Beck & Raghavan 2010; Portnoy et al. 2020). However, research on frontline practitioner identification of DFV, particularly in health services (including AOD and mental health services) and child protection, reveals mixed evidence around practitioner understandings of and confidence in identifying DFV perpetration. This creates ongoing barriers to the identification of DFV perpetration and related risk (Portnoy et al. 2020; Todahl & Walters 2011).

The diverse service system contact of male perpetrators of DFV, often related to co-occurring issues, offers opportunities for identification, risk assessment and the initiation of referral pathways. This has been documented in research and the findings of DFV death review inquiries (DFVDRAB 2021; Hegarty, Taft & Feder 2008; Morgan et al. 2014). The current evidence base highlights the need to further explore current practices and future opportunities across service areas that frequently encounter men with complex presenting issues, including DFV.

Method

This paper presents a subset of findings from a larger national study of perpetrator focused screening and risk assessment practices. Here we draw specifically on the practitioner data from one Australian state (Queensland) to examine current screening and risk assessment practices as well as attitudes in practice areas that frequently come in contact with male clients whose presenting issues intersect with DFV, including mental health, AOD services, child protection and corrections.

Research questions

The larger national study from which we draw was guided by four research questions:

- What screening practices do practitioners report across different non-DFV specialist service areas when assessing or working with male clients or service users?
- What risk assessment practices do practitioners report across different non-DFV specialist service areas when DFV perpetration is identified?
- What are the key barriers to and enablers of screening and risk assessment for DFV perpetration?
- What implications arise for the use of DFV screening and risk assessment in service contacts with potential male perpetrators of DFV across non-DFV specialist service areas that frequently respond to presenting issues which intersect with DFV?

To answer these questions, the study used a two-stage mixed-method design incorporating an online survey (stage 1) and focus groups (stage 2).

Stage 1: Online survey

The survey instrument was developed by the research team and was expected to take approximately 20 minutes to complete. Findings presented here are based on the following three modules: practitioner information, screening and risk assessment practices, and attitudes to screening and risk assessment.

Practitioner information

Participants were asked a series of questions related to their occupation. These items recorded participants' role, practice area, years of experience in their area of practice and in their current role, as well as their level of formal DFV specialist training.

Screening and risk assessment practices

Participants were asked about their screening and risk assessment practices for DFV perpetration among male clients and responded using a series of five-point Likert scales. Participants were asked how frequently they screened for DFV perpetration in the past three months and how frequently they assessed risk of identified DFV perpetration in the past three months. Response options ranged from 'never' (1) to 'always' (5).

Attitudes to screening and risk assessment

Participants were asked how much they agreed or disagreed with a series of eight attitude statements related to screening and risk assessment for DFV perpetration:

1. Screening for DFV perpetration during routine contact with clients/patients/service users is core business in my area of service delivery ('core business' attitude item);
2. My area of service delivery has no time to screen for DFV perpetration in every routine contact with clients/patients/service users ('no time to screen' attitude item);
3. It's pointless to screen for DFV perpetration because most perpetrators will deny the use of DFV unless there is evidence of their abusive behaviour ('pointless because of denial' attitude item);
4. It's pointless to screen for DFV perpetration because of the unavailability of necessary referrals to support and monitor perpetrators of DFV ('pointless because of unavailable referrals' attitude item);
5. Current screening tools used in my organisation to identify perpetration of DFV during routine contact with clients/patients/service users are useful in identifying potential risk for victims and children ('screening tools useful in identifying potential risk' attitude item);
6. Current risk assessment tools used in my organisation to identify severity of perpetration of DFV during encounters with identified perpetrators are useful in identifying heightened risk for victims and children ('risk assessment tools useful in identifying heightened risk' attitude item);
7. Current risk assessment practices used in my organisation to identify severity of perpetration of DFV during encounters with identified perpetrators are useful in generating suitable referral pathways and support options for perpetrators of DFV ('risk assessment practices useful in generating referral pathways' attitude item); and
8. Once a perpetrator of DFV has been referred to a support or specialist service provider, the responsibility for ongoing risk monitoring and management lies with that service provider/organisation ('shared risk management' attitude item).

Participants responded to each statement using a five-point Likert scale ranging from 'strongly disagree' to 'strongly agree'. Statements 2, 3, 4 and 8 were reverse recoded so that a higher score consistently indicated a more positive attitude. Only items 1 and 3 are included in the analyses presented here due to their emergence as key barriers or enablers of screening for DFV perpetration in the qualitative survey and focus group data. For more details on the approach to analyses, please see the full report (Meyer, Helps & Fitz-Gibbon 2022).

Open-ended items

The inclusion of a number of open-ended questions allowed survey participants to provide additional qualitative feedback in relation to their screening and risk assessment practices, including service area and client population specific barriers.

Response rate

Here we focus on the responses received from Queensland participants. In total, 453 Queensland practitioners responded to the survey. This included practitioners across a range of service areas, including corrections (*n*=174, 38%), mental health (*n*=159, 35%), child protection (*n*=100, 22%) and AOD (*n*=20, 4%). Table 1 provides descriptive data on participants' years of experience in their current practice area and their current role.

Table 1: Practitioners' professional experience

	0–2 years	3–6 years	7–10 years	11–19 years	20+ years
Years in current practice area[a]					
n	72	105	77	105	90
%	16.0	23.4	17.2	23.4	20.0
Years in current role[b]					
n	164	148	47	61	33
%	36.2	32.7	10.4	13.5	7.3

a: *n*=449. Four participants did not answer this question
b: *n*=453

As shown in Table 2, most participants (*n*=316, 70%) reported having some formal DFV specialist training, while 30 percent of participants (*n*=137) had none. Most participants' highest level of formal DFV specialist training was a short course (*n*=157, 35%).

Table 2: Practitioners' level of DFV specialist training (*n*=453)

	n	%
No training	137	30.2
Short course	157	34.7
Internal professional development	95	21.0
Single unit, undergraduate	26	5.7
Single unit, postgraduate	15	3.3
Postgraduate degree	23	5.1

Survey data analysis

All survey data were analysed using SPSS Statistics software (V.26). Descriptive statistics were computed for responses on each of the survey items. Several one-way analysis of variance (ANOVAs) were computed to see whether there were any statistically significant differences in screening and risk assessment practices and attitudes between practice areas (child protection, AOD, mental health and corrections). Open-ended survey responses were coded to key themes and analysed thematically using NVivo 12 qualitative analysis software.

Stage 2: Focus groups

In the second data collection stage, seven focus groups were conducted with practitioners whose work involves screening and/or risk assessment for DFV perpetration. Where practitioners were unable to attend a scheduled focus group, one-on-one interviews (*n*=5) were conducted. A total of 39 practitioners participated in this stage of data collection:

- three health practitioners (1 AOD and 2 mental health practitioners);
- six corrections practitioners; and
- 22 child protection practitioners (including 14 intake and investigation and assessment practitioners, 5 DFV specialist practitioners, 3 First Nations practitioners).

All focus groups were facilitated online via video technology due to the COVID-19 related restrictions in place during the data collection period.

Focus group data analysis

Focus group data were coded using thematic analysis. Coding was informed by the research questions and preliminary survey findings and followed a deductive approach. Further, emerging focus group findings informed the final survey data analysis. We used manual coding and NVivo software to identify emerging themes and analyse focus group findings alongside relevant survey results. The focus group and interview transcripts were compiled and collectively analysed. In the presentation of findings, we refer to the focus groups and interviews collectively as focus groups.

Limitations

Findings presented here are subject to several limitations. First, while the current study was focused on male to female perpetrated forms of IPV, a number of findings may equally apply to other forms of DFV (eg adult child to parent violence). Screening for and understanding DFV in a wider family context may therefore be equally useful to identify potential risk to other family members along with relevant support mechanisms for perpetrators and aggrieved family members. Further research should also focus on the identification and support needs of diverse perpetrator populations, including women who use force, young people using DFV in intimate relationships as well as towards parents and other family members, and LGBTIQA+ perpetrator populations.

The findings presented here are Queensland specific. Practitioner practices and perceptions may not extend to other Australian states and territories. Future research should explore current screening practices in a nationally representative sample of relevant practice areas to identify best practice and the factors that create opportunities for organisational commitment and leadership in different jurisdictions and policy settings.

Results

The results are presented in two parts: quantitative survey findings and qualitative open-ended survey and focus group findings.

Quantitative survey results

As outlined in the method, participants were asked a number of questions regarding their screening and risk assessment practices as well as attitudinal questions. One-way ANOVAs were conducted to determine whether there were any statistically significant differences between the means of each practice area (child protection, mental health, AOD and corrections) on the following six dependent variables:

- frequency of screening;
- perceived frequency of positive identification;
- frequency of risk assessment;
- core business attitudes;
- denial attitudes; and
- level of DFV specialist training.

The two individual attitude items (core business and denial) were included in the ANOVA because they were identified in the qualitative survey and focus group findings as key barriers to or enablers of screening and risk assessment. In addition, the practitioners' level of formal DFV specialist training was included in the ANOVA because it emerged as critical in the qualitative survey and focus group results. Not all participants completed all questions or modules within the survey. Partial responses are used where relevant, with the number of responses to each question (*n*) provided.

The results of the ANOVA are provided in Table 3. Due to the high number of statistical tests conducted, the level of statistical significance was adjusted throughout using Bonferroni-Holm correction to reduce the family-wise error rate.

Table 3: Screening and risk assessment practice and attitude ANOVA											
	Child protection		Mental health		AOD		Corrections[c]		ANOVA		
	M(*n*)	*SD*	*M*(*n*)	*SD*	*M*(*n*)	*SD*	*M*(*n*)	*SD*	*F*(*df*1, *df*2)	*M*(*n*)	*SD*
Frequency of screening (1–5)***	3.74 (100)[e]	1.12	2.56 (159)[d]	1.23	2.90 (20)	1.33	–	–	*F*(2, 51.636)= 31.052, *p*<0.001[a]	3.01 (279)	1.32
Perceived frequency of positive identification***	69.36 (89)[e,f]	23.73	23.63 (104)[d]	25.81	29.06 (17)[d]	24.45	–	–	*F*(2, 207)= 84.396, *p*<0.001	43.45	33.31
Frequency of risk assessment (1–5)***	3.75 (85)[e,f,g]	1.11	2.62 (139)[d]	1.55	2.33 (18)[d]	1.37	3.17 (174)[d]	1.51	*F*(3, 76.553)= 15.590, *p*<0.001[a]	3.07 (416)	1.51
Core business attitude item (1–5)***[b]	4.60 (80)[e]	0.59	3.33 (126)[d,f]	1.37	4.20 (15)[e]	0.86	–	–	*F*(2, 38.860)= 41.019, *p*<0.001[a]	3.85 (221)	1.27
Denial attitude item (1–5)***[b]	4.60 (80)[e]	0.74	4.03 (126)[d]	1.00	4.07 (14)	1.54	–	–	*F*(2, 33.772= 10.968, *p*<0.001[a]	4.24 (220)	0.99
Level of DFV specialist training (0–5)***	2.14 (100)[e,g]	1.33	0.91 (159)[d,g]	1.25	1.30 (20)	1.49	1.60 (174)[d,e]	1.18	*F*(3, 449)= 20.978, *p*<0.001	1.46 (453)	1.33

***statistically significant at *p*<0.001

a: Significance reported using Welch ANOVA as assumption of homogeneity of variances was violated

b: For all attitude variables (overall attitude item, core business attitude item, and denial attitude item) a higher score indicates a more positive attitude

c: Corrections respondents only completed the risk assessment questions and were therefore excluded from the analyses of screening practice and attitude items

d: Significantly different from child protection participants

e: Significantly different from mental health participants

f: Significantly different from AOD participants

g: Significantly different from corrections participants

Note: ANOVA=analysis of variance. AOD=alcohol and other drugs. DFV=domestic and family violence

As shown in Table 3, all dependent variables were significantly different between practice areas. Games–Howell and Tukey post-hoc analyses were conducted to explore where differences between groups lie, with results also shown in Table 3. Across the items measured, mean scores were consistently lowest for either mental health or AOD participants and higher for corrections practitioners (on risk assessment items) and child protection participants (across screening and risk assessment items).

These findings suggest that, within the survey sample, mental health and AOD practitioners screen for and assess risk of DFV perpetration less frequently than corrections and child protection practitioners. Mental health and AOD practitioners also expressed less positive attitudes to screening and risk assessment for DFV perpetration. These practitioners were more likely to perceive that this is not core business and that screening for DFV perpetration is pointless because perpetrators will deny their use of DFV. The level of DFV specialist training was low across the practice areas (M=1.46, SD=1.33), with many participants reporting no formal training (n=137, 30%). The level of DFV specialist training received was lowest for mental health (M=0.91, SD=1.25) and AOD practitioners (M=1.30, SD=1.49). The role and intersection of specialist training, attitudes and practices around perpetrator screening and risk assessment are further explored in the qualitative findings below.

Qualitative results: Open-ended survey questions and focus groups

Further insights into attitudes and practices around screening and risk assessment for DFV perpetration were gained through open-ended survey and focus group data. Three key themes are explored here:

- perceptions that screening and risk assessment for DFV perpetration is not 'core business';
- concerns around perpetrator denial of DFV when screening for perpetration; and
- the role of enhanced specialist DFV training and education.

Screening and risk assessment for DFV perpetration not 'core business'

Most survey participants either strongly agreed or somewhat agreed (n=174, 74%) that screening for DFV perpetration during routine contact with clients is core business in their area of service delivery. However, one in five practitioners (n=46, 20%) disagreed with this statement. ANOVA results presented in Table 3 further show that mental health practitioners were significantly less likely to agree that DFV perpetrator screening was core business in their area of practice, compared to AOD and child protection practitioners. This attitude was reiterated in the qualitative responses:

> We are a MH [mental health] service, so our core business is to identify MH issues. (Mental health practitioner, survey participant)

> Our core business is mental health… Everybody's under the pump, and you just see people… meeting just the bare minimum to cover your back and meeting the minimum standards… It's quite frequently not seen as our core business. (Mental health practitioner, focus group participant)

Some participants identified these attitudes as rendering DFV perpetration invisible in mental health settings, as illustrated by this quote:

> It should be core business of everyone not specific DFV organisation. I work in MH, quite often I heard leaders say this is not our core business this also precipitate[s] in front line staffs understanding and administering of DFV screening by minimising or ignoring the obvious signs at time[s]. So it is everyone's business. (Mental health practitioner, survey participant)

These findings highlight that within mental health service settings, the predominant focus is on identifying and responding to mental health concerns, often in isolation of other present risk factors, such as DFV. This poses a significant missed opportunity when considering the prevalence of mental health problems in men using DFV (Aziz & El-Gazzar 2019; Hester et al. 2015).

While predominantly reflected in the mental health space, child protection participants shared similar views that in an environment where case loads are high, and clients present with other priority issues (in this case, child welfare concerns), there are substantive barriers to staff equally prioritising the identification of DFV perpetration as core business. As one practitioner described:

> It's very challenging, there have been and I still believe there is a model concept of get in and get out and that's what we're looking at, how can we do this the fastest way possible? (Child protection practitioner, focus group participant)

Without the time dedicated to conducting screening and risk assessments for DFV perpetration and the view that such practices are 'core business', these assessments may not take place.

Perpetrator denial of DFV

Qualitative findings indicate that concerns about clients denying DFV perpetration remain a persistent barrier to screening and risk assessment. This was articulated by practitioners across numerous practice areas:

> I am concerned that screening tools, on their own, may not capture all the relevant needed information – particularly when clients are not being truthful. (Child protection practitioner, survey participant)

> Offences are routinely denied by the perpetrator. (Corrections practitioner, survey participant)

> We are a phone MH assessment service. We do screen routinely for the presence of aggression and also for victimisation of the consumer. We rely on the respondent to be honest in their responses, although there are some indicators which could lead to the impression that a person is a perpetrator of DFV. (Mental health practitioner, survey participant)

Practitioners felt that perpetrators tend to deny their use of DFV in response to direct screening questions, requiring practitioners to pick up on indicators of DFV perpetration during intake and assessment interviews more broadly. DFV specialist training becomes pertinent here due to the need to rely on DFV-informed professional judgement as opposed to self-reporting.

Need for enhanced training and education

Practitioners expressed a desire for improved and increased DFV training, including screening and risk assessment training. Participants viewed current training opportunities as limited, believing that baseline understandings of DFV across the wider workforce need to be improved. This view is captured in comments from practitioners across numerous service areas:

> More training needs to be available to staff members in this area and more readily available. (Child protection practitioner, survey participant)
>
> More specialised training would be beneficial. (Corrections practitioner, survey participant)
>
> People coming into our agency generally don't have a good understanding of domestic and family violence, and it's something that they're learning either on the job or through a DV person… There's nothing really consistent, as a whole agency. (Corrections practitioner, focus group participant)

While it is not feasible to train whole workforces to be DFV specialist practitioners, improving the baseline level of DFV knowledge, understanding and practice skills is critical given the frequent co-occurrence of DFV and mental health concerns, problematic substance use, child welfare concerns and offending behaviour beyond DFV (DFVDRAB 2021; Gilchrist et al. 2019; Hester et al. 2015; Spangaro 2017; Verbruggen et al. 2020). Almost a third of survey participants reported receiving no formal DFV training (*n*=137, 30%) despite working in practice areas that frequently respond to potential DFV perpetrators.

The lack of and limitations around direct screening questions identified in this study further highlight the critical role of DFV specialist training in enabling practitioners to pick up on more subtle indicators of DFV during intake and assessment interviews. This is illustrated in the following comments from child protection and corrections practitioners:

> It's definitely a practice that every single intake, DV would be considered. And especially those, when dads are phoning, and he might be phoning about issues with mum in relation to mental health or drugs and alcohol. But we would be looking behind that, is this a situation where dad's using systems to become involved with mum, or to use some of that control. (Child protection practitioner, focus group participant)
>
> I think it is always going to sit with the level of confidence with the person who is interviewing the perpetrator and being able to feel comfortable asking questions that the individual across the room from you does not want to answer and they're quite adamant that they're going to utilise their go-to coping strategies and methods of deflection to fight that argument… knowing how to manage that and upskilling the interviewer in being able to I guess go around the garden path a little bit to find out certain information that is pertinent to assessing the level of risk. (Corrections practitioner, focus group participant)

These findings highlight the critical role of DFV-informed professional judgement in identifying potential DFV perpetration among male clients. Such an approach requires consistent skills and practices across service settings and locations to maximise the likelihood of DFV perpetration being identified early on in the service engagement process.

Discussion and implications for policy and practice

Australia's DFV reform agenda has increasingly shifted the focus onto perpetrators of DFV, including through increased focus on the need for perpetrator visibility and accountability and a suite of diverse interventions (Council of Australian Governments 2011; Royal Commission into Family Violence 2016). However, the responsibility to identify and respond to perpetrators of DFV continues to sit predominantly with law enforcement agencies and perpetrator-specific interventions, such as men's behaviour change programs (Storey et al. 2014). While men using DFV often have diverse service system contact throughout their histories of perpetrating DFV against partners, ex-partners and other family members (DFVDRAB 2021), current evidence suggests that their use of DFV often remains invisible to these systems, which are focused primarily on other presenting issues (Davis & Padilla-Medina 2021; DFVDRAB 2021; Royal Commission into Family Violence 2016).

The current study shows that screening of male clients for potential perpetration of DFV in service areas responding to co-occurring issues remains limited and varies greatly across service areas. Further, when in use, instruments tend to be designed to assess risk rather than screen for the potential presence of DFV perpetration. These observations are in line with wider national and international research evidence, which shows that screening for DFV remains primarily victim-focused (Vaughan et al. 2016; Jenney et al. 2014; Penti, Timmons & Adams 2018; Rabin et al. 2009) and limited to specific offender-focused service areas (Storey et al. 2014; Tarzia et al. 2017).

Where initial screening practices for DFV perpetration were used, practitioners raised concerns about perpetrators' frequent denial and minimisation of their use of DFV. Participants reported relying on their professional judgement around indicators of DFV perpetration that may emerge during intake or assessment interviews with clients. DFV specialist training was identified as a key enabler of screening for DFV perpetration, particularly in the absence of standard screening tools.

Overall, practitioners' likelihood of screening for DFV perpetration was supported by their level of DFV expertise and training history, their attitudes to the benefits and relevance of screening and risk assessment more broadly and attitudes that identifying and responding to perpetrators of DFV was core business within their area of practice. These observations support prior research, which highlights the critical role of DFV specialist training and wider sector commitment to DFV-informed practice in supporting frontline practitioners (Aziz & El-Gazzar 2019; Bakon et al 2020, 2019; Maple & Kebbell 2021).

Conclusion

The absence of standard screening questions and actuarial risk assessment tools to elicit indicators of DFV perpetration and related risk across Queensland services is problematic. To equip frontline practitioners across non-DFV specialist service areas to conduct screening for perpetration through a combination of direct screening questions and professional judgement, practitioners require consistent access to DFV specialist training and regular professional development. This should include developing knowledge in established and emerging forms of abuse, available referral pathways and support mechanisms, as well as relevant legislative changes. Potential DFV perpetration will likely remain invisible to many frontline practitioners unless practitioners are equipped with knowledge and awareness of perpetrator patterns of denial, minimisation, manipulation and system abuse. Further, practitioners require knowledge of adequate referral pathways for men using DFV to confidently identify potential DFV perpetration.

Implementing consistent screening protocols, including combining direct screening questions with DFV-informed professional judgement, is recommended across practice areas. This will require organisational leadership and a whole-of-system commitment. Our findings show that the application of a DFV-informed lens—to client interactions broadly and to male clients who may be perpetrating DFV specifically—is more pronounced in organisations and service areas with strong commitment to DFV reforms and leadership around DFV-informed practice. Organisational leadership in DFV-informed practice is a key aspect of ensuring that identifying and responding to male clients using DFV becomes core business across all non-DFV specialist practice areas. The change required must go beyond the practice areas captured in the current study and extend to other areas frequently responding to victim-survivors and perpetrators of DFV, including disability services, Centrelink, housing services, non-statutory child and family welfare services, family law services, legal services and First Nations and culturally and linguistically diverse support services.

Acknowledgements

The authors acknowledge the support of the participating government organisations, including Queensland Health, Queensland Corrective Services and the Queensland Department of Children, Youth Justice and Multicultural Affairs, and all participating practitioners.

The authors acknowledge and would like to thank Dr Harley Williamson for her expertise and oversight which guided the quantitative data analysis and write-up. The authors would also like to acknowledge Dr Tess Bartlett and her involvement in the initial study implementation and evidence review.

References

URLs correct as at August 2022

Australian Institute of Health and Welfare 2021. *Family, domestic and sexual violence data in Australia*. AIHW cat no. FDV6. Canberra: AIHW. https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-data

Australian Institute of Health and Welfare 2019. *Family, domestic and family violence in Australia: Continuing the national story 2019: In brief*. AIHW cat. no. FDV4. Canberra: AIHW. https://www.aihw.gov.au/reports/domestic-violence/family-domestic-and-sexual-violence-in-australia-c/summary

Aziz MM & El-Gazzar AF 2019. Health care providers' perceptions and practices of screening for domestic violence in Upper Egypt. *Sexual & Reproductive Healthcare* 20: 93–99. https://doi.org/10.1016/j.srhc.2019.04.003

Bakon S, Taylor A, Meyer S & Scott M 2020. The provision of emergency healthcare for women who experience intimate partner violence: Part 2: Strategies to address knowledge deficits and negative attitudes. *Emergency Nurse* 28(4). https://journals.rcni.com/toc/en/28/4

Bakon S, Taylor A, Meyer S & Scott M 2019. The provision of emergency healthcare for women who experience intimate partner violence: Part 1: An integrative review. *Emergency Nurse* 27(6). https://doi.org/10.7748/en.2019.e1950

Beck CJA & Raghavan C 2010. Intimate partner abuse careening in custody mediation: The importance of assessing coercive control. *Family Court Review* 48(3): 555–565. https://doi.org/10.1111/j.1744-1617.2010.01329.x

Burge SK, Schneider FD, Ivy L & Catala S 2005. Patients' advice to physicians about intervening in family conflict. *Annals of Family Medicine* 3: 248–254. https://doi.org/10.1370/afm.287

Chang JC, Cluss PA, Burke JG, Hawker L, Dado D, Goldstrohm S & Scholle SH 2011. Partner violence screening in mental health. *General Hospital Psychiatry* 33: 58–65. https://doi.org/10.1016/j.genhosppsych.2010.11.009

Council of Australian Governments 2011. *The National Plan to Reduce Violence against Women and their Children: Including the first three-year action plan*. Canberra: DSS. https://www.dss.gov.au/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children-2010-2022

Davis M & Padilla-Medina DM 2021. Brief Intimate Partner Violence Perpetration Screening Tools: A Scoping Review. *Trauma, Violence, & Abuse* 22(4): 900–913. https://doi.org/10.1177/1524838019888545

DFVDRAB—see Domestic and Family Violence Death Review and Advisory Board

Domestic and Family Violence Death Review and Advisory Board 2021. *2020–21 Annual report*. Brisbane: Domestic and Family Violence Death Review and Advisory Board. https://www.courts.qld.gov.au/courts/coroners-court/review-of-deaths-from-domestic-and-family-violence

Gilchrist G, Dennis F, Radcliff P, Henderson J, Howard LM & Gadd D 2019. The interplay between substance use and intimate partner violence perpetration: A meta-ethnography. *International Journal of Drug Policy* 65: 8–23. https://doi.org/10.1016/j.drugpo.2018.12.009

Hegarty K, Taft A & Feder G 2008. Violence between intimate partners: Working with the whole family. *British Medical Journal* 337: a839. https://doi.org/10.1136/bmj.a839

Hester M et al. 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: 1–10. https://doi.org/10.1136/bmjopen-2014-007141

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: 92–101. https://doi.org/10.1016/j.childyouth.2014.07.015

Kebbell MR 2019. Risk assessment for intimate partner violence: How can the police assess risk? *Psychology, Crime & Law* 25(8): 829–846. https://doi.org/10.1080/1068316X.2019.1597087

Kimberg LS 2007. Addressing intimate partner violence with male patients: A review and introduction of pilot guidelines. *International Journal of General Medicine* 23(12): 2071–2078. https://doi.org/10.1007/s11606-008-0755-1

Kraanen FL, Vedel E, Scholing A & Emmelkamp PMG 2013. Screening on perpetration and victimization of intimate partner violence (IPV): Two studies on the validity of an IPV screening instrument in patients in substance abuse treatment. *PLoS ONE* 8(5): e6368–e63681. https://doi.org/10.1371/journal.pone.0063681

Maple E & Kebbell M 2021. Responding to domestic and family violence: A qualitative study on the changing perceptions of frontline police officers. *Violence Against Women* 27(12–13): 2377–2398. https://doi.org/10.1177/1077801220975483

McEwan TE, Shea DE & Ogloff JRP 2019. The development of the VP-SAFvR: An actuarial instrument for police triage of Australian family violence reports. *Criminal Justice and Behavior* 46(4): 590–607. https://doi.org/10.1177/0093854818806031

Messing JT & Thaller J 2013. The average predictive validity of intimate partner violence risk assessment instruments. *Journal of Interpersonal Violence* 28(7): 1537–1558. https://doi.org/10.1177/0886260512468250

Meyer S, Helps N & Fitz-Gibbon K 2022. *Domestic and family violence perpetrator focused screening and risk assessment: Identifying current practice and future opportunities*. Report to the Criminology Research Advisory Council. CRG 33/19–20. Canberra: Australian Institute of Criminology. https://www.aic.gov.au/crg/reports/crg-3319-20

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 Behavior* 19: 637–642. https://doi.org/10.1016/j.avb.2014.09.008

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): 635–644. https://doi.org/10.3122/jabfm.2018.04.170440

Portnoy GA, Colon R, Gross GM, Adams LJ, Bastian LA & Iverson KM 2020. Patient and provider barriers, facilitators, and implementation preferences of intimate partner violence perpetration screening. *BMC Health Services Research* 20: 746. https://doi.org/10.1186/s12913-020-05595-7

Rabin RF, Jennings JM, Campbell JC & Bair-Merritt MH 2009. Intimate partner violence screening tools: A systematic review. *American Journal of Preventive Medicine* 36(5): 439–445. https://doi.org/10.1016/j.amepre.2009.01.024

Royal Commission into Family Violence 2016. *Report and recommendations*. Melbourne: Victorian Government. http://rcfv.archive.royalcommission.vic.gov.au/Report-Recommendations.html

Spangaro J 2017. What is the role of health systems in responding to domestic violence? An evidence review. *Australian Health Review* 41: 639–645. https://doi.org/10.1071/AH16155

Special Taskforce on Domestic and Family Violence in Queensland 2015. *Not now, not ever: Putting an end to domestic and family violence in Queensland*. Brisbane: Queensland Government. https://www.justice.qld.gov.au/initiatives/end-domestic-family-violence/about/not-now-not-ever-report

Storey J, Kropp PR, 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 Behavior* 41(2): 256–271. https://doi.org/10.1177/0093854813503960

Tarzia L, Forsdike K, Feder G & Hegarty K 2017. Interventions in health settings for male perpetrators or victims of intimate partner violence. *Trauma, Violence and Abuse* 21(1): 1–15. https://doi.org/10.1177/1524838017744772

Todahl J & Walters E 2011. Universal screening for intimate partner violence: A systematic review. *Journal of Marital and Family Therapy* 37(3): 355–369. https://doi.org/10.1111/j.1752-0606.2009.00179.x

Vaughan C et al. 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*. Sydney: Australia's National Research Organisation for Women's Safety. https://www.anrows.org.au/publication/promoting-community-led-responses-to-violence-against-immigrant-and-refugee-women-in-metropolitan-and-regional-australia-the-aspire-project-state-of-knowledge-paper/

Verbruggen J, Blokland A, Robinson AL & Maxwell CD 2020. The relationship between criminal behaviour over the life-course and intimate partner violence perpetration in later life. *European Journal of Criminology* 17(6): 784–805. https://doi.org/10.1177/1477370818825344

World Health Organization 2021. Violence against women: Key facts. https://www.who.int/news-room/fact-sheets/detail/violence-against-women

Silke Meyer is a Professor of Social Work at Griffith University and an Adjunct Professor at the Monash Gender and Family Violence Prevention Centre.

Nicola Helps is a Postdoctoral Research Fellow at the Monash Gender and Family Violence Prevention Centre.

Kate Fitz-Gibbon is the Director of the Monash Gender and Family Violence Prevention Centre and an Associate Professor in Criminology.

General editor, *Trends & issues in crime and criminal justice* series: Dr Rick Brown, Deputy Director, Australian Institute of Criminology. Note: *Trends & issues in crime and criminal justice* papers are peer reviewed. For a complete list and the full text of the papers in the *Trends & issues in crime and criminal justice* series, visit the AIC website: www.aic.gov.au

ISSN 1836-2206 (Online) ISBN 978 1 922478 81 8 (Online)

https://doi.org/10.52922/ti78818

©Australian Institute of Criminology 2023

GPO Box 1936
Canberra ACT 2601, Australia

Tel: 02 6268 7166

Disclaimer: This research paper does not necessarily reflect the policy position of the Australian Government