TILES

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Researching Family Violence

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The Tasmanian Institute of Law Enforcement Studies (TILES) publishes regular Briefing Papers on topics related to the Institute's research program. I am very pleased to announce the publication of our second Briefing Paper that addresses research in the field of family violence. TILES is well placed to observe and evaluate a range of social and institutional changes, program components, client groups, and communities influenced by the introduction of the Tasmanian Government's *Safe at Home* initiative during 2004-5.

In this Briefing Paper, Romy Winter, a PhD student in TILES, canvasses some of the research issues surrounding family violence and the programs that have been developed to address the problem.

Roberta Julian, Director

While family violence is a pervasive and complex problem that affects millions of people across the globe, the issue is particularly topical in Tasmania at the current time, with new family violence legislation proclaimed in 2005, accompanied by a radical revamp of policies which have changed the way police, the courts and the health and community welfare sectors respond to family violence incidents. The policy has been modelled on best practice policies and programs in the USA, the UK and New Zealand. The resulting changes to police response, prosecutions and clinical services have proved to be controversial, attracting significant debate about responses to family violence among various sectors of the community. This paper outlines the changes which have occurred in Tasmania as well as providing summaries of the most recent thinking about issues surrounding family violence.

Domestic violence, domestic abuse, or intimate partner violence arises when one partner in a relationship seeks to physically or psychologically dominate or control the other. This domination can manifest itself in a spectrum of abusive behaviours ranging from non physical types of abuse (such as repeated demeaning or derogatory remarks, restriction of access to finances, family or friends and destruction of property) to physical or sexual assault with a high likelihood of causing injury or death.

Crime and victimisation studies of general populations reveal that official crime statistics expose only the tip of the iceberg with less than one third of any kind of assault being reported to the police[1, 2]. The recently released results of the 2005 Crime and Safety Survey[3] estimates that 770,600 people were assaulted (4.8% of the total population) in more than 2.6 million assaults in Australia in the previous 12 months. In all assault cases in 2005, 84% of the offenders and 54% of the victims were male. The offender was known to the victim in 47% of cases involving male victims and 73% of cases where the victim was female. 18.6% of females were assaulted by a current or former partner, compared to 3.7% of males. The police received a report of the assault in approximately 31% of cases (29.2% if the victim was male and 34% where the victim was female).

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The literature on all kinds of violence observes that most violence is perpetrated by men. Violence against women is extremely pervasive, with the United Nations estimating that millions of women around the world are being physically and sexually abused each year, mostly by men with whom they are in a relationship, or were previously[4, 5]. Australian research by Bagshaw and Chung in 2000 found that while both males and females in intimate relationships perpetrate abuse, men are more likely to be violent towards their (male or female) partners. They also found that:

- men's violence is more severe and more likely to inflict severe injury;
- women were ten times more likely to be victims than men;
- 7% of victims had experienced physical or sexual violence in the last 12 months, most frequently in the home;
- male homicide offenders were responsible for killing 94% of the adult female victims;
- women are more likely to be killed by current or former male partners than anyone else; and
- less than 10% of male homicides in Australia are committed by an intimate partner but in 70% of these cases there is a history of domestic violence perpetrated by the male[6].

For this reason, this paper will mostly use examples of violence against women in discussing the various issues around family violence.

The research agenda

As a result of intensive research, with literally thousands of studies conducted, the family violence research and policy arena has witnessed considerable advances in the past 20 years.

The most important initial step was to recognise that domestic violence was problematic and not a 'normal reaction to stress' or a 'private matter'. The women's movement was instrumental in raising most of these issues and lobbying for widespread change which would eliminate violence against women. Re-definition of violence in the family as a social problem required dramatic changes in perspective and led to a vast number of research projects to help understand domestic violence and design interventions. Domestic violence subsequently became defined as a public health issue, a medical condition and a criminal offence[7], which developed into a variety of social programs and interventions as a result. Early studies helped with the understanding of the nature of perpetration, the cycle of violence, the effect of family violence on children and strategies survivors may develop to resist or escape from violent situations[8]. The broad category of 'domestic violence' was enlarged to include all forms of family violence as well as broken down into subtypes of intimate partner violence, child abuse, sibling violence, elder abuse and so on. The first wave of state responses to domestic violence involved supporting victims to leave violent relationships by providing practical assistance and counselling. While this approach was extremely important it had no impact on the reduction of the incidence of the violence (as interventions take place after the violence has occurred) nor did the policies attempt to change the behaviour of offenders.

In the last ten years, four main areas have been the focus of policies for dealing with family violence. These are:

1. Legal – such as changing reporting requirements, protection and restraining orders, arrest, treatment for offenders. Criminalisation, specialised courts, integrated criminal justice response with other agencies, criminal justice personnel training
2. Social service – shelters, peer support, advocacy
3. Health – screening, identification, medical services, mental health services
4. Collaborations – coordinated community responses, substance abuse treatment, violence treatment, shelters[9].

Examples of emerging fields are that of dyadic violence (where both members of the couple perpetrate violence); female to male violence; violence in same sex relationships, and child to parent violence (most particularly adolescent boys' violence towards their mothers). Recent contributions to the family violence research field have included a focus on the histories and trajectories of offenders and victims, in both family and community contexts, as well as evaluations of interventions and their effect on recidivism. Problem oriented policing and an outcome focus means there are opportunities to conduct research designed to identify 'what works'[10]. This can involve data-driven projects, where data need to be analysed, interpreted and acted upon. It may mean the design and implementation of new initiatives or changes to existing strategies and procedures.

It is unfortunate that much program evaluation has produced equivocal results reflecting the tendency of governments to jump on the bandwagon at the prospect of a successful program to find it isn't replicated in their own jurisdiction. Examples abound such as batterer programs and mandatory arrest policies[11]. Research to date on the prevention of recidivism and effectiveness of current treatment models is not promising[12]. Batterer treatment programs have mixed success dependent on the demographics of the cohort and the length of the program[13]. Recidivism appears to range from between

40-80%. It has also been found that some policies have unintended consequences, such as increasing violence.

One of the main frustrations in working in this area is that, despite two decades of research which has produced spectacular breakthroughs in understanding targeted components, the field still lacks a well developed theory of domestic violence. Progress is hampered by lack of data to accurately measure the prevalence of the different types of family violence. Many jurisdictions lack the ability to mine the information in their own records; there is a lack of capability to monitor and track cases across agencies. There is also evidence of tension between uniformity of response and community applicability/suitability, meaning there are 'standard' practices that need to be evaluated to find out whether they are effective, applied consistently or, worst case scenario, cause harm. There is the challenge of studying a complex institutional response which comprises a combination of interventions, even though such responses hold the most promise for reducing family violence. At present, there are still many untapped opportunities to improve our knowledge and practice in this area.

Safe at Home

The new whole-of-government family violence strategy in Tasmania is a good example of coordinated community response founded on 'best practice' components identified by national and international research and community consultation. The initiative, entitled *Safe at Home* involves police adopting an enhanced pro-arrest, pro-prosecution and pro-interventionist approach to incidents of family violence. A coordinated agency response by key stakeholders enables victims to access an expanded range of services.
The initiative is contained within The *Family Violence Act 2004*[14]. This signifies a radical change of direction that places family violence in the criminal justice framework and has significant consequences for offenders; enables greater protection and recognition of adult and child victims; provides police with enhanced powers; and, impacts upon the judicial system, support agencies and the community.

The key components of the policy are outlined in Table 1.

Table 1: Key components of *Safe at Home*

Specific legislation	Focuses on the criminal nature of family violence. Allows for specific family violence orders, increased penalties for breaches and harsher penalties for violent acts in the presence of children
Family violence response line	24 hour, seven day a week referral telephone number. Operators specifically trained to assess situation quickly and make immediate and active referrals
Victim safety response teams	Additional police recruited and trained to take a proactive role in managing safety issues for adult and child victims that includes: • Removal of offender • Investigations, evidence gathering and supporting information • Assist in preparation of family violence orders • Risk and safety assessments (RAST) including audits, victim safety plans and increased security if required • Investigating breaches of family violence orders
Police prosecutions	Additional police prosecutors employed to cover increased workload
Additional court activity	Funding provided to ensure courts have resources to cope with increased workload and to ensure that breaches of FVOs are dealt with as quickly as possible.
Legal Aid	Extension of legal aid to all eligible victims to ensure that they are not disadvantaged by lack of legal representation and advice
Aboriginal family violence working group	Supports the implementation of culturally appropriate responses for aboriginal people under *Safe at Home*.
Court support and victim liaison service	New state-wide service to assist victims navigate the legal and court processes and also provide information and referral to services for family violence victims
Child witness program	A new service to provide information and support to children participating in legal processes
Adult victim support service	Enhanced counselling and support program for adult victims including new telephone counselling service
Children's counselling and support service	New service to provide specialised counselling and support to child victims
Accommodation brokerage for offenders	Service to cater for those offenders removed from the family home that may have difficulty in obtaining appropriate accommodation.
Offender assessment and intervention program	New program to assess the ongoing risk an offender poses to their family (using SARA – Spousal Assault Risk Assessment tool) and to provide rehabilitation programs for suitable offenders based on a model from New Zealand

A number of research projects have been undertaken around *Safe at Home* in the past 12 months.

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Risk Assessment Screening Tools

The 1990s saw a rapid expansion of violence risk assessment tools. The aim of specifically designed domestic violence risk assessment tools is to gauge the likelihood of reoffending by looking at specific risk factors and calculating a score that approximates the degree of risk. The tools tend to be short and used at the scene of the incident. The rationale behind many of the tools is that they provide structure and information for decisions that are already being made. A number of tools predict violent recidivism with moderate accuracy, with similar predictive accuracy, and most of the measures they used correlated substantially with each other. Increasingly, police jurisdictions around the world began using psychometric tools to assess the risk to the ongoing safety of victims of family violence. As noted above, the *Safe at Home* program includes the practice of attending officers compiling detailed risk assessments at the time of the incident. TILES has had an advisory role in the development of the Tasmania Police Risk Assessment Screening Tool (RAST) and an ongoing role in refining this tool.

The RAST and its counterparts use a range of identified risk 'markers' or 'factors'. Because the group of people that abuse their spouses is heterogenous, risk markers are an array of psychological and psychosocial characteristics, in addition to factors which impact on the dynamics of the relationship. They broadly fall into groups which are clinical factors, historical factors, dispositional factors and context factors. All the factors have been found to act as signals that abuse is likely to escalate quickly and with potentially serious consequences [15].

The primary task of the RAST is to assess the victim's risk of experiencing future violence. It is a victim-based tool aimed at assessing risk. It is not primarily a tool to assess the dangerousness of the offender/perpetrator (although clearly the two are inter-related). It provides information that, in addition to other matters, may affect the prospect of a suspect receiving bail. It is not used as a basis for decisions regarding arrest.

TILES has begun a longitudinal analysis of the RAST to assist in further development of the tool. An analysis of a random sample of 1000 RASTs in 2005 has been undertaken to get a snapshot of the current distribution of risk factors in Tasmania.

Table 2 below shows the frequencies of Group A risks (those that may indicate that a sharp escalation in risk is imminent). The analysis indicates that the most common factor is previous assault of the victim, where in 634 cases, or 65%, there has been prior assault.

Table 2: Frequency of Group A Risk Factors in Tasmanian Family Violence Risk Assessments 2005

		Cases	Percent of Cases
Group A risk factors	victim assaulted in past [16, 17]	634	65
	victim assaulted in this incident [15, 18-20]	481	50
	level of violence escalated [21, 22]	428	44
	bizarre, paranoid or delusional [23] behaviour	339	35
	separation after cohabitation [16, 21, 24-27]	294	30
	victim terrified [15, 18-20]	272	28
	offender breached restraint or P/FVO [16, 28]	227	23
	suicide attempt [29-34]	202	21
	pregnancy or new birth [35-37]	201	21
	threats to kill victim or child(ren) [38, 39]	189	20
	offender stalked victim/others [25, 40]	156	16
	possession or access to firearms [41]	134	14
	child assaulted in the past [21, 42, 43]	81	8
	cultural or disability issues [44-47]	53	5
	child assaulted in this incident [21, 42, 43]	30	3
	offender killed family pet [48, 49]	25	3
	sexual assault or rape arrest [50, 51]	18	2
	previous murder/manslaughter arrest [52-56]	14	1
Total		3778	*

** Does not total to 100% because more than one factor may apply*

In 50% of cases, the victim was assaulted in the current incident. In 44% of cases, the level of violence has increased in recent times while in 35% of cases there was current bizarre, paranoid or delusional behaviour. In almost a quarter of cases, the offender has breached a family violence or other protective order. In 21% of cases there is a pregnancy or new birth in the household and in 1 in 5 of the cases there have been threats to kill the victim or children. Stalking is evident in 16% of cases, while possession or access to firearms is a risk in 14% of cases. The assault of children and killing of pets are documented as indicators that serious harm is imminent, and these types of assaults occurred in 3% of the sample of 1000 cases in Tasmania in 2005. While only small in percentage terms, there were 18 cases where the offender had previous arrest history for rape or sexual assault, and 14 cases where there was a previous arrest for murder or manslaughter.

Table 3 below shows the distribution of Group B risk factors. Group B factors, while being indicators of risk of less severity than Group A factors, remain significant warning signs of potential escalation. The most prevalent Group B factor is jealous and intimidating behaviour by the offender in 71% of cases. In over half the cases, the offender is unemployed. In 43% there is a history of violence against other people. In 42% of cases there is an alcohol problem, and in one-third a drug use problem with 8% not taking prescribed medication.

Table 3: Frequency of Group B Risk Factors in Tasmanian Family Violence Risk Assessments 2005

		Cases	Percent of Cases
Group B risk factors	offender jealous, obsessive, intimidating or bitter [21, 33, 43, 52, 57-62]	689	71
	offender unemployed [27, 63]	494	51
	violence against any other person in past [52-56]	418	43
	victim afraid [15, 18-20]	411	42
	alcohol problem [15, 27, 31, 32, 54, 60, 64, 65]	411	42
	offender or relationship financial difficulty [43, 60]	342	35
	threats to kill in the past [38, 39]	338	35
	drug use problem [15, 27, 31, 32, 54, 60, 64, 65]	325	33
	current or history of depression [29-34]	311	32
	suicidal fantasy or threats [29-34]	233	24
	victim or child/ren physically injured [38, 39]	228	23
	diagnosed mental illness/disorder [29-34]	127	13
	homicidal fantasy or threats [29-34]	109	11
	not taking prescribed medication [29-34]	79	8
	injury or threat to pets [48, 49]	72	7
	strangling or suffocation [27, 36]	60	6
Total		4647	*

** Does not total to 100% because more than one factor may apply*

Whilst methodical risk assessment tools such as the RAST have provided police and courts with the opportunity to better manage risk, there is also a growing critique of the practice[54, 62, 66-68]. We know that the scales can predict violence, but we know less about what exactly they are measuring. The link between risk markers and causal factors is not watertight, because it has proved extremely difficult to gauge the main predictor variables. Various analyses found all correlations to be less than 10%[60]. The only demographic factors that have emerged consistently over a large number of studies are being younger, not fully employed and in their relationship for a shorter length of time. Researchers conclude that the various factors can co-occur with or precede the abuse because they are related to a true causal factor[43, 62]. A recent paper by Campbell suggested that there were three groups of risk factors involved in intimate partner violence which are similar and related, but not the same. There are factors that increase the risk of reassault or revictimisation, those that increase the risk of lethality and those that keep the victim safer by reducing the risk of violence[69]. An example of the complexity involved is prior arrest. Campbell's 12 city study found that arrest for intimate partner violence was protective for women at high risk from a dangerous partner, but increases risk of murder or attempted murder for those with lower risk[69].

Other criticisms abound, ranging from macro level challenges based on the application of positivist and actuarial (static) methodologies to a dynamic and complex social problem to questions about the validity of individual tools being used (particularly the high rates of false positives and false negatives) and the implications of this for transference among different groups[70].

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However, it is agreed that the potential for violence or violent recidivism is a complex issue that requires some type of multivariate technique because risk of reoffending is not static and changes over time. This requires the development of measurements that have the ability to assess change in the likelihood of violent behaviour (both positively and negatively). The quest for accurate risk assessment tools is far from over and it is predicted that the next generation of risk assessment instruments will be required to fit a dynamic actuarial approach[71, 72].

Validation of the RAST

RAST is an assessment tool which has the specific purpose of rating an offender as either at low, medium or high risk of reoffending based on information provided by the victim. Ultimately, the test for RAST is its ability to separate sheep from goats, that is, those at high risk of reoffending and those who are not. Thus, if RAST identified 100 *potential* goats and six ended up *being* goats then it is a blunt instrument - there are too many sheep being defined as goats - and an instrument that lumps too many sheep with too few goats (i.e. has a high rate of misclassification) is a crude instrument.

In an effort to assess the ability of RAST to accurately separate sheep from goats, TILES is undertaking a validation of RAST.

A combination of traditional and non-traditional multivariate techniques will be employed. These are Logistic Regression and Classification and Regression Tree analysis (CART). While logistic regression is commonly used in these types of analyses CART is a more recent development and unlike logistic regression which is a mathematically based approach, CART is based on binary logic (if so...then) which produces 'decision trees' (results are schematically presented in the form of tree roots), which enable easy identification of interactions between risk variables and between risk variables and repeat offending.

The main aims of analysis are:

- To identity those risk factors (contained within the current pro forma) which contribute significantly to violent recidivism and,
- Quantify the relative weight of each in relation to the likelihood violent recidivism.
- Assess the current system of weighting for each risk factor in relation to the potential for future violence. That is, do those risk factors currently categorised as a three (high risk) actually deserve to be graded as such? Conversely, are there any low risk factors that should be classified as high risk factors?

This analysis will provide a picture of domestic violence which identifies those risk factors which contribute significantly to violent recidivism, controlling for the effect of other risk factors, and as a result, provide a relative weighting for each in relation to the potential for future violence. Additionally, it will provide an overall rating for RAST in relation to its ability to predict violent recidivism.

Reporting issues

Previous intimate partner violence is the most effective indicator of further violence with minor violence being a predictor of escalation to major violence[21]. In 35% of households, a second incident occurs within five weeks of the first. Only 10% of intimate partner abuse involves one isolated incident, with 90% involving systematic, repeated beating throughout the relationship[22]. The violence tends to escalate as it is repeated and the time between incidents decreases. It follows that understanding the precursors of violence is critical to gaining insight into intimate partner violence and estimating future risks. Because violence (physical and sexual) is one of the most under-reported criminal acts[70, 71], the factors that precede and precipitate reporting acts of violence to the police are particularly worth investigating because the victim's decision to contact law enforcement officials is often the best indicator that risk has escalated.

A review of recent local and international literature has revealed a complex array of factors involved in making a decision to report assault or abuse. Reasons for reluctance to report can range from personal factors such as trauma and vulnerability, confusion and shame; through fear of retaliation if the perpetrator is known; to torpidity from sustained abuse; social factors such as lack of resources; the myths and rhetoric surrounding sexual violence; and system factors such as deep confusion about, and suspicion of, the legal system and its processes. Factors affecting reporting become more complex as the relational distance between victim and perpetrator decreases[73]. Most victims do not involve police but seek help from family and friends[74].

The types of violent crime that target women (sexual assault and non-stranger violence) both tend to be underreported. The United Nations has recognised that violence against women is the most widespread and socially sanctioned of all human rights violations in the world[5]. In the case of intimate partner violence, we know that violence tends to escalate over the term of the relationship[21] and that between six and 20 incidents will occur before the police are called[18]. Alarmingly, approximately half of the women killed or almost killed by an intimate partner or expartners in a recent US homicide study accurately perceived their risk. Relatively few had had any contact with the criminal justice system or domestic violence services in the year before their

death[69]. The Australian component of the IVAWS survey found that few victims sought help from a specialised agency (shelter, crisis or health centre) but those who did were more likely to have been victimised by an intimate partner and were most likely to contact a counsellor.

There is evidence that sexual assaults have more disabling and chronic psychological impacts on the victim. Studies have shown that more than 90% of adult victims show symptoms of post traumatic stress disorder in the week following a sexual attack and 47% continued to show symptoms nine months after the attack[75, 76]. It has been suggested that serious long term psychological damage occurs in about 15% of assaulted women. In the short and long term aftermath of sexual assault, the question of legal redress is only one of many decisions faced by victims. It may not be the assault itself which precipitates disclosure to formal support services but the psychological symptoms resulting from the attack.
Our current institutional responses are particularly inadequate in the area of intimate partner sexual violence. Research from the US estimates between one-third and one half of female victims of intimate partner violence have also been victims of sexual violence by their partners, in many cases these assaults are frequent[11]. At the same time, intimate partner sexual violence is rarely charged or prosecuted in the criminal justice system, anywhere in the world [1, 5, 51, 77, 78].

It is now widely recognised that any kind of emotional abuse has serious psychological consequences but we find it is seldom measured separately in victim studies[79]. Victimisation studies have found that depression, low self esteem, fear, loneliness, guilt, shame combined with violence, isolation, exhaustion, unpredictability and perhaps entrapment in terms of social values, interact with issues such as economic dependency, lack of alternative housing, and other environmental factors such as support from family of origin, to produce multiple layers of victimisation[80]. Reporting and risk are tied in with perceptions of safety, and this is often easier to resolve if the abuse is severe, but we also need to recognise that many families live with violence that is not life threatening, but regular, and produces intense suffering. In spite of the many studies already conducted in this area, we are still a long way from understanding the complexities around disclosure and help seeking as well as estimating levels of under reporting.

The grey area of reporting assault and abuse in our families reminds us that we still know very little about how people perceive and make decisions about aspects of their personal lives, particularly what individuals are prepared to take a chance on and the level of security that is needed. But we do know that they minimise or deny risk when asked about their intimate relationships, particularly in respect of relationship breakdown[67].

Mandatory reporting

One solution to the under reporting of physical and sexual violence adopted by jurisdictions around the world is the requirement for certain professionals to report suspected family violence cases. The Tasmanian *Family Violence Act 2004* includes a section on mandated reporting but this part of the legislation has not yet been proclaimed. It is interesting that debate rages over mandated reporting of violence against women, as it does not over mandatory reporting of child or elder abuse. Perhaps because children are not expected to have the ability to report and the state is expected to play an *in loco parentis* role, whilst elderly persons can be physically and mentally incapacitated and can have reduced capacity or opportunity to report abuse.

The arguments in favour of mandatory reporting of violence against women are that it enables improvements in identification, which leads to improved referrals and treatments and increased documentation helps to measure the real extent of the problem. It will also provide an opportunity for patient eduction. Others argue that mandatory reporting helps prevent domestic violence by holding perpetrators accountable and providing a means of detecting and tracking domestic violence crimes. It would ensure that perpetrators are investigated and would also reinforce the message to the community that domestic violence is a crime. It also gives mandated reporters clear direction when violence is suspected i.e. 'It's my job to report'.

The arguments against are equally convincing. Women's advocacy groups generally oppose mandatory reporting because of concerns about victim autonomy and increased risks. They see these policies as paternalistic, arguing that victims are adults and should have the right to ask for help or not. Mandatory reporting also violates rights to privacy. Some argue that it increases risk of retaliatory abuse citing findings that up to 50% of abusers make threats of more violence if victim reports and more than 30% assault their partners during prosecution [81]. The opponents consider that it deters victims from seeking medical attention and in fact may not improve patient care because the police are called rather than giving victims the support that is needed. Others argue that mandatory reporting can create expectations in victims about receiving services and protection, whereas it actually can lead to more violence because of the potentially inefficient/ insufficient services to deal with the report. In most cases a delayed response time can increase the danger of retaliation. Finally, opponents suggest that mandatory reporting raises a host of professional and ethical issues for both sufferers and those reporting.

There have been several quantitative studies of victims attitudes to mandatory reporting[61, 65, 81]. Only one qualitative study of survivors was located in which 60 out of 61 did not agree with mandatory reporting). All wanted the violence in their relationships to end and would like the medical system to be involved in stopping the violence. However, they felt that

involving police and the criminal justice system was too big a risk, given that abusers would quickly return to their homes and neighbourhoods creating a severe safety risk for the survivors. These women said that if their doctors had asked about the abuse, they would have lied if they knew the information would not be kept confidential[82]. Another study of doctors found more than half might not comply with mandated reporting if their patients objected. Their main concerns were privacy issues, confidentiality and that the reporting might escalate the violence[83].

Our review of past research found no real evidence to support or refute mandatory reporting. In fact, it is obvious that we do not know how it affects abusers behaviour compared with voluntary reporting or no policy. We also don't know how it affects women's safety in the short and long term. The research suggests that it may only be effective with some groups. Effectiveness may depend on whether victim/survivor participates in the police investigation. It is not known how many people adhere to the policy. Finally, there is more research required to explore whether there are unintended consequences.

So, rather than mandatory reporting, is universal screening a better way to go? Many areas in the US and UK adopt a screening policy in hospitals and clinics. Screening can be implemented as a self-report questionnaire in the waiting room or face-to-face and be as simple as a single question, 'Do you feel safe at home?' or longer and potentially more sensitive and intrusive questionnaires. A review of several hospital screening programs found that when women are screened for intimate partner violence in emergency departments, up to 30% indicate that they are victims[84]. The Peralta and Fleming study in 2003 administered a 44 item questionnaire about intimate partner violence, fear, safety, depression and self-esteem. They found that women in abusive relationships may still not define their home environment as unsafe. The sensitivity of a safety question was poor [34 out of 40 women experiencing physical violence reported feeling safe at home]. Direct questions about being hit, punched or otherwise hurt appear to give better sensitivity and specificity than questions about safety[85]. In spite of its useful findings, there are methodological issues with this study because the women volunteered to take part, so we don't know the impact of self selection bias.

There are problems with the tools being used for screening similar to the issues associated with the police risk assessment tools. Many of them are revised or shortened versions of the Conflict Tactics Scale, which was designed to measure violence rather than screen for violence. Screening appears to be less contentious than mandatory reporting but despite it being introduced as a protocol in the US since 2001, research finds it is implemented in less than 5% of cases. Barriers can include time constraints, insufficient training, discomfort and a feeling of powerlessness[86]. Additionally some medical staff are still hampered by social conceptions of privacy i.e. 'It's not my business'[84].

We did not find any published studies that directly addressed the impact of screening on reducing harmful outcomes. As with other violence risk assessment tools, low risk populations tend to throw up false positive results – which can further compromise clinician-patient relationships and, of course, victim safety.

So we have a conundrum regarding screening and reporting, with all kinds of issues from reluctance to self report to imperfect tools used to measure. If we use imperfect tools and then report to the criminal justice system without the client/patients consent this can create significant abuse of rights to privacy by the state.

Risk and surveillance

These are some of the issues which have led to my own interest in the management and assessment of risk in the realm of intimate partner violence. This is an area which is still poorly understood because of the complex factors which feed into violent relationships. The aim of my PhD research with TILES is to understand how risk is attributed and managed by developing a dynamic approach to testing a related group of theories around risk, reflexivity and surveillance within a case study of intimate partner violence. The current climate of criminalisation of a previously private matter provides a unique opportunity for the examination of social processes as they transmute in the transfer from personal to public.

The study examines two main risk environments, one public and one private. The public or social policy aspect of this is how the state, via its criminal justice system, categorises and manages the risk of serious violence by an intimate partner. The second perspective is from the point of the intimate relationship, where I will examine risk factors, surveillance and control issues, risk management and decision making from the viewpoints of perpetrators and victims.

Using a 'rhizomatic' view of power and a range of analytical tools from the field of ethnography, the research will examine the way that talk and text are embedded in interactions, oriented specifically to institutional settings and identities, and put together rhetorically to achieve surveillance of the population (or the individual) in cases of intimate partner violence.

Discourses and categories will be identified, analysed and mapped as to how they are used to make sense of and discuss intimate partner violence. Examples of questions may be: Is there any confusion about the labels? Are there differences in the meanings attributed to the same words in different environments? How does this impact on the criminal justice system, the health and community sectors, families and couples? Are there certain categories which socially construct/ stigmatise/ traumatise victims and ultimately counteract the objectives of public policy?

Conclusions

The field of family violence is of increasing interest to researchers and policy makers alike. *Safe at Home* provides an opportunity to explore a wide range of issues relating to the development and implementation of policies and practices aimed at reducing levels of family violence. In consultation with various State Government Agencies, TILES has begun to explore possibilities for research on the following:

- *Safe at Home* as an example of a successful whole-of-government strategy – an examination of its development and implementation;
- implementation of the *Safe at Home* initiative among Tasmania Police, the courts, and the key agencies responsible for service delivery;
- mapping outcomes for victims and perpetrators;
- mapping children's pathways through family violence experiences and *Safe at Home* services; and
- the capacity of *Safe at Home* to address intimate partner violence among diverse sub-populations such as the Aboriginal population, the Culturally and Linguistically Diverse (CALD) population, people with a mental illness, and people with a disability.

TILES is excited about the prospects of engaging in a suite of research projects that will focus on the Tasmanian Government's *Safe at Home* initiative to examine family violence from a range of perspectives. It is hoped that such a comprehensive analysis of a community-wide response to family violence will contribute to its reduction in the future.

References

1. Felson, R. and P.-P. Paré, *The Reporting of Domestic Violence and Sexual Assault by Nonstrangers to the Police.* 2003, US Department of Justice.
2. Felson, R., et al., *Reasons for Reporting and Not Reporting Domestic Violence to the Police.* Criminology, 2002. 40(3): p. 617-647.
3. Australian Bureau of Statistics, *Crime and Safety Australia 4509.0.* 2005, ABS: Canberra.
4. Australian Bureau of Statistics, *Women's Safety Australia 4128.0.* 1996, ABS: Canberra.
5. United Nations Population Fund, *State of the World Population 2005*. 2005, United Nations: Geneva.
6. Bagshaw, D. and D. Chung, *Women, Men and Domestic Violence.* 2000, University of South Australia.
7. Waltermaurer, E., *Measuring Intimate Partner Violence (IPV): You may only get what you ask for*. Journal of Interpersonal Violence, 2005. 20(4): p. 501-506.
8. Humphreys, J., P. Sharps, and J. Campbell, *What We Know and What We Still Need to Learn*. Journal of Interpersonal Violence, 2005. 20(2): p. 182-187.
9. Mears, D. and C. Visher, *Trends in Understanding and Addressing Domestic Violence*. Journal of Interpersonal Violence, 2005. 20(2): p. 201-211.
10. Laycock, G., *Research for Police: Who Needs It?*, in *Trends and Issues in Crime and Criminal Justice No. 211*. 2001, Australian Insitute of Criminology: Canberra.
11. Shepard, M., *Twenty Years of Progress in Addressing Domestic Violence: An Agenda for the Next Ten*. Journal of Interpersonal Violence, 2005. 20(4): p. 436-441.
12. Stover, C.S., *Domestic Violence Research: What have We Learned and Where Do We Go From Here?* Journal of Interpersonal Violence, 2005. 20(4): p. 448-454.
13. Maxwell, C., J. Garner, and J. Fagan, *The effects of Arrest on Intimate Partner Violence: New Evidence from the Spousal Assault Replication Program*. National Institute of Justice: Research In Brief, 2001.
14. Family Violence Act (Tasmania), in *http://www.safeathome.tas.gov.au/__data/assets/pdf_file/27585/Family_Violence_Act_2004.pdf*. 2004.
15. Gondolf, E., *Batterer Intervention Systems*. 2002, Thousand Oaks: Sage.
16. Carlson, M.J., S.D. Harris, and G.W. Holden, *Protective Orders and Domestic Violence: Risk factors for re-abuse.* Journal of Family Violence, 1999. 14(2): p. 205-226.
17. Taft, A.J., K. Hegarty, and M. Flood, *Are men and women equally violent to intimate partners?,* in Australian and New Zealand Journal of Public Health. 2001.
18. Millbank, S. *Reducing victimisation of domestic violence and the NDV project.* in *Reducing Criminality: Partnerships and Best Practice.* 2000. Perth, WA.

TASMANIAN INSTITUTE OF LAW ENFORCEMENT STUDIES

19. Hirschel, D. and I. Hutchison, *The Voices of Domestic Violence Victims: Predictors of victim preference for arrest and the relationship between preference for arrest and revictimisation.* Crime and Delinquency, 2003. 49(2): p. 313-336.
20. Coumarelos, C. and J. Allen, *Predicting violence against women: the 1996 Women's Safety Survey.* 1998.
21. Walby, S. and A. Myhill, *Reducing Domestic Violence ....What Works? Assessing and Managing the Risk of Domestic Violence, in Policing and Reducing Crime Briefing Notes.* 2000, Home Office: London.
22. Metropolitan Police (UK), *Enough is Enough: Domestic Violence Strategy.* 2001: London.
23. Richards, L., *Tactical Menu of Intervention Options for Domestic Violence Victims and Offenders*. 2001, Metropolitan Police Service and West Yorkshire Police: London.
24. Mouzos, J. and T. Shackelford, *A Comparative, Cross-National Analysis of Partner-Killing by Women in Cohabiting and Marital Relationships in Australia and the United States.* Aggressive Behaviour, 2004. 30:p. 206-216.
25. Palarea, R.E., et al., *The Dangerous Nature of Intimate Relationship Stalking: Threats, Violence and Associated Risk Factors.* Behavioural Science and the Law, 1999. 17: p. 269-283.
26. Wilson, M. and M. Daly, *Spousal Homicide Risk and Estrangement.* Violence and Victims, 1993. 8(1): p. 11.
27. Campbell, J., et al., *Risk Factors for Femicide in Abusive Relationships: Results from a multi-site Case Control Study.* American Journal of Public Health, 2003. 93(7): p. 1089-97.
28. Young, M., J. Byles, and A. Dobson, *The effectiveness of legal protection in the prevention of domestic violence in the lives of young Australian women*. 2000. Trends in Issues in Crime and Criminal Justice. AIC.
29. Hucker, S., *Psychiatric Aspects of Risk Assessment,* in *Violence Risk.com.* 2004.
30. Prins, H., *Will they do it again? Risk assessment and management in criminal justice and psychiatry.* 1999, London: Routledge.
31. Nestor, P.G., *Mental Disorder and Violence: Personality dimensions and clinical features.* The American Journal of Psychiatry, 2002. 159(12): p. 1973-1978.
32. Robbins, P., J. Monahan, and E. Silver, *Mental Disorder, Violence and Gender.* Law and Human Behaviour, 2003. 27(6): p. 561-571.
33. Bryon, D., *Domestic Aggression and Traumatic Brain Injury,* in *4therapy.com.* 2004.
34. Dutton, D. and M. Haring, *Perpetrator Personality Effects on Post Separation Victim Reactions in Abusive Relationships.* Journal of Family Psychology, 1997.
35. Taft, A., *Violence against women in pregnancy and after childbirth: current knowledge and issues in health care responses.* 2002. Australian Domestic Violence Clearinghouse Issues Paper (6).
36. Richards, L., *MPS Risk Assessment Model for Domestic Violence Cases,* Metropolitian Police (UK), Editor. 2003.
37. Martin, S.L., et al., *Changes in Intimate Partner Violence during Pregnancy.* Journal of Family Violence, 2004. 19(4): p. 201-210.
38. McGrath, C., *A guide to Domestic Violence: Risk Assessment, Risk Reduction and Safety Plan.* 2003, Metropolitan Government of Nashville and Davidson County: Nashville.
39. Laing, L., *Responding to men who perpetrate domestic violence*,2002. Australian Domestic Violence Clearinghouse Issues Paper (7).
40. Websdale, N., *Lethality Assessment Tools: a critical analysis*. n.d., National Resource Centre on Domestic Violence.
41. Richards, J.C., et al., *Understanding Male Domestic Partner Abusers*. Trends and Issues in Crime and Criminal Justice, 2004.
42. Armstrong, K.L., *Children Living With Domestic Violence.* Aboriginal and Islander Health Worker Journal, 1998. 22(2).
43. Saunders, D., *Prediction of Wife Assault,* in *Assessing Dangerousness: Violence by Sexual Offenders, Batterers and Child Abusers*, J.C. Campbell, Editor. 1995, Sage: Thousand Oaks.
44. Carcach, C. and M. James, *Homicide between Intimate Partners in Australia.* Trends and Issues in Crime and Criminal Justice, 1998.
45. Dal Grande, E., et al., *Domestic violence in South Australia: a population survey of males and females.,* in Australian and New Zealand Journal of Public Health. 2003.
46. Easteal, P., *Killing the Beloved: Homicide between adult sexual intimates.* 1993, Canberra: Australian Institute of Criminology.
47. James, M. and J. Hallinan, *Homicides in Australia 1992-93.* Trends and Issues in Crime and Criminal Justice, 1995.
48. Ascione, F.R., *Battered Women's Reports of their Partner's and their Children's Cruelty to Animals.* Journal of Emotional Abuse, 1998. 1(1).
49. Flynn, C., *Woman's Best Friend: Pet Abuse and the Role of Companion Animals in the lives of Battered Women.* Violence against Women, 2000. 6(2): p. 162-177.
50. Australian Bureau of Statistics, *Crime and Justice special article: Violence Against Women 1301.0.* 1998.
51. Lievore, D., *No Longer Silent: A Study of Women's Help Seeking Decisions and Service Responses to Sexual Assault,* Australian Institute of Criminology, Editor. 2005, Australian Institute of Criminology: Canberra.
52. Frude, N., *Marital Violence : An interactional perspective,* in *Male Violence*, J. Archer, Editor. 1994, Routledge: London.

53. Holzworth-Munroe, A. and G. Stuart, *Typologies of Male Batterers: Three Subtypes and the Differences Among Them.* Psychological Bulletin, 1994. 116(3): p. 376-497.

54. Limandri, B. and D. Sheridan, *Prediction of Intentional Interpersonal Violence, in Assessing Dangerousness: Violence by Sexual Offenders, Batterers and Child Abusers,* J.C. Campbell, Editor. 1995, Sage: Thousand Oaks.

55. Tweed, R.a. and D. Dutton, *A comparison of Impulsive and Instrumental Subgroups of Batterers.* Violence and Victims, 1998. 13(3): p. 217-230.

56. Gondolf, E., *An Extended FollowUp of Batterers and their Partners,* in *Centers for Disease Control and Prevention/Injury Prevention Research for Violence Against Women,* Mid-Atlantic Addiction Training Institute, Editor. 2001, Indiana University of Pennsylvania: Indiana, PA.

57. Dal Grande, E., et al., *Interpersonal violence and abuse survey, September 1999.* 2001. www.dhs.sa.gov.au/pehs/PROS/interpersonal-violence-survey.pdf

58. Krakowski, M. and P. Czobor, *Gender differences in Violent Behaviours: relationship to clinical symptoms and psychosocial factors*. The American Journal of Psychiatry, 2004. 161(3): p. 459-65.

59. Kantor, G.K. and J. Jasinski, *Dynamics of Partner Violence and Types of Abuse and Abusers.* 1997, National Network for Family Resiliency.

60. Margolin, G., R. John, and L. Foo, *Interactive and Unique Risk Factors for Husbands' Emotional and Physical Abuse of their Wives.* Journal of Family Violence, 1998. 13(4): p. 315-344.

61. Bledsoe, L., et al., *Understanding the Impact of Intimate Partner Violence Mandatory Reporting Law.* Violence against Women, 2004. 10(5): p. 534-560.

62. Laing, L., *Risk Assessment in Domestic Violence.* 2004, Australian Domestic Violence Clearing House: Sydney.

63. Tyagi, S., *Risk Assessment measures in prediction of domestic/interpersonal violence.* Counterpoint, 2003. 1.

64. Norko, M. and M. Baranoski, *The State of Contemporary Risk Assessment Research.* Canadian Journal of Psychiatry, 2005. 50(1): p. 18-27.

65. Rodriquez, E., et al., *The relation of family violence, employment status, welfare benefits and alcohol drinking in the United States.* Western Journal of Medicine, 2001. 174(5): p. 317.

66. Gillingham, P., *Risk Assessment in Child Protection: Problem Rather than Solution.* Australian Social Work, 2006. 59(1): p. 86-98.

67. Lewis, J., *Perceptions of Risk in Intimate Relationships: The Implications for Social Provision.* Journal of Social Policy, 2005. 35(1): p. 39-57.

68. McSherry, B., *Risk Assessment by Mental Health Professionals and the Prevention of Future Violent Behaviour.* Trends and Issues in Crime and Criminal Justice, 2004. 281.

69. Campbell, J., *Helping Women Understand their Risk in Situations of Intimate Partner Violence.* Journal of Interpersonal Violence, 2004. 19(12): p. 1464-1477.

70. Hansen, R.K., *Twenty Years of Progress in Violence Risk Assessment.* Journal of Interpersonal Violence, 2005. 20(2): p. 212-217.

71. Mills, J., *Advances in the Assessment and Prediction of Interpersonal Violence.* Journal of Interpersonal Violence, 2005. 20(2): p. 236-241.

72. Kroner, D., *Issues in Violent Risk Assessment: Lessons Learned and Future Directions.* Journal of Interpersonal Violence, 2005. 20(2): p. 231-235.

73. Heenan, M., *Just 'keeping the peace': A reluctance to respond to male partner sexual violence,* in *Issues,* Australian Centre for the Study of Sexual Assault, Editor. 2004, Australian Institute of Family Studies: Melbourne.

74. Mouzos, J. and T. Makkai, *Women's Experience of Male Violence: Findings from the Australian Component of the International Violence Against Women Survey (IVAWS)*, in *Research and Public Policy,* Australian Institute of Criminology, Editor. 2004: Canberra.

75. Sochting, I., N. Fairbrother, and W. Koch, *Sexual Assault of Women: Prevention Efforts and Risk Factors.* Violence against Women, 2004. 10(1): p. 73-93.

76. Dutton, M.A., et al., P*atterns of Intimate Partner Violence: Correlates and Outcomes.* Violence and Victims, 2005. 20(5): p. 483-497.

77. Taylor, S.C., *Court Licenced Abuse.* 2004, New York: Peter Lang.

78. Hearn, J., *The Violences of Men: How Men Talk about and How Agencies Respond to Men's Violence to Women*. 1998, London: Sage.

79. Campbell, J. and K. Soeken, *Forced Sex and Intimate Partner Violence: Effects on Women's Risk and Women's Health.* Violence against Women, 1999. 5(9): p. 1017-1035.

80. Herbert, T., R. Silver, and J. Ellard, *Coping With An Abusive Relationship: 1. How and Why do Women Stay?* Journal of Marriage and the Family, 1991. 53(2): p. 311-325.

81. Sachs, C. and M. Rodriguez, *Should Physicians Be Required to Report Domestic Violence to the Police?* Western Journal of Medicine, 2000. 173(4): p. 225.

82. Sullivan, C. and L. Hagen, *Survivors' Opinions About Mandatory Reporting of Domestic Violence and Sexual Assault by Medical Professionals*. Affilia, 2005. 20(3): p. 346-361.

83. Crnkovic, A.E., R. Del Campo, and R. Steiner, *Mental Health Professionals' Perceptions of Women's Experiences of Family Violence.* Contemporary Family Therapy, 2000. 22(2): p. 147-160.

84. Koziol-McLain, J. and J. Campbell, *Universal Screening and Mandatory Reporting: An Update on two Important Issues for Victims/Survivors of Intimate Partner Violence.* Journal of Emergency Nursing, 2001. 27(6): p. 602-606.

85. Peralta, R. and M. Fleming, *Screening for Intimate Partner Violence in a Primary Care Setting: The Validity of 'feeling safe at home' and prevalence results.* Journal of American Board of Family Practitioners, 2003. 16: p. 252-32.

86. Bauer, H., et al., *California's mandatory reporting of domestic violence injuries: Does the law go too far or not far enough?* Western Journal of Medicine, 1999. 171(2): p. 118-124.

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