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

Silke Meyer
Nicola Helps
Kate Fitz-Gibbon

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Abbreviations and acronyms

ANOVA	analysis of variance
AOD	alcohol and other drugs
DFV	domestic and family violence
DFVDRAB	Domestic and Family Violence Death Review and Advisory Board
DV	domestic violence
DVO	domestic violence order
GP	general practitioner
HRT	high risk team
IPH	intimate partner homicide
IPV	intimate partner violence
MARAM	Multi-Agency Risk Assessment and Management
MATCLA	Multi-Agency Triage and Case-Led Allocation
MBCP	men's behaviour change program
ODARA	Ontario Domestic Assault Risk Assessment
RCFV	Royal Commission into Family Violence
S&T	Safe & Together
SARA	Spousal Assault Risk Assessment
VP-SAFvR	Victoria Police Screening Assessment for Family Violence Risk

Abstract

Australia has implemented substantive domestic and family violence (DFV) reforms in recent years. While the identification, risk assessment and management of victim-survivors has increasingly been embedded across service system responses, there is scant understanding and practice in relation to perpetrators of DFV. Men using DFV often have diverse service system contact for co-occurring issues. However, their use of DFV frequently remains invisible, constituting missed opportunities for risk identification, assessment and management, and effective referral pathways.

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, corrections and child protection services. Results show significant variation in screening and risk assessment practices as well as practitioner attitudes across service areas. Specialist DFV training for practitioners and organisational leadership that prioritises responses to DFV are critical to implementing screening and risk assessment protocols for DFV perpetration across service areas.

Executive summary

The last decade has seen unprecedented attention paid at the national and state level to improving and reforming responses to domestic and family violence (DFV). The findings from recent reviews, including Victoria's Royal Commission into Family Violence (RCFV 2016), the Special Taskforce on Domestic and Family Violence in Queensland's (2015) *Not now, not ever* report, and the work of the Council of Australian Governments (2011) Advisory Panel on Reducing Violence against Women and their Children, have revealed the need to improve policy and practice responses to perpetrators of DFV. While significant attention has been paid to ensuring risk identification, assessment and management practices are in place for DFV victim-survivors, there is scant understanding and practice in relation to perpetrators. As a result, opportunities to screen for, identify, assess and manage the risk that a perpetrator poses are often missed. The work of Australian based death review teams has consistently highlighted the need for more DFV-informed perpetrator screening and risk assessment, especially in mental health services, child protection and alcohol and other drugs (AOD) services, along with the need for services including police, corrections and men's behaviour change programs (MBCPs) to use common risk assessment tools.

Screening for potential perpetration of DFV refers to the process of reviewing available information and asking specific screening questions to identify the absence or presence of DFV and to identify potential warning signs during intake conversations. This process is used to alert the practitioner to the presence of DFV without the perpetrator explicitly disclosing the use of DFV. Risk assessment tools are usually based on a standardised set of questions, identifying the absence or presence of factors known to elevate the risk of DFV revictimisation. Actuarial tools rely on quantifiable measures that generate a total score, indicating low, moderate or high risk, whereas other approaches use a combination of standardised questions and professional judgement drawing on other available information. Effectively identifying DFV perpetration and related level of risk is a critical element in working towards safer lives for victim-survivors across Australia.

While investment in victim-survivor support services is crucial, state and federal governments have increasingly responded to the need to improve identification of and responses to DFV more broadly. This includes holding those who perpetrate abuse to account and developing new ways to keep DFV perpetrators 'in view'. As a result, Australian states and territories have in recent years introduced, to varying degrees, DFV perpetrator intervention programs and other service responses designed to hold perpetrators (predominantly men) accountable for their use of DFV. Despite this increased activity, there remains limited evidence around the use and effectiveness of screening and risk assessment tools for DFV perpetration. Where evidence does exist, it is largely focused on the use of DFV risk assessment tools in different service settings. However, this work also remains primarily victim-survivor focused, often relies on victim-survivor contact and communication to identify specific risk factors, and often results in victim-focused rather than perpetrator-focused interventions, risk assessment and management outcomes.

A broad range of services have the opportunity to screen for and identify male perpetrators of DFV, including mental health services, AOD services, child protection and corrections. The co-occurrence of DFV with other complex factors means that perpetrators of DFV frequently have contact with a range of different service sectors for other support needs. Each of these points of contact presents important opportunities to screen for DFV perpetration and conduct a risk assessment where DFV perpetration is identified.

Research objectives and design

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, AOD, corrections and child protection services. The research sought to critically examine the current state of knowledge and practice relating to DFV perpetrator-focused screening, risk assessment and management across different practice areas.

This research was guided by four overarching objectives:

- to identify current DFV screening perceptions and practices by frontline practitioners responding to male clients across different non-DFV specialist service areas (including mental health services, AOD services, child protection and corrections);
- to identify current DFV risk assessment perceptions and practices by frontline practitioners responding to male clients across different non-DFV specialist service areas, including mental health services, AOD services, child protection and corrections;

- to examine whether and how current screening and risk assessment practices around DFV perpetration with men accessing non-DFV specialist services translate into information-sharing and referral pathways to coordinate risk management, monitoring and relevant support options for men using DFV; and
- to identify policy and practice implications arising from this research to improve identification of and responses to potential perpetrators of DFV when accessing non-DFV specialist services with other presenting issues that frequently intersect with DFV, including mental health concerns, problematic substance use, child welfare concerns and other offending behaviour.

To achieve these objectives, the research project used a two-stage mixed-method design, including a survey (stage 1) and focus groups (stage 2). A total of 663 valid survey responses were received. While this research was initially designed to incorporate a national survey with a follow-up case study component focused on Victoria and Queensland, the survey was predominantly completed by Victorian and Queensland practitioners. Of the total survey sample, 532 participants (80%) were Queensland-based practitioners. Focus groups were conducted virtually and involved predominantly Queensland government departments and one Victorian based focus group. Thirty-nine practitioners (31 in Queensland and 8 in Victoria) were engaged through the second stage of data collection. The focus groups provided the opportunity to examine preliminary survey findings in greater depth.

The research findings presented throughout this report are primarily focused on evidence gleaned from Queensland practitioners, with some insights from Victoria specifically exploring current DFV reforms in AOD and mental health service settings.

Research findings

The research findings build the Australian evidence base around DFV perpetrator focused screening and risk assessment practices and opportunities. Key findings included:

- screening and risk assessment of male clients varies and remains limited overall;
- specialist DFV training increases confidence in and likelihood of screening; and
- organisational leadership and individual attitudes shape screening and risk assessment practices.

Each of these key findings is briefly summarised here.

Screening and risk assessment of male clients varies and remains limited overall

Survey and focus group findings reveal that screening of male clients for potential DFV perpetration in service areas that respond to presenting issues which frequently intersect with DFV varies and remains limited overall. While findings show that screening female clients for DFV victimisation has become increasingly common, confidence in and commitment to identifying potential perpetration of DFV among male clients varies greatly across service areas.

Survey findings support existing evidence that perpetration-specific assessment tools are scarce and rarely used across service areas that are not specifically offender focused (such as police, courts and corrections). When in use, existing tools are largely designed to assess risk rather than screen for the presence of DFV perpetration. Where practitioners do screen for DFV, participants involved in this research reflected that they relied heavily on referral information (eg information about DFV perpetration contained in police or court referrals) along with their professional judgement around indicators of DFV perpetration that may emerge during intake or assessment interviews with clients. The likelihood of practitioners screening for DFV perpetration is driven by their level of DFV expertise and training, their attitudes towards the benefits and relevance of screening and risk assessment more broadly and whether identifying and responding to perpetrators of DFV was promoted and supported as core business in their area of practice. This research reveals that in the absence of a standardised screening tool being used consistently within or across practice areas, screening may be limited to a review of referral information containing DFV-specific information in the first instance.

Specialist DFV training increases confidence in and likelihood of screening

Unsurprisingly, the research found that practitioners who reported screening more frequently and consistently also reported identifying a larger percentage of DFV perpetration being present in screened cases. This likely reflects a combination of training, confidence and experience, with those practitioners screening on a regular basis more likely to report higher levels of DFV specialist training, which increases confidence and experience in supplementing available referral information with DFV indicators identified during intake and assessment conversations.

Organisational leadership and individual attitudes shape screening and risk assessment practices

Survey and focus group findings highlight the importance of organisational and individual attitudes that are supportive of screening and risk assessment around DFV perpetration. The research found that practitioners and practice areas that held less supportive attitudes to screening and risk assessment, and areas that were described as not treating, identifying and responding to DFV perpetrators as core business, were less likely to report frequent screening and risk assessment practices. These practitioners were also less likely to identify DFV perpetration in the cases they did screen. These findings highlight the importance of organisational commitment to the implementation of DFV reforms in shaping and supporting attitudes and perceptions of frontline practitioners, specifically regarding perpetrator visibility and accountability.

This research reiterates the importance of organisational commitment, and internal leadership around DFV-informed practice, in supporting frontline practitioners' ability and confidence in identifying and responding to DFV perpetrators. Practice areas where practice and team leaders did not support frontline practitioners to access professional development around DFV or had no DFV specialisation themselves were less likely to identify and respond to DFV perpetration. This results in missed opportunities for information sharing around potential perpetrator risk along with referral pathways for perpetrators and affected family members.

Implications for policy and practice

Our research findings highlight the missed opportunities to identify DFV perpetration across service areas that frequently have contact with men for other issues, including mental health concerns, problematic AOD use, parenting and child welfare concerns and offending behaviour beyond DFV. The findings aim to inform improved DFV perpetrator focused risk identification, assessment and management practices in a range of settings. We also seek to contribute important insights to inform the ongoing effective delivery of key recommendations made by Victoria's RCFV (2016), the Special Taskforce on Domestic and Family Violence in Queensland (2015) and other reviews into the DFV system and its reform, including the forthcoming National Plan to End Violence against Women and Children (Department of Social Services 2022). While the data presented throughout this report is largely Queensland specific, findings are highly relevant to risk screening, identification, assessment and management practices in all Australian states and territories, and in comparable countries.

Specifically, our findings support:

- the use of a combination of direct screening questions and professional judgement to identify potential DFV perpetration and related risk;
- the need for specialist training on understanding and identifying existing and emerging forms of DFV across all service sectors encountering male clients with presenting issues that frequently intersect with DFV;
- the need for education and specialist training on identifying and using relevant referral pathways for men using DFV across all service sectors encountering male clients with presenting issues that frequently intersect with DFV;
- the need for specialist DFV training across different areas and levels of leadership within each service sector to ensure DFV is seen and promoted as core business;
- the integration of DFV specialist practitioners across all service sectors to support frontline practitioners in effectively screening for DFV along with related risk management and monitoring;
- the consistent implementation of multi-agency risk identification, assessment and management frameworks to generate integrated and holistic service responses to potential perpetrators of DFV, including information sharing around risk, shared risk management and monitoring and the facilitation of referral pathways for clients using DFV; and
- the application of the above measures to service sectors beyond those examined in the current study, including disability services, Centrelink, housing and homelessness services, non-statutory child and family welfare services, family law services, other legal services, support services for First Nations people, and support services for culturally and linguistically diverse people.

Without understanding how family violence perpetration can be screened for, and how risk can be identified, assessed, and managed, Australia's family violence reform goal of 'keeping the perpetrator in view' cannot be achieved. The findings of this study highlight that screening for DFV perpetration is different from screening for victimisation and, as such, requires distinct approaches and embedded protocols.

Introduction

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 is highly gendered, with women and children over-represented as victim-survivors (Australian Institute of Health and Welfare 2019; World Health Organization 2021). Especially at the high-risk end, women are particularly vulnerable to serious violence and death, with an average of one woman being killed by a male intimate partner every nine days in Australia (AIHW 2021). In this report we use the term DFV, which is commonly used in the Australian context. DFV covers a range of behaviours, including verbal, emotional, physical, sexual, financial and spiritual abuse along with social isolation and other controlling behaviours (Department of Social Services 2022). While DFV covers more than intimate partner violence (IPV), the main focus throughout this project was identifying and responding to DFV between intimate partners or ex-partners.

There has recently been unprecedented attention at the national and state level focused on improving and reforming responses to DFV. The findings from recent reviews—including Victoria's RCFV (2016), the Special Taskforce on Domestic and Family Violence in Queensland's (2015) *Not now, not ever* report, the Women's Safety and Justice Taskforce (2021) in Queensland and the earlier work of 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 more effectively respond to perpetrators of DFV. Significant attention has been paid to ensuring risk identification, assessment and management practices are in place for DFV victim-survivors. However, understanding of and practice around perpetrator identification and related risk assessment is only just emerging (Davis & Padilla-Medina 2021; Portnoy et al. 2020). As a result, opportunities to screen for, identify, assess and manage the risk that a DFV perpetrator poses are often missed.

In particular, evidence derived from DFV death reviews shows that men using DFV frequently have contact with non-DFV specialist services, including mental health services, alcohol and other drug services, child protection and corrections. Yet their use of DFV often remains invisible in these contexts. As a result, these points of service system contact constitute missed opportunities. While non-DFV specialist services frequently encounter potential perpetrators of DFV, the immediate and long-term risk they may pose to children, partners, ex-partners and other family members remains largely unidentified (Domestic and Family Violence Death Review and Advisory Board 2021). Effectively identifying the risk of DFV perpetration along with its escalation is therefore a crucial element in working towards safer lives for victim-survivors and children affected by DFV and relevant support mechanisms for perpetrators of violence.

The National Plan to Reduce Violence against Women and their Children 2010–2022, soon to be succeeded by the National Plan to End Violence against Women and Children 2022–2032, sets the scene for holistic service responses to DFV in Australia, with the aim of maximising victim-survivor safety and holding perpetrators accountable for their abusive behaviours. However, despite over a decade passing since the initial plan was introduced, screening and risk assessment around DFV has remained primarily victim-survivor focused. While screening for and risk assessment of DFV and its escalation based on victim-survivor reports remains crucial, perpetrator focused screening and risk assessment is equally important to avoid missing critical points for intervention when services respond to potential or identified perpetrators of DFV.

Research conducted in primary healthcare settings as early as 1998 highlighted the opportunity to screen male patients for their use of DFV across different service settings (Oriel & Fleming 1998). Men presenting to family healthcare clinics with problematic alcohol use, childhood trauma or depression were more likely to report using physical violence. Comorbidity of all three factors increased the likelihood of reporting use of physical violence sixfold compared to men without any of the three risk factors. Such findings from over two decades ago highlight the opportunities to identify DFV perpetration across health, mental health and AOD service settings to ensure victim-survivor safety and access to relevant support referrals for men using DFV. More recent Australian research has similarly identified several different service settings including health and mental health services, AOD services, child protection and corrections as common points of contact for men using DFV. However, these service settings remain primarily focused on clients' presenting issues (eg mental health concerns, problematic substance use). Screening for co-occurring use of DFV remains scarce (Domestic and Family Violence Death Review and Advisory Board 2021).

This study is therefore guided by the recent DFV reform agenda, including specific policy and practice reforms implemented in response to recommendations arising from Victoria's RCFV (2016) and the Special Taskforce on Domestic and Family Violence in Queensland's (2015) *Not now, not ever* report. Specifically, our study was informed by recommendations relating to:

- specialist DFV training across service sectors;
- the use of shared DFV risk assessment and management tools across mainstream and specialist service sectors;
- information sharing across service sectors as it relates to elevated risk, with the aim of enhancing opportunities to 'keep perpetrators in view' as they access different service sectors for support; and
- improved access to relevant support services and developing a suite of diverse interventions for men using DFV.

Perpetrator screening and risk assessment practices: An overview

Screening for DFV may refer to a combination of practices, including the process of reviewing available information, asking specific screening questions to identify the absence or presence of DFV (see also Davis & Padilla-Medina 2021) and to identify potential warning signs during intake conversations that may alert to the presence of DFV without the client or patient explicitly disclosing it (see also Hegarty, Taft & Feder 2008; Portnoy et al. 2020). Risk assessment tools are usually based on a standardised set of questions, identifying the absence or presence of factors known to elevate the risk of revictimisation in the context of DFV. Actuarial tools solely rely on quantifiable measures that generate a total score, indicating low, moderate or high risk, whereas other approaches use a combination of standardised questions and professional judgement drawing on other available information (see also Kebbell 2019; Messing & Thaller 2013).

Existing research relating to screening practices for DFV and the assessment of related risk focuses predominantly on victim-survivors. This research has examined a range of service settings, such as mental health services, child protection, and AOD services (Beck & Raghavan 2010; Jenney et al. 2014; Spangaro 2017). Perpetrator-focused screening tools are still emerging, and their use has predominantly been examined in the United States (Davis & Padilla-Medina 2021), with few exceptions (Kraanen et al. 2013). The administration of perpetrator-focused risk assessment tools remains largely limited to intervention for men who are known to use violence (eg assessment during police contact and MBCPs (McEwan, Bateson & Strand 2017; Tarzia et al. 2017).

There are fewer studies, particularly in Australia within the last five years, that explore screening for DFV with perpetrators across mental health, AOD or child protection services, or the benefits of doing so (Davis & Padilla-Medina 2021; Miller & Jaye 2007; Penti, Timmons & Adams 2018). Those that do examine screening tend to combine risk assessment of victim-survivors and perpetrators together, making it difficult to differentiate findings (McEwan, Bateson & Strand 2017) or focus exclusively on the risk of DFV for victim-survivors (Vaughan et al. 2016).

There are also very few Australian studies that look specifically at risk assessments for those perpetrating, or at risk of perpetrating, DVF within or beyond the police, corrections and MBCP context (Storey et al. 2014). Research that is available presents conflicting results that are not always directly related to screening, that use inconsistent terminology, that have differing measurements of behaviour and relationship dynamics, or that focus solely on the perpetration of DFV or IPV, rather than screening for DFV perpetration at the outset of service system engagement (Davis & Padilla-Medina 2021; Kimberg 2007). As well as this, studies that are positioned to explore the screening of IPV or DFV tend to focus on victim-survivors only (Kimberg 2007; Spangaro 2017). There remains a critical need for research that looks specifically at screening for DFV perpetrators across a range of settings, including AOD services, mental health and other healthcare services, police, courts and corrections, child protection, and specialist men's services.

Other research in this area is sporadic and primarily focused on the healthcare sector, which has a number of unique challenges in the screening process. These include, for example, distinguishing the patient's role in the violence, as perpetrators may present as being victimised even when they are the primary aggressor in the relationship (Kimberg 2007); inadequate follow-up policies and resources; and the lack of workplace protocols in place for addressing DFV (Bakon et al. 2019; Tower 2009). Another issue identified in Australian healthcare-based research is that men are seen as unlikely to disclose their violence to clinicians as part of their help-seeking (Hegarty, Taft & Feder 2008). Instead, DFV perpetrators may present with other difficulties, such as controlling their anger (Hegarty, Taft & Feder 2008), or mental health issues including symptoms of depression or anxiety (Hester et al. 2015; Oram et al. 2013).

A recent systematic review of literature relating to health system responses to DFV in Australia and internationally identified best practice in health systems, including their responses to DFV (Spangaro 2017). The review identified few studies that explored the screening of potential perpetrators for DFV. The few that were identified supported evidence mentioned above which shows that perpetrators present for other health-related behaviours or symptoms that may intersect with but are not discussed in the context of DFV. This last point raises a key issue. General practitioners (GPs) are often seen as the main source of professional help accessed by men, and although most men do not explicitly seek help for DFV, research suggests that GP settings present an opportunity for screening and identification of DFV perpetration, in particular for men attending with symptoms of depression or anxiety (Hester et al. 2015). Yet screening for DFV remains inconsistent and predominantly victim-survivor focused (Penti, Timmons & Adams 2018). While the research presented here provides some insight into screening for DFV perpetrators in mental health settings specifically and healthcare systems more broadly, there remain significant gaps in knowledge across a range of sectors including AOD, child protection, and specialist men's services.

Examining research that explores factors leading to more screening in mental health services is revealing as it concomitantly points to the gaps in this area. Again, this is seen in healthcare research where, drawing on patients' accounts, it was reported that screening was positively associated with clinic utilisation and more likely when people have a history of violence. Further, referrals for family conflict were more likely among patients who were women, young and not married, and for those presenting with 'low relationship quality' (Burge et al. 2005: 251). 'Low relationship quality' is measured by Burge et al. (2005) using the Dyadic Consensus scale, which assesses partner agreement on a range of lifestyle issues including finances, major decision making, household tasks and career. This corresponds with the lack of screening processes for those who do not have a known history of violence. This last point was acknowledged in a study on the identification and management of DFV by GPs in New Zealand; difficulties arose in acknowledging the possibility of DFV in families they had previously considered to be 'good' and 'safe' (Miller & Jaye 2007: 99). The New Zealand study also has implications for the importance of ongoing perpetrator screening and assessment practices that are attentive to changing relationship dynamics, where DFV may be identified at a later point even if it was previously screened out. There are, therefore, snippets of information relating to enabling factors and barriers for screening of perpetrators for DFV, yet very little that is extensive, with a focus on perpetrators, in an Australian context.

Existing US and UK based research evidence provides some guidance on screening for DFV perpetration. A US study by Burge et al. (2005) sought advice for physicians from 253 patients (including victim-survivors and a smaller group of perpetrators) about screening for DFV. Findings demonstrated that, although screening was important, in practice it was uncommon, especially in relation to perpetrators. Almost all of the participants were open to discussing family conflict with physicians and believed that physicians should ask about family conflict. However, only two-thirds of participants reported that their physician had ever asked about family conflict (Burge et al. 2005). A key finding in Burge et al.'s (2005) study is that patients want to be asked about family conflict, they want to be listened to and they want information and referrals. While there are challenges and concerns as to how to have these conversations safely, this finding highlights the opportunity that health settings present to have these conversations and to identify DFV, including DFV perpetration.

Similar findings were seen in a study from southwest England that examined men's views on the role of GPs in asking about DFV behaviours (Morgan et al. 2014). A minority of participants (*n*=18, 1.4%) had been asked about DFV perpetration. Consistent with findings by Burge et al. (2005), participants generally felt practitioners should ask about potentially abusive behaviour. Specifically, 278 participants (23%) believed *all* patients should be asked and 822 participants (67%) felt patients should be asked on the basis of symptoms. In contrast, 130 participants (10%) believed that health practitioners should not ask about potentially abusive behaviours (Morgan et al. 2014). In terms of help-seeking behaviours, DFV perpetrators were most likely to go to family and friends for informal support. Importantly, the second most likely avenue for support reported was the family doctor. Both studies point to the important role healthcare professionals play in asking patients about DFV and in listening to their stories. They further point to the need for training and support that enables them to do so safely and effectively (Morgan et al. 2014).

Screening and risk assessment tools

There is limited evidence around the use and effectiveness of screening and risk assessment tools for DFV perpetration. While scant, the studies that do exist provide insights into the tools and other factors that help improve the effectiveness of screening for and management of DFV perpetration. One study based on emergency department data used a computer touchscreen tool to ask 248 patients about DFV victimisation and perpetration (Rhodes et al. 2002). Most disclosures related to experiences of victimisation, but a small number of women (*n*=21, 14%) and men (*n*=15, 22%) self-reported either a history of or concern about hurting someone close to them (Rhodes et al. 2002). The authors found that using the computer touchscreen tool resulted in DFV being noted in the medical records of 19 of the potential 83 cases of IPV, compared with one documented case in the group that received care as usual (Rhodes et al. 2002). The increased identification of DFV demonstrates the importance of creating opportunities to disclose through enhanced screening opportunities.

Along with screening tools, a US study found that communication was a key factor in improving physician–patient relationships and enabling patients to disclose DFV (Burge et al. 2005) and in New Zealand it was crucial in allowing GPs to effectively manage and screen for DFV (Miller & Jaye 2007). Furthermore, this same study noted that, from the point of view of men using DFV, active listening was seen as the most important thing physicians could do when asking about family conflict (Burge et al. 2005). This study also highlighted the importance of listening to men who may not present at the GP in relation to DFV-specific behaviours but who may disclose relevant behaviours of concern when asked (Burge et al. 2005).

An extensive body of research highlights the co-occurrence of use of DFV and a range of other treatment needs including problematic AOD use (Gilchrist et al. 2019; Kraanen, Scholing & Emmelkamp 2010), problem gambling (Freytag et al. 2020) mental health issues including depressive and anxiety disorders (Askeland & Heir 2014; Chang et al. 2011; Hester et al. 2015), and history of trauma (Voith et al. 2020). The co-occurrence of these complex factors means that perpetrators of DFV may come into contact with a range of service sectors for other intersecting behaviours. Each of these points of contact represents an opportunity to screen for DFV perpetration.

While the need to screen is increasingly recognised, screening practices remain limited across non-specialist settings. Research by Chang and colleagues (2011) found that perpetrator screening practices often take place through providers asking general questions about DFV perpetration rather than using a specific screening tool. Little is known about the use and effectiveness of specific screening tools for DFV perpetration. Due to the lack of screening tools for DFV in problematic substance use treatment, Kraanen et al. (2013) developed a four-item screening tool, the Jellinek Inventory for assessing Partner Violence. The authors found this tool to be useful for screening for IPV perpetration among substance abuse patients (Kraanen et al. 2013).

One recommendation put forth regarding risk assessment for perpetrators of intimate partner homicide (IPH) and DFV involves widening the scope of the target population. Eke et al. (2011) examined characteristics of men (*n*=146) who had perpetrated actual or attempted IPH and found 42 percent had prior criminal charges in their history, 15 percent had a history of psychiatric diagnoses, and a further 18 percent had both. Only 24 percent had no prior contact with criminal justice and health systems. Further, using extensive police case file information to examine a subsample of 30 men who had killed their intimate partners, the authors found that 13 men in the subsample had a documented prior incident of partner assault before committing IPH (Eke et al. 2011). This had been documented by either police, community services, shelters, or GPs. The retrospective assessment revealed that offenders who had killed their intimate partners scored in the highest risk category on the Ontario Domestic Assault Risk Assessment (ODARA; Eke et al. 2011). The retrospective assessment also identified opportunities for prior formal risk assessments, reflecting missed opportunities for effective risk assessment and management of DFV perpetration that might enable improved prevention or intervention practices for perpetrators who fall in the highest risk category (Eke et al. 2011).

Similar 'missed opportunities' for identifying DFV perpetration have been highlighted by the Australian Domestic and Family Violence Death Review Network (2018, hereafter referred to as the Network). As part of their review of IPH in Australia between 2010 and 2014 (*n*=152), the Network analysed a subset of data where information relating to histories of violence was available (*n*=105). The Network found that, of the 105 cases in which a male DFV perpetrator killed a female victim, 76 percent (*n*=80) had previously used physical violence against the same female victim, 80 percent (*n*=84) had previously used emotional and psychological violence against the same female victim, 61 percent (*n*=64) had previously used social abuse towards the same female victim, 12 percent (*n*=13) had previously used sexual abuse against the same female victim, and 36 percent (*n*=38) had stalked the same female victim (2018: 26–27). In addition to characteristics of perpetrators and violence indicating increased risk, perpetrators of DFV often have prior service contact. In their 2020–21 annual report, the Queensland Domestic and Family Violence Death Review and Advisory Board (DFVDRAB) reported that in 87 of the 118 IPH cases where a history of DFV was established, the primary perpetrator of DFV had prior service contact. In the majority of cases, prior service contact occurred with police (89%), followed by Magistrates' Courts (47%), mental health services (29%), corrective services (26%), child protection (15%), hospitals (14%), GPs (13%), DFV services (8%), relationship services (4%), legal services (3%) and other services (4%). Perpetrators' service system contact creates opportunities to identify the presence of DFV-related risk and to organise suitable referral pathways, and for risk management to be shared by the services referring on and those receiving the referrals.

While not all high-risk offenders go on to commit IPH, they are at the highest risk of committing future assaults and causing the most injuries (Hilton et al. 2008, 2004). They therefore represent an important target for prevention and intervention efforts (Eke et al. 2011). Treating offenders who come to the attention of criminal justice agencies or who have diverse and repeat service system contact as an at-risk group may therefore provide an opportunity to identify the presence of DFV perpetration early and prevent escalating violence through earlier and more targeted interventions (Eke et al. 2011). This observation has also been made in the Australian context, with death review boards identifying that IPH and IPH-suicide perpetrators frequently have diverse and repeated historical service system contact (DFVDRAB 2021). These service system contacts offer opportunities for identification, risk assessment and management, information sharing and individually relevant referral pathways that are currently often missed (DFVDRAB 2021). Recent efforts have been made to overcome barriers to different service systems sharing information (see *Family Violence Protection Act 2008* (Vic) pt 5A; *Domestic and Family Violence Protection Act 2012* (Qld) pt 5A). However, the initial identification of potential DFV perpetration by male clients accessing services for other intersecting needs remains limited (DFVDRAB 2021).

While there remains a paucity of knowledge relating to screening and identifying DFV perpetration across a range of service areas, evidence exists around the use of DFV risk assessment tools in different service settings. This work also remains primarily victim-survivor focused, often relies on victim-survivor contact and communication to identify specific risk factors, and often results in victim-focused risk management outcomes (Messing & Thaller 2013; Storey et al. 2014). It is common for studies to draw on victim-survivor related information and experiences to predict risk, and some risk assessments such as the Danger Assessment were designed to be used specifically with victim-survivors (Messing & Thaller 2013). In their review of five DFV risk assessment instruments—the ODARA, the Danger Assessment, the Domestic Violence Screening Inventory, the Kingston Screening Instrument for Domestic Violence, and the Spousal Assault Risk Assessment (SARA)—Messing and Thaller (2013) note that none of the instruments was specifically designed for use with perpetrators. Only the SARA was designed to incorporate interviews with perpetrators and could be completed using case files, clinical information, interviews with victim-survivors and/or interviews with perpetrators (Messing & Thaller 2013).

The SARA uses questionnaires and professional judgement to assign a risk rating to individuals who come into contact with police or other criminal justice system agents and has been shown to have some predictive power in assessing risk of perpetrating IPV (Kropp & Hart 2000). The SARA assessment is described by Kropp and Hart (2000: 103) as 'adopting a structured professional judgement model', 'due to its lack of a fixed and explicit information-gathering procedure'. In Kropp and Hart's (2000) study, SARA ratings were predominantly made based on interviews with the perpetrators, as well as a review of relevant case notes, with a smaller number of assessments based on file notes only.

Beyond the limited direct engagement with men in the administration of risk assessment tools, other limitations have been raised related to the administration of assessments, as well as their accuracy. In their review of DFV risk assessment instruments, Messing and Thaller (2013) reported that risk assessment instruments were commonly incorrectly administered. They found that proxy instruments (for example, using fewer items or different questions to those intended) were used in place of validated risk assessment instruments, and drawing on alternative sources of information (such as case files instead of interview data) was common. For example, instruments such as the Danger Assessment are intended for use in interviews with victim-survivors (Messing & Thaller 2013) but have also been used to conduct risk assessments from criminal justice case files (Hilton et al. 2008, 2004).

Messing and Thaller's (2013) review found differing levels of predictive validity between instruments, with the ODARA rating highest on average predicative validity, while the Kingston Screening Instrument for Domestic Violence was the least predictive. Similar observations have been made in recent Australian studies. When examining the predictive validity across studies of the B-SAFER (Brief Spousal Assault Form for the Evaluation of Risk) and ODARA in the context of policing Kebbell (2019) found that validity of these two instruments varied subject to format and context of administration. An analysis of the predictive validity of an Australian DFV risk assessment used in New South Wales also found varying degrees of predictive validity. Many of the 12 factors used in the Domestic Violence Safety Assessment Tool to determine the risk of revictimisation were deemed to be weak predictors. Further, using the total score of present risk factors to identify medium-risk and high-risk clients had low predictive validity and would miss clients at risk of repeat harm (Ringland 2018).

The variation in predictive validity across tools and settings is problematic. Risk assessment tools are designed to predict the likelihood of future harm, including fatal violence. However, the wider body of research on the ability of the most common risk assessment tools discussed here reveals that most tools presently used in relevant service settings have a low accuracy in predicting future violence and fatal outcomes (see Kropp & Hart 2000; Messing & Thaller 2013; Storey et al. 2014), with the exception of the ODARA (Kebbell 2019; Messing & Thaller 2013).

Findings from Australian research based in Victoria indicate that previous versions of the 'L17 Family Violence Risk Assessment and Management Report' (hereafter referred to as L17) used by Victoria Police when responding to DFV did not accurately predict future DFV (McEwan et al. 2017). The study by McEwan and colleagues used DFV incident data recorded by frontline Victoria Police officers attending an occurrence and assessing related risk. Frontline police were expected to engage with victim-survivors and perpetrators in the process of gathering data. The actual level of engagement with or reliance on victim-survivors compared to perpetrators is, however, unclear from the study findings. Victoria Police has since updated the original L17 report to now embed the Victoria Police Screening Assessment for Family Violence Risk (VP-SAFvR) to assist police decision-making and screening practices in DFV occurrences. The score from the VP-SAFvR is used to determine whether the case will be referred to the specialist police family violence team and other DFV specialist services. Subsequent research has examined the predictive validity of the revised L17, incorporating the VP-SAFvR, and suggested the revised risk assessment tool has been strengthened (McEwan, Shea & Ogloff 2019).

Other relevant developments in risk assessment across Australian states and territories include the ongoing implementation of the Multi-Agency Risk Assessment and Management Framework (MARAM) in Victoria, the Common Risk and Safety Framework in Queensland, the ACT Risk Assessment and Management Framework, and the Tasmanian Government's integrated responses to DFV under the Safe at Home model, which uses the Risk Assessment Screening Tool. These recently introduced measures across states and territories draw on an inter-agency approach to risk assessment and information sharing. Their frameworks are predominantly victim-survivor centred and rely on information provided by the victim-survivor to identify risk of revictimisation. With the exception of the recently developed MARAM perpetrator practice guidance, these approaches are not designed to be administered with male service users to identify perpetration of DFV where no contact with the victim-survivor exists. To the authors' knowledge, at the time of writing this report, Victoria is the only Australian jurisdiction which has recently finalised a comprehensive perpetrator-specific common risk assessment tool.

In addition to the majority of risk assessment tools being victim-focused, these tools remain largely adult-centred. As a result, they do not specifically examine potential risk to children in the context of DFV. Instead, risk to children is examined in the context of risk identified for adult survivors. This is problematic as adult-centred risk assessment tools may miss risk of harm specific to children (Stanley & Humphreys 2014). In an attempt to overcome some of these issues, the Victorian RCFV recommended the development of a child-centred approach to DFV risk assessment and management. Victorian based research has since lent further support to this recommendation for child-centred risk assessment questions (Fitz-Gibbon et al. 2019; McCulloch et al. 2016), and at the time of writing the MARAM children and young people guidance is in development.

It is important to note here that evidence around the validation of the different risk assessment tools discussed above and their ability to accurately identify risk of future DFV and escalation of violence remains scarce. Research has therefore highlighted the need for validation of different tools (Mason & Julian 2009; Ringland 2018). However, if administered correctly, many of these tools are able to identify elevated levels of risk of future harm, in order to inform referral pathways to specialist DFV services and thus shared risk management and monitoring practices. Further, their ability to retrospectively identify the service system contact and support needs of perpetrators in the lead-up to escalating forms of DFV highlights opportunities for earlier intervention. This emphasises the value of common risk assessment tools and frameworks in the context of the current study. The focus here is not on the varying predictive validity observed across risk assessment tools in other research but rather the research evidence that these tools are able to identify missed opportunities for intervention. In other words, these tools may have limited ability to accurately predict which perpetrator will end up engaging in subsequent and severe forms of DFV, but existing evidence shows that those perpetrators who do often have prior service system contact where their use of DFV was not identified. This constitutes the missed opportunity to screen and assess risk for DFV perpetration in order to create referral pathways for perpetrators of DFV to relevant interventions and monitor the ongoing risk they may pose.

Overall, evidence regarding the use of screening and risk assessment of men using DFV is only just emerging (Davis & Padilla-Medina 2021; Portnoy et al. 2020). While sectors that frequently have contact with both victim-survivors and perpetrators (such as police and child protection) have the benefit of assessing risk in consultation with the victim-survivor, many others have to rely on information shared by potential perpetrators. Service sectors that have contact with (unidentified) perpetrators due to intersecting risk factors (eg mental health problems, AOD use or other offending behaviours) are therefore well placed to screen male clients for the potential use of DFV. However, the research evidence reviewed here highlights a clear knowledge gap as it relates to perpetrator-focused screening and risk assessment, information sharing and the ability to generate appropriate referral pathways and shared risk management across a range of different service sectors. There is a clear need for more research to identify current practices around screening and risk assessment across service areas that frequently see male clients with presenting issues known to intersect with DFV. The current study aims to address some of these knowledge gaps.

Aims and objectives

This study aims to critically examine the current state of knowledge and practice relating to DFV perpetrator-focused screening, risk assessment and management across different practice areas. It is guided by the following four overarching objectives:

- to identify current perceptions and practices in relation to DFV screening among frontline practitioners responding to male clients across different non-DFV specialist service areas (including mental health, alcohol and other drug services, child protection and corrections);
- to identify current perceptions and practices in relation to DFV risk assessment among frontline practitioners responding to male clients across different non-DFV specialist service areas (including mental health, alcohol and other drug services, child protection and corrections);
- to examine whether and how current screening and risk assessment practices around DFV perpetration among men accessing non-DFV specialist services translate into information-sharing and referral pathways to coordinate risk management, monitoring and relevant support options for men using DFV; and
- to identify policy and practice implications arising from this research to improve identification of and responses to potential perpetrators of DFV when accessing non-DFV specialist services with other presenting issues that frequently intersect with DFV (including mental health concerns, problematic substance use, child welfare concerns or other offending behaviour).

Methodology

Research questions

The following research questions guided the data collection and analysis for this project:

- 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 predictors of:
  - screening men for DFV perpetration in non-DFV specialist service areas?
  - conducting risk assessment in non-DFV specialist service areas when DFV perpetration is identified?
- What are practitioner perceptions of the relationship between identification and risk assessment of DFV perpetration and related information-sharing and referral pathways in non-DFV specialist service areas?
- 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?

Research design and methodology

The research project used a two-stage mixed-method design, as shown in Figure 1 and discussed in detail below.

Figure 1: Research stages

October 2020 – September 2021
Online survey (Qld *n*=453; Vic *n*=70)

September 2021 – October 2021
Practitioner focus groups with 39 participants (Qld *n*=31; Vic *n*=8)

The research findings presented throughout this report are primarily focused on the survey responses gleaned from Queensland practitioners, with a separate section drawing on Victorian data as it relates to the MARAM. In stage 2, the research team was able to conduct one Victorian community practitioner focus group, which specifically explored Victorian DFV reforms in alcohol and other drugs and mental health service settings.

Stage 1: Online survey (October 2020 to September 2021)

In stage 1 we developed an anonymous online survey that was distributed to state and territory peak bodies and professional networks for wider circulation among practitioners. The survey was designed to capture participants' service areas, roles, specialisation and perceptions and practices around screening male clients for potential perpetration of DFV and related risk.

To maximise participation from practitioners working across government departments, the research team sought research approval for data collection with practitioners from child protection, health (public mental health and AOD services), corrections and police agencies. As it was not feasible for the study to seek such approvals in all Australian jurisdictions, research applications were limited to agencies in Victoria and Queensland. These two jurisdictions were chosen based on the research team's strong industry relations and the jurisdictions' significant DFV reform agendas implemented in recent years, following the Victorian RCFV (2016) and the Special Taskforce on Domestic and Family Violence in Queensland (2015).

Due to the ongoing impacts of the COVID-19 pandemic on service operations, particularly in Victoria, a number of departments (eg Department of Health and Human Services, which covers child protection and health services in Victoria, Corrections Victoria, Victoria Police and the Queensland Police Service) were unable to process research approval applications throughout the duration of data collection for this study. Participating agencies included:

- Queensland Health (mental health and AOD services) (March – May 2021)
- Queensland Corrective Services (May – June 2021)
- Queensland Child Safety (August – September 2021)

The research team received Monash University human research ethics approval (#23173), as well as approval from external industry partners. Wider survey circulation by the research team via peak bodies and stakeholder networks commenced in October 2020. Survey circulation within participating departments occurred in phases following relevant organisational research approval from each of the industry partners. Once research approvals had been obtained, industry partners circulated the survey via site- and region-specific organisational leaders. Survey distribution included an initial survey invitation and fortnightly survey reminders over a six-week timeframe.

Survey instruments and items

The survey instrument was developed by the research team. The survey was expected to take approximately 20 minutes to complete and consisted of four modules:

- practitioner information;
- screening and risk assessment practices;
- attitudes towards screening, risk assessment and referral pathways; and
- jurisdiction-specific DFV reform questions relating to Victoria or Queensland.

Practitioner information

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

Screening and risk assessment practices

Participants were asked about their screening and risk assessment practices for both DFV victimisation among female clients and DFV perpetration among male clients across a series of five-point Likert scales. For example, participants were asked how frequently they screen for DFV perpetration; how frequently they screen for DFV victimisation; how frequently they assess risk of DFV perpetration; and how frequently they assess risk of DFV victimisation. Possible responses ranged from 'never' (1) to 'always' (5). Participants who identified screening for DFV perpetration (ie those who said they 'seldom' to 'always' perform this screening) were asked an additional question regarding how often they identify DFV perpetration as being present in the cases they screen. This question was answered using a 'slider', allowing participants to indicate a percentage.

It is important to note here that practitioners were not asked about how they screen for DFV perpetration among female clients or victimisation among male clients. Self-reported screening practices may therefore vary and range from screening of referral information received from other agencies for the documentation of DFV, to actively asking clients about potential behaviours during intake conversations or follow-up contact.

Attitudes towards 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).

In the absence of measures specific to DFV perpetrator screening and risk assessment, the above statements were developed by the research team, informed by the existing evidence as it relates to DFV victimisation screening and attitudes and beliefs around perpetration screening (Hegarty, Taft & Feder 2008; Kimberg 2007; Portnoy et al. 2020; Todahl & Walters 2011). They do not constitute a validated tool and are analysed individually rather than as an aggregate score. Participants responded to each statement using a five-point Likert scale ranging from 'strongly disagree' (1) to 'strongly agree' (5). Statements 2, 3, 4 and 8 were reverse recoded so that a higher score consistently indicates a more positive attitude.

Jurisdiction-specific questions on Victoria and Queensland

Given the substantive DFV reform agendas underway in Victoria and Queensland, the survey contained some questions specific to each of these jurisdictions. In Victoria, the MARAM framework was developed and implemented as part of a whole-of-system reform stemming from the RCFV (2016). The development of the MARAM, led by the Victorian Government in consultation with the sector and academics, was informed by the RCFV findings, the findings of the coronial inquest into the death of Luke Batty (Gray 2015), and the 2016 review of the Common Risk Assessment and Management Framework (McCulloch et al. 2016). The aim of the MARAM is to improve victim safety through closer collaboration and shared approaches to risk identification, assessment and management between mainstream and specialist agencies across the Victorian family violence system. The framework is legislated under the *Family Violence Protection Act 2008* (Vic), pt 11, which sets out the organisations that are required to align current practices and practitioner roles and responsibilities with the MARAM. The Victorian Government has adopted a phased approach to the use of the MARAM, seeking to align its implementation with other key reforms, including the introduction of the Family Violence Information Sharing Scheme (see further McCulloch et al. 2020).

Phase 1 of the MARAM was introduced in 2018 across 850 organisations. Organisations included child protection, AOD and mental health services, police, courts and DFV specialist services. In phase 1 of the MARAM rollout, the focus was on enhancing the identification of DFV-related risk in service system contact with victim-survivors and in sharing risk-related information with relevant partner agencies which subscribe to the use of the MARAM. More recently, in February 2022, a perpetrator-focused version of the MARAM was finalised (for further information about the MARAM, see https://www.vic.gov.au/information-sharing-schemes-and-the-maram-framework). Survey participants who identified Victoria as their jurisdiction were therefore asked if they had received MARAM training. Victorian participants who indicated that they had received MARAM training were asked a series of follow-up questions (using a five-point Likert scale) to examine whether the introduction of the MARAM had increased their confidence in screening for DFV victimisation or perpetration and in assessing risk of subsequent DFV victimisation and perpetration. Possible responses to these questions ranged from ‘strongly agree’ to ‘strongly disagree’.

In Queensland, the Department of Child Safety, Youth and Women (now the Department of Children, Youth Justice and Multicultural Affairs) adopted the Safe & Together model (hereafter the S&T model) in 2016. The S&T model was developed in the United States by David Mandel (for further information on the model, see https://safeandtogetherinstitute.com/). The S&T model is a child-centred, DFV-specific approach to perpetrator risk identification, assessment and management. The model is premised on the basis that children are not 'disconnected' from the violence that occurs between a male perpetrator and a female victim-survivor. Through this child-centred focus, the model informs practice by unpacking the impact of men's use of violence on children, mothers and the family unit. The S&T model adopts a victim-survivor strength-based approach and understands DFV perpetration as a pattern of violent behaviours and a parenting choice. While initially adopted within the statutory child protection setting in Queensland, the model has been adopted to varying degrees in other Australian jurisdictions and different service settings (eg non-statutory child and family services, AOD services, family law).

The implementation of the S&T model is supported by the use of the S&T perpetrator mapping tool. This tool assists frontline practitioners in mapping abusive behaviours and their impact on the victim-parent, family functioning and individual and family wellbeing. It is designed to make patterns of DFV visible in child protection interventions, rather than limiting assessments to incidents of harmful behaviour. It further assists practitioners, in partnership with mothers in their role as victim-parent, to identify her protective strategies, how these may be undermined by the abusive co-parent and what support is needed to better protect mothers and children. (For further information on S&T practice tools, see https://safeandtogetherinstitute.com/what-we-offer/safe-together/safe-and-together-model-practice-tool-trainings-new/.)

Queensland child protection practitioners were asked similar questions to the ones posed to Victorian survey participants regarding the implementation of the MARAM, including whether the introduction of S&T has increased their confidence in screening for DFV victimisation and perpetration and assessing related risk. Further, informed by consultation with our project industry partner, Queensland child protection practitioners were also asked if the introduction of the S&T model increased their ability to initiate suitable referral pathways for mothers or female carers as victim-survivors of DFV as well as for fathers or male carers as perpetrators of DFV.

Open-ended items

In addition to the closed-ended items described above, participants were able to provide additional qualitative feedback in relation to their screening and risk assessment practices, including service area and client population specific barriers.

Response rate

There were 663 valid survey responses. While initially designed as a national survey, the survey was predominantly completed by Victorian and Queensland practitioners. Table 1 shows that response rates were low (*n*<30) in all other state and territory jurisdictions.

Table 1: Response rate by jurisdiction (*n*=663)

Response rate	Qld	Vic	NSW	WA	SA	ACT	NT	Tas
n	532	70	19	14	11	7	7	3
%	80.2	10.6	2.9	2.1	1.7	1.1	1.1	0.5

As Table 1 shows, most of the 663 survey participants (*n*=532, 80%) were from Queensland. The over-representation of Queensland-based participants in the survey reflects the involvement of key industry partners in this project, including Queensland Child Safety (part of the Department of Children, Youth Justice and Multicultural Affairs; hereafter referred to as child protection), Queensland Corrective Services (hereafter referred to as corrections) and Queensland Health. As a result of the high response rate from Queensland (80%), survey results presented throughout this report are limited to those from Queensland, with the exception of the MARAM-specific survey findings section, which examines the findings from Victoria.

As shown in Table 2, the predominant practice area within the Queensland sample was Queensland Corrective Services (*n*=174, 33%), followed by Queensland Health, including mental health (*n*=159, 30%) and AOD (*n*=20, 4%) services, child protection (*n*=100, 19%) and DFV and MBCP services (*n*=30, 6%). The remaining Queensland participants (*n*=49, 9%) were categorised as 'other' and include practitioners from areas where fewer than 20 responses were received. Practice areas within the 'other' category include, for example, Aboriginal specialist services, other justice services (excluding corrections), and crisis accommodation, housing and homelessness services.

Table 2: Queensland sample: Response rate by practice area (*n*=532)

Response rate	Corrections	Health		Child protection	DFV and MBCP	Other
		Mental health	AOD			
n	174	159	20	100	30	49
%	32.7	29.9	3.8	18.8	5.6	9.3

Note: AOD=alcohol and other drugs. DFV=domestic and family violence. MBCP=men's behaviour change programs

Due to the low response rate (*n*<20) for the range of practice areas in the 'other' category and the DFV specialist practitioner responses being outside the scope of the current study, these survey responses were excluded from further analysis. Results presented here therefore focus on the screening and risk assessment practices and attitudes among practitioners representing one of the four priority practice areas: child protection, corrections, mental health and AOD services.

Following the analysis of the Queensland data derived from these four practice areas, we also present separate analyses of Queensland child protection practitioner survey responses (*n*=100) related to the S&T model and training and Victorian survey responses (*n*=70) related to the introduction of the MARAM. These separate analyses examine practitioner perceptions specific to recent practice reforms implemented across Victoria's service sector more broadly and within Queensland child protection specifically.

Queensland priority practice area sample characteristics

As shown below in Table 3, the majority of the 453 participants represented corrections (*n*=174, 38%) and mental health (*n*=159, 35%), followed by child protection (*n*=100, 22%) and AOD (*n*=20, 4%).

Table 3: Queensland priority practice area sample: Response rate by practice area (*n*=453)

Response rate	Corrections	Health		Child protection
		Mental health	AOD	
n	174	159	20	100
%	38.4	35.1	4.4	22.1

Note: AOD=alcohol and other drugs

Table 4 illustrates how long participants have worked in their current role, and in their current area of practice. On average participants had been in their current area of practice between seven and 10 years and in their current role between three and six years.

Table 4: Queensland practitioners' professional experience

	0–2 years	3–6 years	7–10 years	11–19 years	20+ years	*M*	*SD*
Years in current practice area[a]							
n (%)	72 (16.0)	105 (23.4)	77 (17.2)	105 (23.4)	90 (20.0)	3.08	1.38
Years in current role[b]							
n (%)	164 (36.2)	148 (32.7)	47 (10.4)	61 (13.5)	33 (7.3)	2.23	1.27

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

Most participants (*n*=316, 70%) reported having some formal DFV specialist training, while 30 percent (*n*=137) had no formal DFV specialist training. Participants were also asked about the type of training they received, which was analysed to determine the highest level of formal DFV specialist training. As shown in Table 5, the most common form of specialist training completed by participants was a DFV-specific short course (*n*=157, 35%).

Table 5: Queensland 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

The survey also included questions related to screening and risk assessment practices and attitudes (see *Survey instruments and items* section, above). Due to a branching error in the online survey design, corrections practitioners were taken to the same questions as DFV and MBCP practitioners, who were only asked about risk assessment practices in relation to known victim-survivors and perpetrators. As a consequence, risk assessment related data are available for the full Queensland priority practice area sample (*n*=453), while data related to screening practices and attitudes are only available for the mental health, child protection and AOD subsample (*n*=279). The number of responses to each question (*n*) is provided throughout.

Data analysis: Practitioner survey

Survey data were analysed using SPSS Statistics software V.26. Descriptive statistics were computed for responses to each of the survey items. Several one-way analyses of variance (ANOVAs) were computed to compare screening and risk assessment practices and attitudes between practice areas (child protection, AOD, mental health and corrections). Post-hoc analyses were conducted using Games–Howell where the assumption of homogeneity of variances was violated and using Tukey where there was homogeneity of variances. Paired sample *t*-tests were conducted to analyse differences in screening for DFV perpetration compared to DFV victimisation and differences in risk assessment between DFV victimisation and DFV perpetration. Multiple regression analyses were used to identify predictors of screening and risk assessment within the survey sample. Data related to the MARAM (Victoria), and the S&T model (Queensland child protection) were analysed using paired sample *t*-tests. 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. In addition to quantitative survey measures, the online survey contained open-ended questions, offering practitioners opportunities to provide additional qualitative information. Open-ended survey responses were coded and thematically analysed using NVivo 12 (qualitative analysis software).

Stage 2: Focus groups (September to October 2021)

The second stage of the project was designed to unpack preliminary survey findings with frontline practitioners from participating industry partners. The following practice areas and practitioner groups were represented across the focus groups, small group interviews and individual interviews in Queensland:

- 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).

Five practitioners were interviewed individually because they were unable to attend the scheduled focus group times. In addition to the Queensland based focus groups and interviews, the research team conducted one focus group with Victorian DFV specialist practitioners and community service provider representatives across a small number of AOD and mental health services in the Greater Melbourne area (*n*=8). All focus groups were facilitated online via video technology due to the ongoing COVID-19 related restrictions affecting the research team's ability to travel. The virtual facilitation of focus groups also maximised opportunities for participation across metropolitan and regional practitioners.

Data analysis: Focus groups

Qualitative data were coded using thematic analysis. Coding was informed by the key research questions and preliminary survey findings and followed a deductive approach to data processing. We used manual coding and NVivo software to identify emerging key themes and analyse focus group findings alongside relevant survey results. The focus group and interview transcripts were compiled and collectively analysed. Throughout this report we refer to the focus groups and interviews as 'focus groups.'

Limitations

The project findings are subject to several limitations. While the initial scoping of the study sought to include a national survey, the findings are largely limited to Queensland practitioner practices and perceptions, with some insights into Victoria's recent reforms around identifying and responding to DFV. Findings therefore primarily reflect practice in Queensland and may not apply to other Australian states and territories. This is evident in the mental health and AOD findings, which identify substantial shifts towards DFV-informed practice, including perpetrator identification and support, in the Victorian mental health and AOD-specific focus group findings, which were not evident to the same extent in the Queensland data. Further, other research on shifting child protection responses towards DFV-informed practice reveals that the progress made in Queensland child protection work does not necessarily reflect child protection practices in other jurisdictions (Pfitzner et al. 2022). Despite data collection primarily being limited to one jurisdiction, the findings offer new insights into current attitudes and practices around identifying and responding to perpetrators of DFV and raise implications for organisations and service areas beyond Queensland.

While the current study was focused on male perpetrated IPV, a number of findings may equally apply to other forms of DFV (eg violence perpetrated by adult children against a parent), which may also often intersect with perpetrators' mental health issues or problematic substance use. 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 the perpetrator and affected family members.

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. Further research should consider expanding the current study focus to the identification and support needs of diverse perpetrator populations, including women using force, young people engaging in DFV in intimate relationships as well as towards parents and other family members, and LGBTIQA+ (lesbian, gay, bisexual, transgender, intersex, queer, asexual plus) perpetrator populations and their unique support needs. Finally, the barriers to screening and referral pathways specific to First Nations and culturally and linguistically diverse populations touched on in this report require future culturally sensitive examination. While a lack of culturally suitable and sensitive screening and risk assessment tools was noted by survey and interview participants, an in-depth exploration of what these should look like was beyond the scope of this study.

Results: Survey

The results are presented in two parts: survey findings and focus group findings. This section provides details of the survey findings. Not all participants completed all questions or modules within the survey. Further, due to the branching error in the online survey discussed in the *Methodology* section, the level of missing data was high for questions about screening attitudes and practices. Partial responses are used where relevant, with the number of responses to each question (*n*) provided. Percentages reported throughout are valid percentages, adjusted for missing values where appropriate. 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.

Screening and risk assessment in different practice areas

As outlined in the methodology, survey participants were asked a number of questions regarding their screening and risk assessment practices, as well as their attitudes towards screening and risk assessment. Comparisons between the practice areas (child protection, mental health, AOD and corrections), were conducted using ANOVA to analyse the following six dependent variables:

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

We included two individual attitude items (core business and denial) 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, level of formal DFV specialist training was included in the ANOVA because it emerged as critical in the qualitative survey and focus group results. Comparisons between practice areas were also conducted using ANOVA to compare the level of formal DFV specialist training between groups. The results of the ANOVA are provided in Table 6.

Table 6: 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 a higher score indicates a more positive attitude

c: As corrections participants only completed the risk assessment items, no data is presented for screening practice and attitude items for this group

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 can be seen in Table 6, all dependent variables (frequency of screening, perceived frequency of positive identification of DFV, frequency of risk assessment, core business attitudes, denial attitudes, and level of DFV specialist training) were significantly different between practice areas. This demonstrates that there is a difference in the group means but does not tell us which practice areas differ from each other for each dependent variable. Games–Howell and Tukey post-hoc analyses were conducted to explore where mean differences between groups lie. Significance is reported using the Bonferroni-Holm adjustment (p<0.017 for dependent variables with three groups (ie three comparisons); p<0.008 for dependent variables with four groups (ie six comparisons)). 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).

Frequency of screening scores were statistically significantly different between practice areas (Welch's F(2, 51.636)=31.052, p<0.001). Frequency of screening mean scores were lowest for the mental health group (M=2.56, SD=1.24), followed by the AOD (M=2.90, SD=1.33) and child protection groups (M=3.74, SD=1.12). A Games–Howell post-hoc analysis revealed that the mean difference between mental health and child protection (1.18, 95% CI [0.83, 1.53]) was statistically significant (p<0.001). No other group differences were statistically significant.

The mean scores for the perceived percentage of positive identification of DFV perpetration were statistically significantly different between practice areas (F(2, 207)=84.396, p<0.001). The perceived percentage of positive identification of DFV perpetration scores were lowest for mental health practitioners (M=23.63, SD=25.81), followed by AOD practitioners (M=29.06, SD=24.45) and child protection participants (M=69.36, SD=23.73). A Tukey post-hoc analysis revealed that the mean difference between mental health and child protection practitioners (45.73, 95% CI [37.27, 54.20]) was statistically significant (p<0.001), as was the difference between AOD and child protection participants (40.30, 95% CI [24.78, 55.82], p<0.001). No other group differences were statistically significant.

The mean scores for the frequency of risk assessment were statistically significantly different between practice areas (Welch's F(3, 76.553)=15.590, p<0.001). The frequency of risk assessment mean scores were lowest for AOD participants (M=2.33, SD=1.37), followed by mental health (M=2.62, SD=1.55), corrections (M=3.17, SD=1.51) and child protection practitioners (M=3.75, SD=1.11). A Games–Howell post-hoc analysis revealed that the mean difference between child protection and corrections (0.58, 95% CI [0.15, 1.01]) was statistically significant (p=0.003), as was the difference between child protection and mental health (1.13, 95% CI [0.67, 1.60], p<0.001), and child protection and AOD (1.42, 95% CI [0.46, 2.38], p=0.002). No other group differences were statistically significant.

The attitude that screening for DFV perpetration is core business differed significantly between practice areas (Welch's $F(2, 38.860)=41.019$, $p<0.001$). The mean scores for the attitude that screening is core business were lowest for mental health participants ($M=3.33$, $SD=1.37$), followed by AOD ($M=4.20$, $SD=0.86$) and child protection practitioners ($M=4.60$, $SD=0.59$). A Games–Howell post-hoc analysis revealed that the mean difference between mental health and child protection participants was statistically significant (1.27, 95% CI [0.94, 1.59], $p<0.001$), as was the difference between mental health and AOD practitioners (0.87, 95% CI [0.23, 1.50], $p=0.006$). No other group differences were statistically significant.

The attitude that screening for DFV perpetration is pointless because perpetrators will deny their use of violence differed significantly between practice areas (Welch's $F(2, 33.772)=10.968$, $p<0.001$). This attitude measure was reverse recoded, with lower scores indicating greater agreement with the statement. Mean scores were lowest for the mental health group ($M=4.03$, $SD=1.00$) followed by AOD ($M=4.07$, $SD=1.54$) and child protection practitioners ($M=4.60$, $SD=0.74$). A Games–Howell post-hoc analysis revealed that the mean difference between mental health and child protection groups (0.57, 95% CI [0.28, 0.85]) was statistically significant ($p<0.001$). No other group differences were statistically significant.

Mean scores for the level of formal DFV specialist training were statistically significantly different between practice areas ($F(3, 449)=20.978$, $p<0.001$). Level of formal DFV specialist training mean scores were lowest for mental health practitioners ($M=0.91$, $SD=1.25$), followed by AOD ($M=1.30$, $SD=1.49$), corrections ($M=1.60$, $SD=1.18$) and child protection participants ($M=2.14$, $SD=1.33$). A Tukey post-hoc analysis revealed that the mean difference between child protection and corrections was statistically significant (0.54, 95% CI [0.14, 0.95], $p=0.003$), as was the difference between child protection and mental health (1.23, 95% CI [0.82, 1.65], $p<0.001$), and corrections and mental health (0.69, 95% CI [0.34, 1.05], $p<0.001$). No other group differences were statistically significant.

These findings suggest that, within the survey sample, mental health and AOD practitioners screen for and assess the risk of DFV perpetration less frequently than practitioners from child protection and corrections. Mental health and AOD practitioners also expressed less positive attitudes to screening for DFV perpetration, including the attitude that screening is not their core business and that it 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%). DFV specialist training was lowest for mental health ($M=0.91$, $SD=1.25$) and AOD practitioners ($M=1.30$, $SD=1.49$).

Attitudes to screening and risk assessment

As outlined in the methodology, survey 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. Mean scores for each practice area, as well as overall mean scores for the eight individual attitude items, are shown in Table 7.

Table 7: Screening and risk assessment attitudes by practice area

Item	Child protection *M* (*n*)	Health		Corrections *M* (*n*)	Mean score (*n*)
		Mental health *M* (*n*)	AOD *M* (*n*)		
Screening for DFV perpetration is core business[a]	4.60 (80)	3.33 (126)	4.20 (15)	–	3.85 (221)
Area of service delivery has no time to screen for DFV perpetration[b]	3.86 (80)	3.62 (126)	3.53 (15)	–	3.70 (221)
Screening for DFV perpetration is pointless because perpetrators will deny use of DFV[b]	4.60 (80)	4.03 (126)	4.07 (14)	–	4.24 (220)
Screening for DFV perpetration is pointless because of the unavailability of necessary referrals[b]	4.22 (80)	3.94 (126)	4.20 (15)	–	4.06 (221)
Current screening tools used by my organisation to identify perpetration of DFV are useful in identifying potential risk for victims and children	3.65 (79)	2.89 (124)	3.14 (14)	–	3.18 (217)
Current risk assessment tools used in my organisation to identify severity of perpetration of DFV encounters with identified perpetrators are useful in identifying heightened risk for victims and children	3.60 (80)	2.83 (123)	2.93 (14)	3.05 (163)	3.09 (380)
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	3.38 (80)	2.80 (124)	2.93 (14)	3.21 (163)	3.10 (381)
Once a perpetrator of DFV has been referred to a support or specialist service provider, the responsibility of ongoing risk monitoring and management lies with that service provider/organisation[b]	3.23 (80)	3.02 (125)	3.50 (14)	3.86 (163)	3.44 (382)

a: The lower response rate for the screening attitude items reflects that only mental health, AOD and child protection survey participants answered the screening questions

b: These variables were reverse recoded; a higher score indicates a more positive attitude towards screening and risk assessment for all attitude variables

Note: Mean score out of 5

As shown in Table 7, survey participants overall hold positive attitudes towards DFV screening and risk assessment. While concerns around perpetrator denial and minimisation are raised throughout this study's qualitative findings, practitioners reject that these factors make screening pointless. As discussed above in the ANOVA results, this attitude differed significantly between the mental health and child protection groups, with child protection practitioners more likely to disagree with the statement. However, practitioners appear to be less convinced that current screening and risk assessment tools and practices used within their respective organisations are useful in identifying heightened and potential risk of DFV and in identifying useful referral pathways for perpetrators of DFV.

Screening and risk assessment for DFV perpetration and victimisation

In addition to questions about DFV perpetration, survey participants were also asked about screening and risk assessment for DFV victimisation. Participants responded to each question using a five-point scale ranging from 'always' to 'never'. The results of the descriptive overview of responses for DFV victimisation compared with DFV perpetration are shown in Table 8 to identify the current state of victim- and perpetrator-focused screening and risk assessment practices. Victim-centred practices are only presented here as part of a descriptive overview. They are not examined further in multivariate analyses as they were beyond the focus of this study.

Overall, fewer than 50 percent of participants reported that they always or nearly always screen for DFV victimisation (*n*=125, 45%) and DFV perpetration (*n*=112, 40%), and that they always or nearly always assess the risk of DFV victimisation (*n*=170, 41%) and DFV perpetration (*n*=189, 46%), as shown in Table 8.

Table 8: Frequency of screening and risk assessment for DFV victimisation and perpetration

	DFV victimisation *n*(%)			DFV perpetration *n*(%)			*t*	Cohen's *d*
	Always/ nearly always	Some-times	Seldom/ never	Always/ nearly always	Some-times	Seldom/ never		
Screening frequency (*n*=279)***	125 (44.8)	79 (28.3)	75 (26.9)	112 (40.1)	72 (25.8)	95 (34.1)	3.724	0.22
Risk assessment frequency (*n*=415)	170 (41.0)	82 (19.8)	163 (39.3)	189 (45.5)	76 (18.3)	150 (36.1)	−2.138	−0.11

***statistically significant at $p<0.001$
Note: DFV=domestic and family violence

Paired *t*-tests were conducted to compare the frequency of screening and risk assessment for DFV victimisation and DFV perpetration. Participants reported more frequent screening of DFV victimisation ($M=3.20$, $SD=1.35$, $t(278)=3.724$, $p<0.001$), compared to DFV perpetration ($M=3.00$, $SD=1.32$). This is a statistically significant mean difference of 0.19 (95% CI [0.09, 0.30]), although the effect size is small ($d=0.22$). Conversely, participants reported more frequent risk assessment for DFV perpetration ($M=3.07$, $SD=1.50$, $t(414)= -2.138$, $p=0.033$) compared with DFV victimisation ($M=2.98$, $SD=1.50$). This result is not statistically significant ($p<0.0125$, Bonferroni adjusted).

Further to the bivariate analyses presented above, we conducted two multiple regression analyses to identify predictors of more frequent screening and risk assessment.

Factors associated with screening for DFV perpetration

In the first ordinary least squares regression analysis, we examined whether practice area (child protection, mental health), level of formal DFV specialist training, years of experience in practice area, and years of experience in current role were associated with frequency of screening for DFV perpetration. The model explains 21.4 percent of the variance in participants' reported frequency of screening for DFV perpetration. As shown in Table 9 below, level of formal DFV specialist training ($\beta=0.154$; $p<0.002$) predicted more frequent screening for DFV perpetration.

These results suggest that those who had a higher level of formal DFV specialist training were more likely to report that they screen for DFV perpetration. No other variables were statistically significant.

Table 9: Frequency of screening for DFV perpetration (*n*=277)			
Effect	**B (*SE*)**	**β**	***T***
Constant	2.628 (0.353)		7.450
Child protection practitioner	0.756 (0.304)	0.274	2.483
Mental health practitioner	−0.217 (0.258)	−0.081	0.746
Years' experience in practice area	−0.096 (0.065)	−0.101	−1.476
Years' experience in current role	0.132 (0.068)	0.130	1.940
Level of formal DFV specialist training	0.174 (0.056)	0.186**	3.130

**statistically significant at $p<0.01$ (Bonferroni adjustment)

Note: Corrections practitioners were excluded from this model as this cohort did not complete this measure. $R^2=0.21$, $\Delta R^2=0.20$. DFV=domestic and family violence

Factors associated with risk assessment for DFV perpetration

A second ordinary least squares regression model was run to determine if practice area (child protection, mental health or corrections), level of formal DFV specialist training, years of experience in practice area and years of experience in participants' current role were associated with frequency of risk assessing for DFV perpetration. The model explains 12.9 percent of the variance in participants' reported frequency of assessing risk for DFV perpetration. As shown in Table 10 below, being a child protection practitioner (β=0.348, $p<0.001$), years' experience in current role (β=0.162, $p=0.006$) and level of formal DFV specialist training (β=0.187, $p<0.001$) were positively associated with more frequent risk assessment for DFV perpetration. No other variables were statistically significant.

Table 10: Frequency of risk assessment for DFV perpetration (*n*=414)			
Effect	**B (*SE*)**	**β**	***T***
Constant	2.008 (0.404)		4.976
Child protection practitioner	1.295 (0.379)	0.348***	3.419
Mental health practitioner	0.419 (0.356)	0.131	1.175
Corrections	0.776 (0.358)	0.254	2.170
Years' experience in practice area	−0.134 (0.067)	−0.123	−1.994
Years' experience in current role	0.194 (0.071)	0.162*	2.754
Level of formal DFV specialist training	0.210 (0.055)	0.187***	3.801

***$p<0.001$, *$p<0.008$ (Bonferroni adjustment)

Note: $R^2=0.13$, $\Delta R^2=0.12$. DFV=domestic and family violence

Queensland child protection: Safe & Together

Queensland child protection survey participants (*n*=100) were asked additional questions regarding the S&T model, as well as the S&T perpetrator mapping tool. The vast majority of the Queensland child protection participants who answered this question (*n*=67, 99%) had some familiarity with the S&T framework (32 participants did not answer this question). Paired *t*-tests were conducted to:

- compare the confidence in screening and risk assessment related to DFV victimisation and perpetration following the introduction of the S&T model; and
- compare the ability to initiate suitable referral pathways for mothers or female carers as victim-survivors and for fathers or male carers as perpetrators of DFV.

Responses are illustrated below in Table 11.

Table 11: Impact of Safe & Together framework on confidence in screening and assessing risk and ability to initiate referral pathways for DFV victimisation and perpetration

	DFV victimisation *n*(%)			DFV perpetration *n*(%)			*t*	Cohen's *d*
	Agree	Unsure	Disagree	Agree	Unsure	Disagree		
Increased confidence in screening (*n*=67)[a]	58 (86.5)	6 (9.0)	3 (4.5)	58 (86.5)	6 (9.0)	3 (4.5)	0.445	0.054
Increased confidence in assessing risk (*n*=68)	56 (82.4)	8 (11.8)	4 (5.9)	57 (83.8)	7 (10.3)	4 (5.9)	0.000	0.000
Increased ability to initiate suitable referral pathways (*n*=68)***	53 (78.0)	6 (8.8)	9 (13.2)	42 (61.7)	10 (14.7)	16 (23.5)	3.889	0.472

***statistically significant at $p<0.001$

a: One participant did not answer this item

Note: Only 68 of the 100 Queensland child protection participants answered the S&T items. DFV=domestic and family violence

Most survey participants agreed with each of the statements suggesting that the introduction of the S&T model had increased their confidence in screening and risk assessment for DFV victimisation and DFV perpetration, as well as increasing their ability to initiate suitable referral pathways. Here, it is noteworthy that practitioner survey findings suggest that the introduction of the S&T model had a greater impact on confidence in screening and risk assessment than on the ability to initiate suitable referral pathways. In particular, participants rated their ability to initiate suitable referral pathways as lower for fathers or male carers as perpetrators of DFV (*n*=42, 62%), compared with mothers or female carers as victim-survivors of DFV (*n*=53, 78%). Further, participants reported a greater increase in ability to refer mothers or female carers as victim-survivors of DFV (*M*=3.88, *SD*=1.02, *t*(67)=3.889, *p*<0.001), compared with fathers or male carers as perpetrators of DFV (*M*=3.53, *SD*=1.25). This is a statistically significant mean difference of 0.35 (95% CI [0.17, 0.53]), although the effect size is small (*d*=0.47). This is likely a reflection of the limited availability of suitable referral pathways for men using DFV, including MBCPs (see *Referral pathways and lack of available programs*, below). Confidence in screening and risk assessment for DFV victimisation and for perpetration were not statistically significantly different following the introduction of the S&T model.

Victoria: MARAM

Victorian survey participants (*n*=70) answered additional questions about MARAM. Almost two-thirds of Victorian participants (*n*=45, 64%) had received MARAM training. Of those, the majority (*n*=40, 89%) were in a practice area that currently subscribed to the use of the MARAM. All Victorian participants who had received MARAM training were asked four questions to identify whether the introduction of the MARAM increased practitioner:

- confidence in screening for DFV victimisation;
- confidence in screening for DFV perpetration;
- confidence in assessing risk related to DFV victimisation; and
- confidence in assessing risk related to DFV perpetration.

Paired *t*-tests were conducted to compare the confidence in screening and risk assessment between DFV victimisation and perpetration following the introduction of the MARAM. Results are illustrated below in Table 12.

Table 12: Impact of MARAM on confidence in screening and assessing risk for DFV victimisation and perpetration

	DFV victimisation *n*(%)			DFV perpetration *n*(%)			*T*	Cohen's *d*
	Agree	Unsure	Disagree	Agree	Unsure	Disagree		
Increased confidence in screening (*n*=44)**	39 (88.6)	2 (4.5)	3 (6.8)	31 (70.5)	5 (11.4)	8 (18.2)	3.317	0.500
Increased confidence in assessing risk (*n*=44)**	39 (88.6)	1 (2.3)	4 (9.1)	33 (75)	4 (9.1)	7 (15.9)	2.725	0.411

**statistically significant at $p<0.01$
Note: DFV=domestic and family violence

Similar to the introduction of the S&T model in Queensland, the introduction of the MARAM in Victoria was generally linked to increased confidence in screening and assessing risk for both DFV victimisation and perpetration. However, while the introduction of the S&T model saw similar increases in confidence in screening and risk assessment for both victimisation and perpetration of DFV, the introduction of the MARAM had a greater impact on practitioners' confidence in screening and risk assessment for victimisation. Participants reported a greater increase in confidence for screening of DFV victimisation (M=4.16, SD=0.81, $t(43)$=3.317, $p<0.005$), compared to DFV perpetration (M=3.64, SD=1.12). This is a statistically significant mean difference of 0.52 (95% CI [0.20, 0.84]), although the effect size is small (d=0.50). Participants also reported a greater increase in confidence for assessing risk of DFV victimisation (M=4.14, SD=0.93, $t(43)$=2.725, p=0.009), compared with DFV perpetration (M=3.73, SD=1.17). This is a statistically significant mean difference of 0.41 (95% CI [0.11, 0.71]), although again the effect size is small (d=0.41). This likely reflects the time at which the survey was conducted, which occurred when the MARAM's comprehensive perpetrator-specific risk assessment tool had not been finalised or rolled out across the relevant practice areas. While the overarching MARAM framework and related training is intended to give practitioners a greater and more nuanced understanding of DFV, including victimisation and perpetration patterns, the tools available to practitioners at the time of data collection remained predominantly victim-centred.

Opportunities for future practice

In addition to the quantitative survey results presented above, the practitioner survey provided participants with the opportunity to provide open-ended feedback and input on numerous items, including perceived barriers to and enablers of perpetrator-focused screening and risk assessment. Findings presented hereafter provide some more detailed insights into the quantitative survey findings. Many participants (n=265) answered at least one of the open-ended questions. Key themes were identified through a thematic analysis and are explored below.

Barriers to effective screening and risk assessment of DFV perpetration

Survey participants discussed several barriers that limit practitioners' abilities to effectively screen for and assess risk of DFV perpetration, including:

- denial of DFV behaviour by perpetrators;
- screening for DFV perpetration not being 'core business';
- screening and risk assessment tools not being focused on DFV-specific behaviours;
- diverse perpetrator populations and a lack of appropriate screening tools; and
- lack of available and appropriate referrals.

Each of these barriers is explored in greater detail below.

Denial of DFV behaviours by perpetrators

As part of the eight-item scale identifying participants' attitudes towards screening and risk assessment, survey participants were asked to respond to the statement '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'. Most participants either strongly disagreed or somewhat disagreed with this statement (*n*=193, 82%). While only a small number of participants (*n*=24, 9%) either agreed or strongly agreed with the statement, ANOVA results presented earlier show that the mental health practitioners surveyed were significantly more likely to share this attitude than the child protection practitioners (see Table 6). Further, open-ended survey responses indicate that concerns around clients denying the use of DFV remain a persistent barrier to screening and risk assessment. These concerns were voiced by practitioners from each of the 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)
>
> Offences are routinely denied by the perpetrator. (Corrections practitioner)
>
> Will not discuss their behaviour or see it as 'wrong'. Victim blame, use the children as an excuse for contact. (Corrections practitioner)
>
> We are a phone MH [mental health] 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)

As the above quotes illustrate, some practitioners felt that perpetrators would deny their use of DFV and that screening and risk assessment relied, at least in part, on their clients' willingness to disclose their use of DFV. Challenges associated with asking potential perpetrators direct questions about DFV perpetration and relying on their disclosure are further unpacked in our analysis of the focus group findings (see *Results: Focus group* section). These include the role of DFV specialist training and practitioners' reliance on professional judgement during intake and assessment conversations.

Screening for DFV perpetration not 'core business'

As part of the eight-item scale identifying survey participants' attitudes towards screening and risk assessment, participants were also asked to respond to the statement 'Screening for DFV perpetration during routine contact with clients/patients/service users is core business in my area of service delivery'. Most survey participants either strongly agreed or somewhat agreed (*n*=174, 74%) with this statement. However, one in five practitioners (*n*=46, 20%) either strongly disagreed or somewhat disagreed with this statement. ANOVA results presented in Table 6 further show that mental health practitioners were significantly less likely than AOD and child protection practitioners to agree that DFV perpetrator screening was core business in their area of practice. This attitude was also reflected in open-ended survey responses from mental health practitioners:

> We are a MH [mental health] service, so our core business is to identify MH issues.
>
> The organisation sees our core business as mental health so there does not appear to be much focus on family violence.

Some participants identified this as problematic and argued that it renders DFV perpetration invisible in mental health settings, as illustrated by this comment:

> 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)

These quantitative and qualitative findings highlight that, in mental health service settings, practitioners' focus is on identifying and responding to mental health concerns, often in isolation of other present risk factors including DFV. This poses a missed opportunity when considering the well-evidenced co-occurrence of DFV and mental health problems in men using DFV (DFVDRAB 2021; Gilchrist et al. 2019; Hester et al. 2015; Spangaro 2017).

Screening and risk assessment tools not focused on DFV-specific behaviours

One of the most common issues raised by participants in response to the open-ended questions was that the screening and/or risk assessment tools currently used in their area of practice were tailored towards risk of violence more broadly (and where relevant, other criminogenic risk factors) rather than enquiring about specific indicators of DFV. Practitioners across several different practice areas described the limitations of current screening and risk assessment tools and processes:

> No DFV-specific risk screening tools, however, could be covered under risk assessments for aggression and/or vulnerability. (Mental health practitioner)
>
> We have no validated DV-specific tools to use, which relies purely on the officer's knowledge, time available and understanding of DV risks. (Corrections practitioner)
>
> Screening and risk assessment requires the practitioner to utilise separate knowledge gained from safe and together training to add to existing screening tools/risk assessment tools. (Child and family welfare practitioner)

Most survey participants (*n*=191, 82%) stated that their current area of practice was not using a specific screening tool for DFV perpetration, reiterating that screening for DFV perpetration relies heavily on professional knowledge, training and judgement in order to identify DFV perpetration. These observations are further explored in the focus group findings presented in later sections of this report.

Diverse perpetrator populations and a lack of appropriate screening tools

Participants noted a general lack of screening and risk assessment tools tailored towards DFV perpetration. Specifically, participants raised the lack of DFV screening and risk assessment tools that are culturally sensitive and commented that the inability in some practice settings to overcome language barriers can impede effective practice:

> Language used to describe specific behaviours that constitute DFV can be misinterpreted through cultural, social and gender beliefs. When screening there can be both false positives and false negatives when the person using violence doesn't understand how their specific behaviours are DFV. Additionally, if people doing the screening don't understand how the perception of the person using violence impacts on their responses, the screening is not accurate. (Child and family welfare practitioner)

> With respect to First Nations clients, it can be difficult to establish rapport specifically as a Gov employee as there is a long history of poor relationships with Gov workers and their communities. It can be difficult to build a relationship to be able to understand their family dynamics, explore belief systems and obtain a proper in-depth assessment of their risk. (Corrections practitioner)

> Language barriers and not being able to have an interpreter available at all times. Language barriers between workers and Indigenous populations where there are no interpreters available. (Corrections practitioner)

As captured here, screening and risk assessment practices specific to DFV appear to be limited across a number of practice areas. In addition, current practice is further complicated by the need for more nuanced approaches to intake and ongoing assessments of presenting risk and related support needs among diverse and priority client populations.

Lack of available and appropriate referrals

As illustrated by some of the open-ended comments presented above, practitioners often felt they had to rely on their professional judgement, and some participants felt confident they could identify DFV perpetration and assess risk without the use or guidance of specific assessment tools. However, practitioners described limitations to the management of identified DFV risk. These limitations were primarily raised in relation to a lack of appropriate and available referral pathways for male clients identified as using DFV, including but not limited to MBCPs. Few service options and long waitlists were described as the main barriers to effective referral. In particular, corrections and child protection practitioners raised the lack of suitable referral pathways and options as a key limitation to ensuring adequate support and accountability of perpetrators once risk is identified:

> The issue does not lie with the risk assessment practices around DFV, most workers are skilled in identifying and assessing the level of risk a perpetrator of DFV holds. The issue is what to then do with this risk. There are limited services available for perpetrators and they are rarely held accountable in the courts. (Child protection practitioner)
>
> There are no programs available to refer to and limited DV informed psychologists. (Corrections practitioner)

The lack of available and appropriate referral pathways remains a key barrier in responding effectively to DFV perpetration. This problem is examined further in the analysis of focus group results. It is noteworthy that limitations around referral pathways were predominantly raised by corrections and child and family welfare practitioners. Few mental health and no AOD practitioners raised this concern. This may partly reflect that practitioners from both of these service areas see themselves primarily as responding therapeutically to presenting AOD and/or mental health concerns and less as a service provider identifying additional support needs and facilitating referrals more broadly.

Improving screening and risk assessment practice

In addition to the limitations and barriers to screening for DFV and assessing and managing risk discussed above, participating practitioners also identified areas for improvement that would assist them to better identify and respond to DFV perpetration. These suggestions provide valuable insights into the needs of practitioners who conduct intake or ongoing assessments with male clients who may be perpetrating DFV against a partner, ex-partner or other family members. Key findings here include a desire for a specific DFV-informed screening tool; the need for ongoing training and education; and improved information sharing and collaboration.

Desire for a specific screening tool

Most participants (*n*=191, 82%) identified that their service area was not using a specific screening tool. The remaining 18 percent (*n*=43) were using some form of screening tool, although it is notable that these tools were not specific to DFV perpetration and related either to screening and risk assessment more broadly or to DFV victimisation specifically. Advice sought from participating practice areas suggests that none of the participating areas currently use a DFV perpetration focused screening tool. Practitioners therefore rely on their training, knowledge and professional judgement to identify DFV perpetration.

Participants identified in their open-ended responses that a specific screening tool, as well as information and guidance around screening more generally, would be valuable. Participants also identified that consistent screening practices not only within their service area but also across services and across Australian jurisdictions would be useful in better identifying and responding to men using DFV. This view is captured in the following practitioner comments:

> Use of a standardized risk assessment tool would be useful as this would reduce workload in assessment and allow more time for intervention and management of the risk. (Corrections practitioner)
>
> Lack of training and standardised tools are major deficits in rolling out these approaches. (Mental health practitioner)
>
> I would love QLD health mental health to implement DV routine screening. (Mental health practitioner)
>
> I would find a screening tool for DFV very helpful and so that screening and identifying DFV could be second nature in our assessment process. (Mental health practitioner)
>
> QCS [Queensland Corrective Services] does not have a screening and or risk assessment specific to DFV perpetration. We rely on information from a verity [sic] of other Government and NGOs regarding their assessment of risk… Not having a consistent screening tool can create challenges between organisations who are jointly identifying and implementing management strategies as there is not always consensus on the risk profile, specific to DFV perpetration. (Corrections practitioner)

As highlighted by the quotes above, mental health practitioners in particular voiced a desire for screening tools, consistent screening practices around DFV perpetration and relevant training. This is a critical observation and suggests that, while mental health practitioners feel that identifying and responding to DFV perpetration is currently not treated as core business within their organisational setting, frontline practitioners have a desire to improve their responses to DFV, including in their engagement with perpetrators. Further, the stated desire for standardised screening tools to assist with identifying DFV perpetration across practice areas indicates the need for shared language and approaches to identification and management of risk across service areas, which is further examined in the focus group results.

Need for enhanced training and education

Survey participants further reiterated the need for greater access to DFV training, both through their organisation and through relevant tertiary courses. Specifically, practitioners expressed a desire for improved training in screening and risk assessment practice, including in the use of specialist tools. Participants were of the view that current training opportunities were limited and that baseline understandings of DFV across the wider workforce require improvement, as illustrated by the feedback provided by practitioners across several services areas:

> More training needs to be available to staff members in this area and more readily available. (Child protection practitioner)
>
> More specialised training would be beneficial. (Corrections practitioner)
>
> I would like to do training in specialist tool. (Mental health practitioner)

While it is not possible to train the entire workforce to be DFV specialists, improving the baseline level of DFV knowledge, understanding and practice skills is important. The level of formal DFV training received by practitioners varies and is currently the highest in child protection, followed by corrections (see Table 6). AOD and mental health practitioners reported the lowest levels of DFV specialist training and qualifications in the current study sample. In addition to upskilling frontline practitioners in DFV-informed intake and assessment processes, focus group findings further highlight the value of having designated DFV specialists available across service areas for consultation to assist frontline practitioners to identify DFV perpetration and related risk, along with suitable referral pathways.

Information sharing and collaboration

Participants provided open-ended responses regarding the importance of information sharing between agencies and the challenge of accurately screening and risk assessing for DFV when they have access to only 'part of the puzzle.' In particular, the value of collaboration and practitioners' desire for a multi-agency response was raised. Practitioners considered this to be essential to effectively identifying DFV perpetration and managing associated risk where different agencies hold different pieces of information, as illustrated by the following responses from mental health and corrections practitioners:

> Increase collaboration between all services – multi agency approach to managing risk, sharing information etc. multi-agency meetings needed, for clinicians to attend and provide input. (Mental health practitioner)
>
> Collaborate [sic] case management would solve a lot of issues; with that comes information sharing barriers. At times this can inhibit progress towards a common goal due to multiple Agency's [sic] trying to engage with the family or individual. (Corrections practitioner)
>
> Working in corrections, we don't always have information regarding the patterns of behaviour the men have demonstrated, for instance we are given information from the courts on specific events, that does not encompass the dynamics in the relationship, or patterns of behaviour. As a facilitator, I only have the prisoners view of the event, not the perspective of partners. (Corrections practitioner)

The role of information sharing and service integration are further explored in the focus group results presented in the following section.

Results: Focus groups

The focus group findings from this study reiterate the barriers to and enablers of screening and risk assessment identified in the survey results. Informed by the themes that emerged from the survey results, focus group findings are grouped under the following themes:

- availability and accessibility of DFV training;
- making DFV screening and risk assessment core business;
- importance of DFV-informed leadership at the organisation and location-specific level to support pro-screening and risk assessment attitudes and practices;
- specialist DFV practitioner roles;
- limitations of screening practices and role of professional practice;
- importance of an integrated service response and system accountability;
- referral pathways and lack of available programs; and
- limitations and opportunities related to information sharing.

Availability and accessibility of DFV training

As examined in the survey results, the level of DFV specialist training practitioners had received was an important factor influencing screening and risk assessment practices for DFV perpetration (see Tables 8 and 9). This was further reiterated in the focus groups. Focus group participants reflected on the inconsistent level of training across their area of practice:

> 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, Queensland)

> [The training is] very brief, it's very high-level stuff. I don't think it at all equips us for the complexities that we deal with every day, and I think we manage those in our teams more than anything… it's a very tick-box, mandatory training, that we all go, "OK, we've done some DV training,"… if you said, "What's in it?" I don't know. I can't remember, it was at the start of the year. (AOD practitioner, Queensland)

A number of focus group participants from different practice areas held DFV specialist positions within their organisations and had a high level of DFV specialist training, and several participants were also involved in training other practitioners. It was common for focus group participants—both those with a high level of training and those without—to reflect on their level of training as driven by them and supported by their team leaders:

> My mentor is very DV focused, so I've also had a lot of individual one on one sort of on-the-job training… It's also something I've sort of sought out for in that respect – formal training… Some of that training I will say is self-elected, and not mandatory. (Corrections practitioner, Queensland)

> I've been here since 2018, I haven't seen myself any specific training happening at all… [you] have to be overly proactive if you want to do such training. (Mental health practitioner, Queensland)

Many focus groups participants had a specific interest in the DFV space; indeed, this was often a factor in their decision to participate in the study. It is perhaps not surprising then that these participants were proactively looking for opportunities to upskill and build their knowledge around DFV. While the self-driven approach to training may work in relation to developing a DFV specialisation, relying on practitioners whose base level of DFV-informed practice is limited to proactively seek out training is an inadequate approach to ensuring DFV-informed frontline practice across staff. Further, time constraints created barriers to accessing training, even where training was available to staff in theory. In particular, child protection practitioners in intake roles discussed tensions between workload demands and time available for professional development:

> The phones have to be answered, emails have to be done… you just can't pull everyone off the phones to go [to training]… We just don't get enough offline time. (Child protection practitioner, Queensland)

> It is a bit tricky for us to find the space and time for [training]. (Child protection practitioner, Queensland)

Lending further support to the open-ended survey findings discussed above, there is a clear need to improve the baseline level of DFV knowledge, understanding and practice skills for all practitioners, and to provide opportunities for interested practitioners to develop DFV specialisation. In addition, a broader range of practice areas need to be sufficiently resourced to undertake regular DFV specialist training without impeding upon their fulfilment of day-to-day tasks.

Making DFV screening and risk assessment core business

A prominent enabler of screening for DFV perpetration was the perception that DFV screening is 'core business'. Whether practitioners felt that it was core business in their area of service delivery to identify and respond to male clients who may be using DFV in addition to presenting with other issues varied between and within practice areas. Mental health practitioners, for example, commonly said that screening for DFV perpetration was not core business in the context of mental health services:

> In the ED [emergency department]… it might not be something that's on the radar as much or might not be seen as a mental health issue. (Mental health practitioner, Queensland)

> Our core business is mental health… Everybody's under the pump, and you just see people doing – 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, Queensland)

Child protection practitioners shared similar views that an environment where case loads are high and clients present with other priority issues (in this case, child welfare concerns) creates barriers to staff equally prioritising the identification of DFV perpetration as core business:

> 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, Queensland)

> In the intake space we often have a very limited amount of time that we work with – I don't even know if you can say we work with families. (Child protection practitioner, Queensland)

Without sufficient time to dedicate to screening and risk assessment for DFV perpetration, and the organisational view that such practices are 'core business', practitioners revealed that these DFV assessments often do not take place. These practitioner insights also reflect a disconnect between the need to assess harm or risk of harm to children and the need to identify perpetration of DFV. Further, where screening for DFV perpetration is not seen as 'core business', and consequently where DFV perpetration is present but is not identified, this has flow-on effects to later stages of child protection work. As child protection participants highlighted throughout the focus groups, if a case is not specifically screened in for DFV at intake, perpetration of DFV may not be investigated at the investigation and assessment stage. One of the consequences of the limited time and ability to assess for DFV perpetration at intake is that victim-survivors may become the focus of responses in their role as primary carers, while fathers may remain invisible in their role as perpetrators of DFV. As one practitioner commented:

> I have made referrals for domestic violence, but it's mostly to support the mum. Because we don't know how Dad will respond to that, so the focus would be – I would leave the number for the mum to be called, not the dad… [The] better chance of being able to help the family is to help Mum in the limited interaction we have. (Child protection practitioner, Queensland)

The participating child protection department has made significant strides in reforming child protection responses towards DFV-informed practice through the rollout of the S&T model (as discussed above). The assertion by one practitioner that 'we're definitely better than we were five years ago' (DFV specialist, child protection) was shared by a number of child protection practitioners throughout this study. The substantial reforms have shifted the way screening and risk assessment for DFV perpetration is prioritised as 'core business.' As the following practitioners explain:

> Since the rollout of Safe & Together…even for some of the staff that haven't been Safe & Together trained, they are able to identify DV more. They're able to delve into it, they're questioning things a bit differently… Moving away from that victim-blaming, that failing to protect assessments from mums…and really putting that focus and accountability back on Dad, or the perpetrator of violence… That's a massive difference since the Safe and Together has been rolled out. (DFV specialist, child protection, Queensland)

> [We were trained to] ring Mum about XYZ and everything in between… [but] there was little encouragement to talk to Dad… there was very little emphasis on Dad's relationship with children… As an Aboriginal worker in this context, I had found that did not align with my family values… the white system of child protection didn't align with my family values… I think I got trained to unsee dads, and I think with Safe & Together, it made me see dads. (First Nations practitioner, child protection, Queensland)

While child protection practitioners reflected on the shifts that they have seen in relation to the rollout of the S&T model, and in particular the reorientation towards perpetrator accountability, they also expressed the view that there remains a significant amount of work to do in consistently embedding screening and risk assessment practices for DFV perpetration as 'core business' across the department:

> We're really still in that infancy like we're making the shifts but there's still a long way to go (DFV specialist, child protection, Queensland)

> For us is this is only a tiny change… while it's huge for white people, it's not for black people… That's what we hear from elders, particularly in those remote communities and in metropolitan, [name of location], that community is removed from the mainland but they're still a part of and included in here in all the work that happens and the decisions that roll out but did we go out and consult? (First Nations Practitioner, child protection, Queensland)

> We've always had this thing about well Safe & Together works well, some workers, some locations so it's just like a postcode lottery like you might come through an intake system where the worker's done Safe & Together training, is very good on it and they get it. But you could just as likely go somewhere else. (DFV specialist, child protection, Queensland)

As these experiences demonstrate, even in practice areas that have undergone substantial reforms towards DFV-informed practice, including a stated focus on addressing perpetrator visibility, ensuring consistent developments across regions and service locations requires long-term commitment and investment.

This is further illustrated by findings derived from the Victorian focus group, which explored experiences with the implementation of reform strategies following the RCFV (2016) recommendations. Since the RCFV, Victoria has implemented a multi-agency screening and risk assessment framework around DFV along with specialist DFV practitioner roles across service areas including mental health and AOD. AOD and mental health focus group participants reflected on the way in which the wider sector struggled with the shift from siloed service delivery towards a more integrated and intersectional lens taken when identifying clients' support needs as well as the risk they may pose to themselves and others. Overall, Victorian AOD and mental health practitioners felt that DFV is increasingly becoming 'core business' in their service settings:

> You've got people in AOD as you do other services that have been there a long time. They see AOD as AOD… waving the flag or the lens for family violence in an AOD space before the legislation change was a bit of an uphill event because… [the attitude was] it's not our business… The legislation changes really support continuing to drive that [change]. (AOD practitioner, Victoria)

> I'm noticing staff being – and me myself being more confident and having those conversations since the rollout of the reform… It's not the elephant in the room anymore. (AOD practitioner, Victoria)

> Most of the work done in the first year was actually around getting clinicians comfortable with that perceived threat of…a therapeutic relationship breaking down because they've had to identify or actually name some problematic behaviours within their clients' relationships… Prior to the reforms and prior to there being a lot more language around it now and also a lot more of a service response in terms of who we can refer to and who we can engage the idea of not wanting to open up pandora's box and deal with it was very much what people named and I think that now there's permission, we can talk about it. (DFV specialist, mental health and AOD practitioner, Victoria)

The transformation occurring within the Victorian reform context demonstrates that screening for DFV perpetration can be 'core business' across service sectors, including AOD and mental health services, if supported by whole-of-sector and individual organisational commitment. Given the need for mental health and AOD practitioners to develop rapport with clients for treatment more broadly, they are well placed to engage in these conversations. As one practitioner explained, this environment can be harnessed as a 'protective factor':

> We've got specialists in the sector that we can invite in to actually help clinicians have those conversations into the culture they already work with [sic] as opposed to asking staff to become experts in identifying their clients and then fixing the problem, it's actually around, "How do we look at this in the lens of – they're already receiving mental health treatment. We know that they're going to be engaged with the service. Let's use the protective factor of a mental health service," as opposed to it being seen as a threatening action and I think that's taken a long time for staff to get around the idea of that. (DFV specialist, mental health and AOD practitioner, Victoria)

While there is still work to be done in the Victorian context, the focus group findings illustrate the potential of embedding DFV-informed practice as 'core business' across practice areas. DFV specialist practitioners within mental health and AOD settings have been fundamental to this transformation. This is explored further below in relation to the role of specialist practitioners.

Importance of DFV-informed leadership

Participants across several practice areas discussed the importance of DFV-informed leadership—at both the location-specific and organisational level. Leadership was seen as crucial for driving and embedding DFV-informed understanding, knowledge and practice among frontline practitioners:

> It's a broader change. But also very pocketed based on service centres… different service centres are at different places with their own DV-informed practice. And I think it really speaks to top down, so management down is dependent on how the practice is, on those frontline staff. (DFV specialist, child protection, Queensland)

> Unless you've got someone who's leading that space, it's quite easy to forget [to check for DVO]. …I don't think there's people turning around going, "No, I don't need to do that at all." I think it's definitely on people's mind, however it's [whether] they put it on their priority list. I think that's definitely different when you have different leaders who are actively going, "No we really need to make sure that that's in that top half, that priority list." (Corrections practitioner, Queensland)

> When things are filtered from top, we respond better to change. If management think it's a primary issue… It will become part of the practice. (Mental health practitioner, Queensland)

As the above quotes from practitioners in child protection, corrections and mental health illustrate, variations in DFV-informed leadership at both the location-specific and organisational level can contribute to inconsistent practice. Where relevant leadership is lacking, screening for DFV perpetration may not take place:

> Workers on the ground are very influenced by their leadership in that service centre so if they're not being given the authorising environment to dig deeper and I guess that support and confidence that when you dig deeper likely you're going to find out this information and you will end up locating the perpetrator and you will end up having to have a conversation with him. If they're not given that support and encouragement and confidence to do that then they're not going to want to dig because they don't want to have that conversation with the perpetrator. (DFV specialist, child protection, Queensland)

As captured in the quote above, some participants expressed a reluctance to screen for DFV perpetration associated with the fear and discomfort of having conversations with potential perpetrators. As the participant quotes in this section illustrate, embedding DFV-informed leadership is an important component of giving frontline staff the attitudes, confidence and support they need to screen for DFV perpetration. Upskilling those in leadership roles in relation to DFV-informed practice is therefore a critical element of embedding DFV-informed practice as organisational 'core business.'

Specialist DFV practitioner roles

Participants across several service areas discussed the desire for or value of having specialist DFV practitioners embedded in their practice areas. Some practitioners discussed the need for specialisation in the context of having a DFV high risk team (HRT) practitioner in their service location, while others discussed having internal specialist DFV practitioner roles, held by corrections or child protection practitioners, for example. The implementation of such roles varied across participating practice areas, predominantly featuring in child protection and corrections in the Queensland context. Participants discussed the availability of such roles and their benefits to frontline practice.

Focus group findings suggest that the availability of specialist roles also vary within organisations across locations and service centres. Where available, these roles were seen as being of substantial value to frontline practitioners, who can draw on this expertise in case assessment, management and suitable referral pathways:

> Having our HRT rep [name], any DV ones [cases] that we're worried about we will often ask for her consult… that's been a real big help getting the information that we need pretty quickly and [HRT rep] will often also go through some of that mapping… [and] provide a bit of an overview from a HRT perspective… which has been really helpful. (Child protection practitioner, Queensland)

Comparatively, mental health and AOD practitioners in Queensland noted the absence of specialist roles to support frontline practitioners, who may primarily respond to presenting mental health or AOD-related concerns and would benefit from having access to DFV specialist input into case and risk management. While practitioners acknowledged the presence of health/hospital social workers, they equally shared perceptions that there may be an over-reliance on social workers in place of DFV specialists. This is particularly problematic in fast-paced healthcare settings where patients may not have contact with a hospital social worker who is only available during certain hours and may not be specialised in DFV-informed screening and risk assessment practices. Practice concerns are further exacerbated here if no initial screening process has been undertaken to identify concerns for further assessment by the social worker. As one practitioner reflected:

> Sometimes things like [DFV perpetrator screening and risk assessment] are left for the social workers and I think sometimes, for a lot of people, it's too hard and the reason behind that would be lack of training or experience of domestic and family violence, so people are worried about the re-triggering of traumas and stuff, so it's a very hard topic. Let's not touch it. Give it to the social workers. …mental health is very medical focused… the whole focus is to stabilise the patient, ensure things settle down, get the person out of the system and back home. (Mental health practitioner, Queensland)

A dedicated DFV specialist accessible to frontline practitioners was identified as highly valuable in supporting screening for DFV perpetration along with risk management and referral pathways. As one participant concluded:

> It would be really great if we had funding, whether it was in just an AOD service of having staff, perhaps one in each team… whose sole job was working with DV, they were the connection between. So, they saw, or were able to – perhaps they didn't carry a caseload, that the team could flag with that person that this is happening and then they could do a lot of that follow-up stuff and be that connection between the referral. I think that would be my dream because I think it's so important. …I think that would be a real commitment from our service of saying that there's a commitment to seeing that we do something. (AOD practitioner, Queensland)

In Victoria, specialist practitioner roles have been implemented across a number of service areas, including mental health and AOD services, as part of the implementation of the RCFV (2016) recommendations. In the Victorian AOD and mental health-specific focus group, practitioners discussed the benefits and limitations of these roles:

> [T]he response to family violence and how handy it is to have [name of DFV specialist], easy to email and they're obviously in the same organisation so it's very easy to get in contact with them and say, "Hey, this is the situation. What do we do?" (AOD practitioner, Victoria)

Accessibility of specialist practitioners was highly valued by mental health and AOD practitioners in the Victorian based focus group. Similarly, participants raised concerns around the lack of availability of such specialists, depending on service, region and office location. While specialist DFV practitioners have generally been implemented across certain service areas, variations in the availability of practitioners were noted and participants felt that some service areas and locations may be better off, while others may have limited or no access to a specialist practitioner:

> There would be a time constraint attached to it because if I'm in the office and [name] is sitting just across the road or in the same office, she can turn her chair. Whereas between [name] and me, there would be an appointment and it could be a week or two weeks or two days, depending on what the calendar looks like. …Timewise, that's not as available as someone sitting in the same office. …There are some advisors who are only employed to do the role 1.5 days a week, which you can only do that much for that region or for that organisation that you're sitting with than a person who's employed for three days. There's a big discrepancy between who does what or how long. (DFV specialist, AOD practitioner, Victoria)

> We've noticed some of our regional and rural smaller mental health services who don't have that backing of a big institution … are having a much harder time rolling out these reforms and getting some legitimacy in the workplace … having those formal supports are really helpful but I think that's probably where a gap in the system lies, is that the department probably gave some instructions around each organisation can implement it as appropriate. So, therefore if you've got specialist roles like these, we can drag a lot of that but for the organisations who don't have specialist workforces, it obviously often comes down to more of a management and a clinical line without someone really driving the family violence lens and message and I think that's probably a barrier but I think overall, the actual creation of a framework for Victoria has been a really great equaliser. (DFV specialist, mental health and AOD practitioner, Victoria)

The above quotes highlight the progress made through the implementation of specialist practitioner reforms in Victoria while also emphasising the ongoing need for greater and more consistent resourcing of specialist practitioner roles to ensure access regardless of service size or location.

In addition to time constraints associated with specialist practitioners working on a part-time basis or being spread too thinly across multiple regions or service providers, time constraints associated with specialist practitioners carrying their own case load were also raised. While the Victorian model overall and the Queensland child protection-specific model had mostly moved away from this approach, practitioners from corrections raised concerns that the DFV specialist simultaneously manages their own case load. Holding this dual load was seen as a barrier to maximising the benefits of the specialist DFV practitioner role:

> I'm getting a lot of training myself, but because I'm sitting in a role where I have a caseload, it's very difficult for me to pass on that knowledge… it's not being passed on. (Corrections practitioner, Queensland)

This experience highlights the importance of adequately resourcing specialist DFV practitioner roles to maximise their value to all frontline practitioners.

Limitations of screening practices and role of professional practice

At the time of the data collection, none of the participating departments or service areas included in this study were using a specific screening tool focused on male perpetration of DFV. Some DFV-specific questions are incorporated into risk assessment tools specific to individual areas of practice and specific presenting issues—for example, questions about the use of violence generally. However, focus group findings highlight that these tools and questions often fail to identify perpetration of DFV and related risk adequately. Here, some participants said that DFV perpetration and related risk often remained invisible altogether. Other practitioners felt that, while DFV perpetration may be on practitioners' radar, the current tools and questions used do not allow for a nuanced identification of DFV as a pattern or the risk associated with patterns of abuse.

Mental health practitioners, for example, noted that the mental health-based risk assessment is focused on identifying risk of harm to self and others more broadly, with the risk of DFV not being assessed specifically. As a result, it often remains invisible where a service provider does not have contact with the victim-survivor or other affected family members:

> There is only one section that is risk assessment, so in the risk assessment, you see risk for self, risk to others, risk to other family members. That also has just one question around risk of domestic and family violence. So many times, when we do the risk assessment we go with, "Are you feeling like harming yourself or harming others?" That's where it ends. (Mental health practitioner, Queensland)

Child protection practitioners, on the other hand, felt that DFV perpetration and the risk it poses is generally recognised in child protection practice but may remain invisible because the assessment tools and questions remain focused on incidents rather than patterns of behaviour, at least at the initial intake stage of child protection work. Participants further described the challenge of child protection-specific risk assessment tools being primarily focused on risk to children rather than risk to children and the non-offending parent as a unit, which raises the need for improved identification and risk assessment practices around DFV perpetration. One DFV specialist practitioner noted that the screening tool used at intake:

> …doesn't separate a nonoffending parent from a person using violence… it certainly doesn't acknowledge coercive control to the extent that it should. …Across the board the level of understanding on how coercive control and the level of coercive control, how that can really play into risk is not as well-known as it could be… In the intake … because they are often going off a piece of information that is time-specific or incident-specific it's very difficult to really assess DV risk… Additionally the intake process currently does focus on the children. …if there's mother and children, that risk is inclusive. The tool itself currently doesn't really encapsulate that. (DFV specialist, child protection, Queensland)

Aside from discussing specific screening tools or questions, participants were asked to discuss other processes that assist in identifying DFV perpetration and related risk, including screening for current domestic violence orders (DVOs) or DFV-specific offending histories that may have been flagged in information-sharing systems available in certain service areas. While mental health, AOD and child protection practitioners described more involved processes required to access information held by other departments and service areas about potential perpetrators of DFV, corrections practitioners described the benefit of having access to an information-sharing system that allows quick oversight of key information related to DFV and other offending behaviour. While this allows practitioners to gain immediate access to a potential history of DFV offending and any related protection orders, participants noted that access to the system is limited to specialist staff who may not always be available or have capacity to conduct a search at the time such information is required:

> We do a DVO search via Quick… In saying that Quick is not always available. The people that use Quick are not always available. (Corrections practitioner, Queensland)
>
> We have a few people trained in the office who hold licences to access [the Quick system], so you have to approach them, and obviously they carry their own workload as well so you can't be going across every five minutes to ask their help. (Corrections practitioner, Queensland)

Child protection, mental health and AOD practitioners described different experiences regarding screening for a current DVO. Child protection participants from the intake service area described primarily relying on information provided in the child welfare concern notification. Where this is made by police, information regarding current DVOs is generally included. However, where notifications are made by other formal or informal sources, this information may not be readily available. Here, this information is more likely going to be captured by the subsequent investigation and assessment stage, with practitioners representing this service area noting that they tend to ask mothers and fathers (where contact is made with both parents/carers) whether a protection order is currently in place and, if so, who is identified as the aggrieved and respondent and what conditions are listed on the order as part of the wider assessment process. As one practitioner described:

> [T]hat would be a standard question, is there a domestic violence order, who is the respondent, who's the aggrieved, and what are the conditions? That's a common question that we would ask a notifier, particularly a dad who's calling. (Child protection practitioner, Queensland)

Mental health practitioners, on the other hand, acknowledged that, while their area of practice can seek information regarding the presence of a current DVO, this is generally only done if relevant concerns around DFV perpetration are first identified. Given the lack of screening questions used in mental health services to identify potential DFV perpetration, screening for a current DVO appears to be less common in this space.

Given the inconsistent screening for a current DVO and the limited use of DFV perpetration-specific screening questions across practice areas, identifying DFV perpetration and related risk predominantly relies on practitioners' professional judgement and their ability to identify indicators of potential DFV perpetration 'in conversation' with clients during initial or ongoing contact. As illustrated by the following comment, this may be in form of picking up on indicators of potential false allegations made by DFV perpetrators as a way of abusing the system:

> 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, Queensland)

Some practitioners noted that identifying potential DFV perpetration and related risk requires DFV-specific training and skills because perpetrators of DFV will likely deny any use of DFV and are often highly skilled at manipulating service systems and practitioners, as illustrated by the following comment:

> We had the father actually attend, and I went up to take the intake and it was hard not to fall into the trap that he was a victim, because that's what he was really primarily talking about. But very quickly we realised he was using a systems abuse to try and get the mum into trouble. So it can be quite challenging, but I guess having some understanding about the DV and training we have had, we're able to have those discussions to draw him back to, "Okay, where did this come from? Let's talk about the DV. Where did the DV start from?" And he was really utilising systems abuse to try and get the mum into trouble and try and get us involved. And really saying if he wasn't in that household, all those kids would be neglected. So we do get that in intake, and in the work that comes through, a lot of the team will be able to have those direct discussions, going, "Okay, tell me about the DVO," and challenge notifiers respectfully when the male perpetrator calls. (Child protection practitioner, Queensland)

Corrections participants described similar challenges in identifying DFV perpetration and highlighted the role of practitioners' DFV knowledge and skills along with confidence to ask DFV-specific questions and pick up on relevant risk indicators:

> 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, Queensland)

AOD practitioners equally felt that, due to the absence of DFV perpetration-specific questions in the intake assessment tool, identifying potential risk relies on the practitioners' DFV awareness and how they approach the intake assessment:

> There's no specific questions around domestic and family violence in that risk screen at all, and you could actually work your way through that working with someone without even knowing… We have access to what's called a 'viewer', which is their hospital presentations… It might come up domestic and family violence [alerts]. It would flash and you could see that, but other than that there's not a standardised tool and that risk assessment very much relies on how the clinician uses that, or talks with the client around that [DFV], and filling out that form. (AOD practitioner, Queensland)

The above findings highlight the role and value of professional judgement in identifying potential DFV perpetration among clients. Practitioners noted that while victim-survivors may be more inclined to respond to direct screening questions for DFV, perpetrators of DFV will likely deny, minimise or deflect their use of DFV, thus placing greater emphasis on practitioner DFV knowledge and assessment skills as well as their ability to pick up on DFV indicators by 'reading between the lines' during intake and assessment conversations. Such an approach requires consistent DFV-informed skills and practices across service settings and locations to maximise the likelihood of DFV perpetration being identified early in the service engagement process. In particular, child protection practitioners noted that failing to identify DFV perpetration during the intake process has flow-on effects for working with families affected by DFV in a safe and informed way:

> From an intake perspective they're looking at the information they've got… so if it's identified alcohol or drug use that's what they screen, if there's DV that's what they screen… I would question if the intake workers themselves are specifically analysing the information to say "oh there could be DV here", I don't think that's what's happening at all… what they screen in [at intake] is generally the focus then of the IA [investigation and assessment], whether or not you have been able to piece together and having that good DV lens, knowing that if there's alcohol and drug and mental health and you've got a coercively controlling person who's using violence, you're not going to piece those two together unless you've got that good [DFV] lens. (DFV specialist, child protection, Queensland)

The above quote further highlights that while frontline practitioners may regularly screen existing intake or referral information for DFV-specific information, they may not necessarily follow up with DFV-informed screening questions where the intake information does not explicitly state concerns around DFV. In order to support frontline practitioners to identify DFV perpetration early on in the process, a DFV-informed lens is therefore critical.

Further, participants emphasised the importance of organisational leadership to support DFV-informed practice that prioritises a DFV lens across the different stages of child protection work:

> We're not consistent at all in how we practice from the DV continuum, whether it be destructive, competent, pre-competent, whatever… it just comes down to who's going to take the call at that time and what experience they have and what team leader experience they have to be able to support that worker in processing that intake. (DFV specialist, child protection, Queensland)

In addition to the broader challenges and limitations around screening tools and questions to identify DFV perpetration and related client support needs, practitioners discussed the importance of culturally sensitive and language-specific considerations. In particular, First Nations child protection practitioners raised concerns that Western tools and approaches to identifying DFV and related risk may be met with resistance due to the persistent impact of colonisation on First Nations families and children. As one practitioner described:

> Part of the assessment… [is] "This behaviour is impacting on your parenting for your child and their future," but there has to be some more in terms of planning to how we see the longevity of that and the view of the child and their growing years and where they're at and what's the focus around stopping the cycle, however your Aboriginal and Torres Strait Islander families and communities, the colonisation was a lot about that violence and about that removal and about that distrust and things in that space. …Resistance means also too that, "Why are you talking to me about these behaviours when your people were the first ones that came here and treated our people like this?" …Apology and acknowledgement is a huge thing, and until that happens, we'll never move to the next step… When we're asking families to tell us now, their trust is lacking because of previous historical impacts, systemic impacts along the way. (First Nations practitioner, child protection, Queensland)

In addition to ensuring culturally safe and meaningful assessment and engagement processes with First Nations families, practitioners also raised the importance of culturally safe language being used in the interaction between child protection and First Nations families:

> The other part of it is language in the context that it is understood, what that is culturally, because even when someone comes to me and says, "I need to understand what this is culturally," and they give me their interpretation and it doesn't even fit my cultural [understanding], but I've got to help that person understand that context for their assessment… and if they haven't got that, then there's misinformation for an Aboriginal – or any Aboriginal or Torres Strait Islander person. …Because practitioners who have been in this space for years, 15, 20 odd years …and the bias that you have to challenge with and then also, our CPAs [cultural practice advisers] talk about… when we've had new staff come on board and they're students straight out of uni that have never even met an Aboriginal person in their lives and we're asking them to make assessments for Aboriginal and Torres Strait Islander mothers and fathers. (First Nations practitioner, child protection, Queensland)

The above quotes reflect wider concerns raised by First Nations practitioners in this study that a one-size-fits-all approach lacking culturally informed practice continues to dominate service responses to First Nations families and communities in this space. It was noted that this creates barriers to meaningful engagement with First Nations families. Given the over-representation of First Nations people as clients across all participating service areas in this study, ensuring culturally safe and informed practice alongside DFV-informed practice is critical across all service areas.

Importance of integrated service responses and system accountability

Practitioners across service areas sometimes rely on information shared by other service areas, which means a collaborative and integrated approach is needed to identify DFV perpetration. Such integration was further identified as critical in responding to perpetrators of DFV and keeping them visible and accountable more broadly. Here, participants spoke about shortfalls embedded throughout the system of agencies that have contact with potential perpetrators of DFV. Participants highlighted that barriers to screening, risk assessment and referral pathways for DFV perpetration experienced within their respective practice areas reflected wider system challenges. They described a system that remains primarily victim-survivor focused and is thus not set up to effectively support perpetrators of DFV and hold them accountable. In particular, child protection practitioners discussed their own service area's accountability in identifying, working with and monitoring perpetrators of DFV along with the wider service system and its approach to working with men using DFV:

> If he's using systems abuse… how are we as an agency being accountable and making sure that those other agencies know what he's doing? That's where I think that we definitely don't get it because we go "we have to hold him accountable" but we're not accountable or the system itself is not accountable for engaging with him, acknowledging him and sharing that information that he is a risk and doing what we can to support that change. (DFV specialist, child protection, Queensland)

> We might be using all of those techniques to look at safety and look at the protective factors, at the end of the day you end up working with that person [victim-survivor] more than the person using violence at times, because there are those limited opportunities or limited ability to hold that perpetrator accountable through systems… That person might disappear and then start using violence with another partner and then you end up in this situation where you're then involved with that person again with a different partner. (Child protection practitioner, Queensland)

Participants felt that current practice allows perpetrators to remain invisible at numerous points of the system. As a result, perpetrators frequently remain unsupported because the wider service system around DFV remains focused on victim-survivors rather than perpetrators. Service areas that undergo substantial reforms to provide DFV-informed practice may therefore see improvements in their own service provision but eventually face the limitations of the wider service system. Here, support and accountability mechanisms for men using DFV may remain limited because external referral pathways are unavailable or other elements of the wider service system do not share the same focus on identifying, monitoring and supporting men who use DFV. As one practitioner explained:

> This shift that we're trying to go through where we pivot to look at him, that's not just exclusive to us, that's the whole system. So it's not surprising then at the end of some of these processes we see cases where we'd like to refer out but we just don't know where to go… it's a system wide issue. (DFV specialist, child protection, Queensland)

Practitioner reflections and experiences were generally more positive in regions where the relevant area of practice was part of a formalised integrated service response. Examples include DFV integrated service responses, DFV high risk teams and Multi-Agency Triage and Case-Led Allocation response (MATCLA). These initiatives bring together a number of agencies that frequently respond to individuals using or affected by DFV—including police, corrections, child protection, health and DFV specialist services—to collectively assess and manage risk of DFV perpetration. For example:

> Gold Coast has the domestic and family violence triage, which sort of acts – similar people that sit on the table as HRT, that provide that – I don't want to say lower level, but there's like, "Hey, we've got some DV bubbling in this situation. It's not quite HRT level, but can we have a collaborative response in that sense?" I think that's what Gold Coast does really, really well. Brisbane just doesn't have something in place like that and I think that we would really benefit from that… because I've found holding him accountable is very, very difficult. (Corrections practitioner, Queensland)

> The HRT has been – and I'm really disappointed it's only in eight locations because that has been – invaluable… the information sharing aspect alone has been so great in that having everyone sitting at the table and putting their information all out on the table and everyone is then basically – it's like a puzzle piece, you pull it together… That's where I think information sharing has opened up this world where you actually can assess risk far better because you can access the pieces of the puzzle. (DFV specialist, child protection, Queensland)

> We have MATCLA… I think we're the only region that have it… All the agencies at that table are around what can we do, how do we intervene with the perpetrator… We can often CCR [child concern report] things that come out of there because they have a response to that perpetrator to increase the safety. So, it does keep people out of the system… We have a lot of opportunities in [region] to refer families to these MATCLA, and DV CAM [Domestic Violence Cross Agency Monitoring] and HRT, all of it. It's good. (Child protection practitioner, Queensland)

While participants reflected on the value and usefulness of these opportunities for an integrated service response, the findings from this study highlight significant variations in the level of service integration across regions and agencies. This was reiterated in one focus group where a participant was reflecting on the value of MATCLA in their region and most participants in the group had not heard of the program and noted that nothing like the initiative was available in their regions. The limited availability of integrated service systems has implications for the capacity of the wider system and its individual service areas to identify and manage risk of DFV perpetration and likely results in missed opportunities for identifying DFV perpetration and related risk and support needs across some regions.

Beyond the importance of integrated service responses and increased access to practices such as MATCLA and HRTs, practitioners also highlighted the need for and benefits of a shared language, understanding and prioritisation of screening and risk assessment for DFV perpetration across services. In particular, child protection participants noted the challenges associated with victim-blaming language or inaccurate screening of cases in police referrals:

> We're seeing the shifts [within Queensland's child protection system] but at the same time we're working with partner agencies who aren't there… We're seeing really destructive language used in say police reports and sometimes we're not changing that and then that's actually coming through to child safety reports. When you still see stuff like that you think oh crap, I thought we were better, I thought we'd moved but we didn't. (DFV specialist, child protection, Queensland)

These findings highlight the need for greater accountability for agencies across the system, including consistent upskilling of frontline practitioners across service areas to screen for DFV and accurately identify the primary aggressor and victim-survivor. Further, these findings highlight the need for a consistent rollout of integrated service responses that are widely accessible across regions. While recognising that there was a comparatively small number of focus group participants from Queensland Health and Queensland Corrective Services, it is noteworthy that reflections on limited system accountability, shared understanding of DFV and a shared language around identifying DFV and related risk in this section came overwhelmingly from Queensland child protection participants. This may reflect the internal progress made by Queensland child protection in working towards greater DFV-informed practice, including identifying and engaging perpetrators in child protection work. While findings presented here show that inconsistencies regarding progress towards DFV-informed practice remain within child protection as well, of the participating service areas in Queensland, child protection has likely undergone the most substantial reform to implement and promote DFV-informed practice, including embedding a commitment to perpetrator accountability.

Referral pathways and lack of available programs

In addition to limitations around greater service system integration, limited referral pathways and a lack of available programs were consistently raised by practitioners throughout the survey and focus groups. This was viewed by practitioners as a barrier to identifying DFV perpetration, adequately managing identified risk and supporting perpetrator behaviour change. While mental health and AOD practitioners predominantly described a need for referral pathways for female clients identified as victim-survivors of DFV, corrections and child protection participants in particular noted their frequent need for referral opportunities to better support identified perpetrators of DFV and ensure their accountability and visibility across service responses. These participants described experiences of long waitlists and a shortage of MBCPs more broadly:

> The wait lists [for MBCPs] can be 18 months… We only have [one MBCP] here. And they have been severely impacted by COVID. (Corrections practitioner, Queensland)

> We only have one behaviour change program [in this region] … usually between nine and 12 months waitlist to even get into the program. …There's not enough programs for men who choose to use violence. (Child protection practitioner, Queensland)
>
> We generally tend to have a very steady supply of clients… around half of the people who are currently here being managed have at least one domestic violence order… we're normally waitlisting clients. (P4, corrections practitioner, Queensland)

In addition to the demand for referral pathways and support options by far exceeding the availability of suitable programs, practitioners noted the need for a more diverse suite of programs that cater for diverse perpetrator cohorts and support needs, in particular culturally diverse populations of men using DFV:

> Identifying supports/referral pathways is super tricky. More so in the space of perpetrator intervention. There's nowhere to really refer that's heavily culturally responsive… sometimes you've got CALD [culturally and linguistically diverse) families who may not necessarily speak English, and because they need an interpreter, the general behaviour change programs won't actually accept them… It's kind of like where do you go? What do you do, and how do you create that ability, or that opportunity for there to be that engagement around accountability/intervention for parents using violence? (DFV specialist, child protection, Queensland)
>
> There's lots of cases where it is the – it's a white man perpetrating violence against an Aboriginal woman… It comes down to culture around referral pathways and potentially opportunities, the right opportunities within those resources or support services… If you think about a white man will go, potentially get a referral to a white service about violence against – will predominantly be focused on violence against a white woman… That cultural context within that… does he find it easier, that space, to talk amongst his white, non-indigenous service rather than actually face… sit in it culturally. (First Nations practitioner, child protection, Queensland)

A concern that flows from the lack of diverse service options and long waitlists for managing risk is that practitioners may feel they are left holding any identified risk in the absence of suitable referral pathways. As has previously been identified in other research around screening for DFV victimisation, practitioners' lack of knowledge about where to refer or how to bring in external support to take a shared approach to risk management and monitoring (Macvean, Humphreys & Healey 2018; Todahl & Walters 2011) creates barriers to holding perpetrators to account and supporting behaviour change. Some mental health practitioners specifically noted that not having relevant referral pathways available when identifying DFV perpetration can create a substantial barrier to practitioners' willingness to screen for DFV perpetration in the first place:

> As a practitioner, you obviously fear that if there is something, [a] person disclose[s] and I don't know what to do with it, then obviously I will not ask those questions. …It's a lot more than just screening. The whole system has to update itself to accommodate what may come out of this screening. (Mental health practitioner, Queensland)

The above-described barriers associated with the limited referral pathways available for identified perpetrators of DFV make it difficult to hold men using DFV accountable for their behaviour. Long waitlists and a shortage of available and appropriate programs further undermine the benefits of screening for DFV and related risk and may create a reluctance among practitioners to screen for DFV perpetration in the first place. Finally, where DFV perpetrators are motivated and willing to engage in behaviour change programs, long waitlists have the potential to erode this motivation. As one participant explained: 'If they've got motivation now, we need to be really striking while the iron is hot' (Corrections practitioner). These findings highlight the need for greater investment in appropriate response options—including MBCPs and motivational programs—to ensure timely and appropriate referral pathways are available where DFV perpetration is identified.

Limitations of and opportunities for information sharing

As noted earlier in the examination of screening tools and practices, all participating service areas have access to information-sharing provisions. These were implemented in Queensland in 2017 under the information-sharing amendments to Queensland's *Domestic and Family Violence Protection Act 2012*, pt 5A. While all participant service areas previously had opportunities to formally request information on clients where relevant safety concerns for clients or others were identified, the DFV-specific information-sharing legislation allows key service areas (eg child protection, health, police, corrections, DFV specialist services) to share and seek relevant information where DFV-related risk is identified or requires further validation. This includes sharing information where risk is identified as well as seeking information to validate perceived risk.

Overall, practitioners felt that the introduction of DFV-specific information-sharing provision has made information sharing more accessible and accurate:

> We've had DVCAM [Domestic Violence Cross Agency Monitoring] for as long as I can remember. It's been around for a while before the legislation, but I think now that the legislation's come in, it's just made it a lot more easy [sic] …it makes us a lot more comfortable sharing that information. (Corrections practitioner, Queensland)

> Under section 159 we could absolutely ask for information and to have that information shared to us from QPS [Queensland Police Service] and a variety of other agencies however unless we were very specific and knowing what we wanted to ask we didn't necessarily get that information whereas the DV Act and Part 5A has been absolutely a godsend because it is DV-focused… [But that's] Not [used] outside the HRT locations. (DFV specialist, child protection, Queensland)

While practitioners generally perceived the Queensland legislation as positive, some concerns were raised that the knowledge of the information-sharing legislation has not been consistently embedded within or across service areas. One mental health practitioner, for example, noted that the opportunities the new provision creates may not be on the radar of all frontline practitioners in their service area:

> Whether all practitioners are aware about those legislative changes. Some time we just have some emails come through updating about legislation, but if it's just one of those bulk email, just read through, you forget about it, because you don't practice them day in, day out. (Mental health practitioner, Queensland)

The above quote likely reflects the broader finding from this study that mental health practitioners frequently noted that identifying and responding to DFV perpetration was not core business in mental health services. As a result, training regarding any DFV-specific legislative changes may not be embedded as a priority.

In addition to information-sharing provisions being underused as a result of practitioners' lack of awareness of relevant legislative pathways and complementary reforms, child protection practitioners in particular described the move to use the new DFV-specific information-sharing provision as a work in progress. Many child protection practitioners said they continued to rely on the prior, more familiar information-sharing legislation. This was seen as a missed opportunity by several practitioners, due to the limited DFV-specific information made available under the previous legislation:

> I still think that a lot of service centres go through 159 pathways under the Child Protection Act, rather than utilising 5A. I don't think that's something that's very commonly practiced, or really maybe even known about… the 5A information sharing through the HRT pathway is super beneficial for guys on the frontline to identify other pieces of information from different agencies that we may not necessarily be requesting under 159. Housing, I have discovered, hold a bucketload of information, because it's not a threatening agency. Perpetrators of violence and victims of violence, they will actually go into a Housing service centre and just say whatever they need to say, and it's all pretty accurate. Whereas they're not going to tell corrections that, and they're not going to tell us. They're not going to tell police. (DFV specialist, child protection, Queensland)

These findings highlight the need for regular education and upskilling of practitioners around legislative changes and their implications for practice. The under-utilisation of the information-sharing provisions to access additional perpetrator-related information as part of the screening and risk assessment process observed in some service areas suggests that education and training should be compulsory for practitioners across service areas subject to the relevant legislation. In the absence of such training, service areas that are less likely to view the identification of DFV perpetration as core business may in turn be less likely to prioritise upskilling of staff in related reform areas. Given the rollout of family violence information-sharing schemes in other jurisdictions, including Victoria (McCulloch et al. 2020), these observations present lessons from other states and territories as they align information-sharing reforms with changes in risk identification, assessment and management practices.

Discussion and implications for policy and practice

Australian reform agendas around domestic and family violence have increasingly shifted the focus onto perpetrators of DFV, recognising that achieving the safety of victim-survivors requires an embedded commitment to ensuring perpetrator visibility and accountability at numerous points of the response system (see Council of Australian Governments 2011; RCFV 2016). Across several states and territories this broad commitment has been translated into reforms which seek to enhance perpetrator focused practices and increase the availability of a suite of perpetrator interventions, including MBCPs. This shift in focus onto the perpetrator has occurred while maintaining the primary goal of ensuring women and children's safety at all points of the response to DFV.

This study demonstrates, however, that despite significant reforms in some jurisdictions—at both the policy and practice levels—the responsibility for identifying and responding to perpetrators of DFV remains predominantly with law enforcement agencies and perpetrator-specific intervention programs, including MBCPs. Research and death review evidence, however, consistently reveals that men using DFV often have diverse service system contact throughout their histories of perpetrating DFV against partners, ex-partners and other family members. This commonly includes contact with corrections, child protection, mental health and alcohol and other drugs services (DFVDRAB 2021). Research further suggests that men's use of DFV often remains invisible in service system contacts that are focused on the individual's other presenting issues (Meyer, Burley & Fitz-Gibbon 2022; RCFV 2016), highlighting missed opportunities to identify risk and related support needs (DFVDRB 2021).

Findings presented throughout this report highlight the ongoing gaps in knowledge and missed opportunities to identify DFV perpetration across service areas that frequently have contact with men for other presenting issues, including mental health concerns, problematic AOD use, parenting and child welfare concerns and offending behaviour beyond DFV. The findings aim to inform improved perpetrator-focused risk identification, assessment and management practices in a range of settings.

Current screening practices

Findings from the survey and focus groups reveal that screening of male clients for potential DFV perpetration in service areas that respond to presenting issues which frequently intersect with DFV remains limited and varies greatly across service areas. While findings show that screening for DFV victimisation has become increasingly common, with many practitioners reporting confidence in screening female clients for victimisation experiences, confidence in and commitment to identifying potential perpetration of DFV among male clients varies greatly across service areas. These observations are in line with wider research evidence, which shows that screening for DFV remains primarily victim focused (Jenney et al. 2014; Penti, Timmons & Adams 2018; Rabin et al. 2009; Vaughan et al. 2016) and limited to specific service areas (Storey et al. 2014; Tarzia et al. 2017). In addition to significant variations observed across service areas in the survey results, focus group data further reveal that variations in screening consistency and commitment remain within areas that have overall demonstrated a strong commitment to implementing numerous DFV reforms in frontline practice.

Survey findings support existing research evidence that perpetration-specific assessment tools are scarce and are rarely used in service areas that are not specifically offender focused, such as police, courts and corrections. When in use, existing tools are largely designed to assess risk rather than screen for the potential presence of DFV perpetration to start with. The implications of this are discussed in the following section.

In relation to initial screening practices for DFV perpetration across practice areas, practitioners were relying on the screening of referral information (eg information about DFV perpetration contained in police or court referrals) along with their professional judgement around indicators of DFV perpetration that may emerge during intake or assessment interviews with clients. Practitioners' likelihood of screening for DFV perpetration was driven by their level of DFV expertise and training, their attitudes towards the benefits and relevance of screening and risk assessment more broadly and whether identifying and responding to perpetrators of DFV was promoted and supported as core business within their area of practice.

In particular, child protection practitioners in this study were most likely to report regular screening for the presence of DFV perpetration during contact with male clients. It is important to note here that this finding is based on self-reported screening frequency. As mentioned in the *Methodology* section, what practitioners consider as screening for DFV perpetration may vary across participants. In the absence of a standardised screening tool being used consistently within or across practice areas, self-reported screening frequency for DFV may therefore range from the screening of referral information for DFV-specific information to practitioners actively asking about or listening for warning signs and subtle indicators of DFV during intake or assessment conversations with male clients. This variation in screening practices was supported by the focus group findings presented here. To enable practitioners to move beyond relying on DFV-specific information contained in referral documentation, consistent upskilling of frontline practitioners to support DFV-informed intake and assessment conversations is critical.

Mental health practitioners were least likely to report regular screening of clients for potential DFV perpetration. As highlighted by the qualitative survey results as well as the focus group findings, mental health practitioners more commonly reported that identifying and responding to perpetrators of DFV was not core business in their area of practice. Practitioners described mental health services, in particular in emergency settings and crisis responses, as fast paced and under-resourced. As a result, practitioners prioritised the presenting mental health issues, including identifying mental disorders and associated risk of harm posed to others, rather than the potential intersection with DFV. These observations are in line with the findings of wider research evidence, which suggest that practitioners are unable to prioritise intersecting presenting issues in fast-paced environments that are focused on diagnosing health-related risks (Aziz & El-Gazzar 2019; Bakon et al. 2019; Tower 2009).

Unsurprisingly, practitioners who reported screening more frequently and consistently in their 'core' practice also reported identifying DFV perpetration being present in a larger percentage of screened cases. This likely reflects a combination of training, confidence and practice experience, with those practitioners screening on a regular basis more likely to report higher levels of DFV specialist training, which increases confidence and experience in supplementing available referral information with DFV indicators identified during intake and assessment conversations with male clients.

Current risk assessment practices

Findings regarding risk assessment practices were predominantly derived from the survey data. They reveal that, while a number of practice areas use victim-centred risk assessment tools, none reported using a DFV perpetration specific tool. As noted in the discussion of findings on risk assessment practices, some practitioners use an area-specific risk assessment tool, which may contain DFV perpetration specific questions. These ranged from an individual risk assessment question in mental health and AOD services to a more sophisticated perpetrator behaviour mapping tool in child protection services.

This research found that AOD practitioners were least likely to report frequent risk assessment where DFV perpetration is known or identified in male clients, followed by mental health practitioners. While the focus groups primarily centred on identifying DFV perpetration in the first place, qualitative survey results suggest that AOD practitioners share some concerns that asking questions about potential use of DFV among male clients may have negative implications for building rapport with clients in AOD service settings. It may thus also generate some reluctance among AOD practitioners to ask risk-related questions where DFV perpetration is known. It is important to note that the sample of AOD practitioners was relatively small in both the survey and focus groups and the results are therefore limited to the small cohort of AOD practitioners who participated in this study.

Other findings around risk assessment relate to screening practices more broadly. Child protection practitioners were most likely to report frequent risk assessment of known perpetrators of DFV, followed by corrections. Further, higher levels of DFV specialist training and more years of experience in the current practitioner role were associated with a greater likelihood of regularly conducting a risk assessment with identified male perpetrators of DFV. These observations are in line with the findings of other research evidence, which suggest that specialist training and practice experience contribute to practitioner confidence in and ability to deliver DFV-informed practice responses (Aziz & El-Gazzar 2019; Bakon et al. 2020).

As discussed in the overview of existing research on risk assessment tools, their predictive validity remains limited and their administration inconsistent. The latter is supported by observations made in this study. It is therefore important to note here that, while some practitioners expressed a desire for a common risk assessment tool, the accuracy of such actuarial tools in predicting future violence varies considerably (Kebbell 2019; Messing & Thaller 2013; Ringland 2018). This study further highlights the need for validation of risk assessment tools (as well as screening tools) prior to their implementation in different practice areas. It is also important to ensure that tools designed for specific practice areas (eg policing, child protection) or target populations (eg victim-survivors vs perpetrators of DFV) are used accordingly to maximise their relevance and accuracy (Messing & Thaller 2013). Finally, consistent implementation of risk assessment tools or frameworks (rather than versions varied or shortened internally by different organisations) and practitioner training have been found to increase the accuracy of such tools (Kebbell 2019). The latter particularly aligns with the need for increased and consistent access to DFV specialist training across practice areas identified in this study.

Evidence suggests that current risk assessment tools are able to retrospectively identify the service system contact and support needs of perpetrators in the lead-up to escalating forms of DFV. This highlights important opportunities for earlier intervention. In other words, these tools may have limited ability to accurately predict which perpetrator may end up using severe and potentially fatal forms of DFV, but existing evidence shows that those who do often have prior service system contact where their use of DFV was not identified (DFVDRAB 2021; Eke et al. 2011). This emphasises the critical need to screen for DFV perpetration during service system contact to identify potential risk to start with and to create referral pathways for DFV perpetrators that facilitate shared risk monitoring and management.

Attitudes to screening, risk assessment and shared risk management

Survey and focus group findings highlight the importance of organisational and individual attitudes that are supportive of screening and risk assessment for DFV perpetration. Unsurprisingly, practitioners and practice areas that held less supportive attitudes to screening and risk assessment and areas that were described as not treating, identifying or responding to DFV perpetrators as core business were less likely to report frequent screening and risk assessment practices. They were also less likely to identify DFV perpetration in the cases they did screen. These observations highlight the importance of organisational commitment to implementing and embedding DFV reforms in shaping the attitudes and perceptions of frontline practitioners, specifically regarding perpetrator visibility and accountability. Mental health practitioners were the least likely to view and promote identifying and responding to perpetrators as core business. Further, mental health and AOD practitioners in this study reported the lowest levels of DFV specialist training and qualifications.

These observations are interconnected in service areas that appear to be less committed to the broader DFV reform agenda of bringing perpetrators into view and thus enabling risk management and monitoring along with support options for men using DFV across the service system. It is critical for these service areas to invest in staff training and professional development along with leadership around DFV-informed practice to create an environment where identifying DFV perpetration and creating referral pathways becomes core business.

Specialist DFV training

This research builds on existing Australian evidence around the relationship between specialist training, organisational commitment to DFV as core business and practitioner practices around screening and risk assessment (see Humphreys et al. 2020; Meyer et al. 2019). Upskilling of practitioners across service areas around DFV more broadly and the identification of DFV perpetration specifically is critical. In the absence of standardised questions or tools to identify DFV perpetration, practitioners rely on their DFV expertise to ensure that their professional judgement can adequately inform their intake and assessment interviews with male clients. Unlike victimisation risk, which is frequently assessed through standardised screening questions in many practice areas (McCulloch et al. 2016; Messing & Thaller 2013; Rabin et al. 2009), screening for perpetration of DFV relies heavily on practitioners being able to read between the lines, pick up on subtle warning signs and prompt further information (Hegarty, Taft & Feder 2008; Kimberg 2007). Specialist knowledge and training along with access to regular professional development around DFV, including perpetration, therefore forms a critical component in promoting identification of DFV perpetrators, assessing their level of risk, seeking from and sharing relevant information with other services subject to legislation, and creating relevant referral pathways and support options for men using DFV. These findings support wider research evidence that highlights DFV specialist training as critical in shaping DFV-informed frontline practice responses (Aziz & El-Gazzar 2019; Bakon et al. 2020; Humphreys et al. 2020; Maple & Kebbell 2021).

Screening tools or professional judgement?

Findings presented here reconfirm existing evidence that DFV perpetration-specific screening tools remain scarce (Kraanen et al. 2013) and in the context of the current study are not in use in participants' practice areas. This is likely the result of a combination of factors. Firstly, perpetrator focused DFV screening tools are only just emerging (Davis & Padilla-Medina 2021; Portnoy et al. 2020). Further, as highlighted by our findings, practitioners have reservations around perpetrators' willingness to disclose use of DFV via standard screening questions. While victim-survivors may be inclined to answer direct questions about their victimisation experiences in order to access support and protection, perpetrators may be more inclined to deny and minimise their perpetration behaviour in anticipation of repercussions rather than support. While there are also limitations to victims' disclosure of DFV (eg out of fear of losing care of their children, experiencing retaliatory violence or not wanting police or court involvement; Heron & Eisma 2021), research shows that screening for victimisation in different service areas supports identification and increases victim-survivors' safety and access to support (Aziz & El-Gazzar 2019; Heron & Eisma 2021). As illustrated by the current study findings, perpetrators are on the other hand perceived as manipulative and unlikely to admit their use of DFV.

While emerging research on the validation of perpetrator screening tools suggests that DFV perpetration may be identified using standardised instruments (Davis & Padilla-Medina 2021), our findings suggest that a more nuanced approach to screening for DFV perpetration may be required. Findings highlight the need for DFV-informed practitioners to be able to ask questions about the potential use of DFV as well as being able to 'read between the lines' and listen out for warning signs and indicators of DFV during intake conversations with clients.

This is further supported by emerging research evidence on screening men in healthcare settings for DFV perpetration, which suggests that a combination of screening questions and conversational assessment can generate disclosure of DFV perpetration (Portnoy et al. 2020). Findings based on the perceptions of male healthcare system users suggest that client practitioner rapport is a critical element of disclosure and that relying on a mix of questions rather than a standard 'tick box' assessment approach promotes men's disclosure of DFV perpetration (Portnoy et al. 2020).

Our findings support to the use of a multi-layered approach to screening for DFV perpetration. First, a more consistent approach to screening for the presence of a current DVO is required, with findings showing great variation in screening for DVOs across practice areas. Findings suggest that some practitioners rely on asking male clients whether a DVO is currently in place, others access relevant information-sharing systems to identify whether a DVO is in place, whereas some practitioners do not employ either screening strategy. In addition to screening or asking for the presence of a DVO (and, where present, its details and conditions), our findings highlight the importance of identifying indicators and warning signs of DFV perpetration during intake and assessment interviews with male clients. Practitioners' ability to identify nuanced and often subtle indicators of DFV perpetration requires DFV specialisation (eg through professional development, such as S&T training, or DFV-specific education or qualifications). Consistent training and education of frontline practitioners is critical to ensuring effective professional judgement and enabling practitioners to identify signs of perpetrator's coercive control, victim-blaming attitudes and system abuse during intake or risk assessment. While the data presented throughout this report is largely Queensland specific, these findings are highly relevant to risk identification and assessment practice in all Australian states and territories.

The role of organisational commitment to and leadership in DFV-informed practice

Organisational commitment and internal leadership around DFV-informed practice play a key role in supporting frontline practitioners' ability and confidence in identifying and responding to DFV perpetrators (Humphreys et al. 2020; Meyer et al. 2019). Practice areas where DFV perpetration was not seen as core business were less likely to identify and respond to DFV perpetration. Similarly, practice areas that lacked organisational or managerial support for frontline practitioners to access professional development around DFV or where team leaders had no DFV specialisation themselves were less likely to identify and respond to DFV perpetration. These settings constitute missed opportunities for DFV identification and information sharing about potential risk and support needs. These findings align with other research evidence that emphasises the role of organisational and team leadership in driving practice reforms (see, among others, Humphreys et al. 2020; Meyer et al. 2019; Meyer & Mazerolle 2014; Todahl & Walters 2011) and highlights the importance of DFV specialist training and education for team and practice leaders to better support their frontline practitioners to implement DFV-informed practice. Further, these findings highlight the need for adequate resourcing of practice areas to ensure manageable case loads for frontline practitioners. Unless practitioners are supported to allocate time to screening for DFV perpetration, our findings demonstrate that non-DFV specialist practitioners will prioritise other intake and assessment questions that are seen as core business in their area of practice, especially in service areas that are time poor, fast paced and often understaffed and under-resourced.

DFV-informed practice frameworks

Findings specific to policy and practice reforms in Queensland and Victoria highlight the value of DFV-informed frameworks in supporting frontline practitioners to implement DFV-informed approaches across different practice areas. Specifically, findings around practitioner awareness and perceptions of the MARAM in the wider Victorian service system context and the introduction of the S&T model in Queensland's child protection system show that the introduction of such frameworks, combined with relevant training around their application in practice, are beneficial in increasing practitioners' understanding of DFV and their ability to identify and respond to DFV. Findings presented here show that these frameworks support greater practitioner knowledge and confidence in identifying and responding to DFV victimisation and perpetration. While the effect appears to be stronger for practitioner confidence in screening for and identifying risk of victimisation than perpetration, overall findings show that the introduction of both frameworks in the relevant jurisdictions and practice areas also had a positive effect on identifying and responding to perpetration of DFV. The discrepancy in impact on screening for and risk assessment of victimisation compared to perpetration is likely the result of greater past investment in and commitment to victim-centred policy and practice reforms (Todahl & Walters 2011), with perpetrator identification and responses being a more recent policy and practice priority (Davis & Padilla-Medina 2021; Healey et al. 2018; Kuskoff, Clarke & Parsell 2022; RCFV 2016; Special Taskforce on Domestic and Family Violence in Queensland 2015).

While the S&T model related findings presented here are limited to one practice area in the current study, the MARAM findings highlight the potential of multi-agency frameworks to increase practitioner knowledge and confidence across practice areas. Focus group findings further support this by highlighting that, particularly in the Victorian context, the introduction of MARAM has improved an understanding, identification and risk management approach that is shared across practice areas. However, survey and focus group findings also reveal variation in the translation of practice frameworks into frontline practice within and across service areas, highlighting the need for consistent implementation and rollout of frameworks and consistent access to related training for all frontline practitioners across all practice areas.

Information sharing

Information sharing was identified as a critical component of effectively identifying and responding to perpetrators of DFV. Findings highlight the critical nature of information sharing in shared risk management and monitoring, a key component underpinning multi-agency frameworks and integrated service system responses (McCulloch et al. 2020). While practitioners across practice areas noted the availability of information seeking and sharing pathways available to them, the use of such pathways varied greatly within and across practice areas. Qualitative findings revealed that participants from corrections and child protection appeared to use information seeking and sharing pathways more frequently than practitioners in other service areas. However, corrections and child protection practitioners also noted ongoing limitations around information sharing. These included inconsistent awareness among frontline practitioners of the current DFV-specific information-sharing provision, a related under-utilisation of the provision, and access to specific information-sharing systems being limited to specific practitioners who may not always be available when information is being gathered to determine DFV perpetration related risk.

These findings highlight the need for consistent training of frontline practitioners within and across practice areas around available information seeking and sharing pathways to ensure practitioners are aware of and familiar with relevant avenues of seeking and sharing information related to suspected or identified perpetrators of DFV. Further, these findings highlight the need to increase the number of staff able to access specific information-sharing systems where such access is related to specialist training to facilitate timely access to cross-agency information critical to determining the presence of DFV perpetration and related risk.

Referral pathways, service integration and system accountability

Our findings highlight the critical role of available referral pathways for identified perpetrators of DFV, including referral options for diverse perpetrator populations, to facilitate holistic service responses. Multi-agency responses, including the Victorian MARAM or the integrated service responses and HRTs in Queensland, offer important opportunities for shared language, understanding and risk management around DFV more broadly, including perpetration. For these reforms to be successful, it is critical that all relevant partner agencies and stakeholders have a shared understanding of DFV as core business (McCulloch et al. 2020, 2016) and view identification of DFV perpetration and related risk as a priority area (Portnoy et al. 2020). This requires non-DFV specialist service areas to identify and respond to clients' primary presenting issues as well as intersecting risk(s) (Humphreys et al. 2020).

Our findings highlight that where service areas prioritise solely the presenting issue relevant to their service mandate (eg mental health concerns, problematic AOD use, child welfare concerns, other offending behaviour), responses to potential perpetrators remain siloed and DFV perpetration remains invisible. These findings demonstrate the ongoing need for greater system integration and related system accountability to ensure DFV perpetration is identified, kept in view and addressed through relevant support and monitoring of perpetrators. These findings are in line with recent research and the findings of Australian based reviews, which highlight the need for system accountability in overcoming siloed responses to clients' symptomatic help-seeking and service presentations and identifying and responding to intersecting issues through information sharing and appropriate referral pathways (Council of Australian Governments 2011; Meyer et al. 2019; Meyer, Burley & Fitz-Gibbon 2022; RCFV 2016; Special Taskforce on Domestic and Family Violence in Queensland 2015).

Conclusion

This research builds on existing evidence around the limited use of DFV perpetrator focused identification and risk assessment tools and practices. While brief perpetrator focused assessment tools are emerging (Davis & Padilla-Medina 2021), awareness, education and prioritisation of identifying and responding to perpetrators of DFV is a relatively recent policy and practice priority in the Australian context (Healey et al. 2018; Kuskoff, Clarke & Parsell 2022; Meyer & Stambe 2021; RCFV 2016). The findings from this research highlight opportunities for screening and risk assessment of male clients across service sectors and the need to ensure screening for DFV perpetration becomes core business.

Specifically, our findings support:

- the use of a combination of direct screening questions and professional judgement to identify potential DFV perpetration and related risk;
- the need for ongoing specialist training in existing and emerging forms of DFV and relevant referral pathways across all service sectors encountering male clients with presenting issues that frequently intersect with DFV;
- the need for regular specialist DFV training across different areas and levels of leadership within each service sector to ensure DFV is seen and promoted as core business;
- the implementation of DFV specialist practitioners across all service sectors to support frontline practitioners in screening for DFV along with related risk management and monitoring; and
- the consistent implementation of multi-agency frameworks to generate integrated and holistic service responses to potential perpetrators of DFV, including information sharing around risk, shared risk management and monitoring and the facilitation of referral pathways for male clients using DFV.

Our findings show that screening for DFV perpetration is different from screening for victimisation and requires different approaches and protocols. While victim-survivors are likely to disclose experiences of DFV in response to explicit screening questions (Rabin et al. 2009; Todahl & Walters 2011), perpetrators may employ strategic manipulation, denial and minimisation to ensure their use of violence remains invisible (Beck & Raghavan 2010; Kimberg 2007; Portnoy et al. 2020). Practitioners in this study raised concerns that many perpetrators of DFV will likely deny using DFV when asked direct questions around potential perpetration.

However, they also believed that this does not make screening for DFV perpetration redundant. Instead, findings highlight that screening for DFV perpetration needs to combine some direct questions along with DFV-informed interview and assessment skills that rely on DFV-informed professional judgement. Further, the inconsistent screening for the presence of a current DVO listing a male client as the respondent observed in the current study highlights the need for consistent screening for the presence of a current DVO and its relevant conditions across practice areas as a starting point. While the absence of a current DVO does not indicate an absence of DFV perpetration, and while the presence of a DVO is only one indicator of DFV and related risk, it is a consistent feature in victim-survivors' experiences of DFV, coercive control, escalating forms of abuse and intimate partner femicide (DFVDRAB 2021; Douglas 2018; Reeves 2021).

To more effectively 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 training and regular professional development around DFV. This should include training on established and emerging forms of abuse, available referral pathways and support mechanisms, and relevant legislative changes. Unless equipped with knowledge and awareness of perpetrator strategies and patterns of denial, minimisation, manipulation and system abuse, along with confidence in using available referral pathways, potential DFV perpetration will likely remain invisible to many frontline practitioners in the absence of standard screening questions and tools that are able to elicit indicators of DFV perpetration and related risk.

Implementing consistent screening protocols further requires organisational leadership. Findings show that applying a DFV-informed lens to client interactions more broadly and to male clients accessing relevant service areas is more pronounced in organisations and service areas with strong commitment to DFV reforms and leadership around DFV-informed practice. Commitment and leadership around DFV-informed practice are key aspects of ensuring that identifying and responding to male clients using DFV is organisational core business. In the Queensland context, this research found a strong organisational shift in child protection towards promoting DFV, including responding to DFV perpetrators, as core business. Health settings on the other hand, including mental health and AOD services, continue to prioritise clients' primary presenting issues over common intersecting issues that may create significant safety concerns in the background of clients' relationships and families. Findings generated from the Victorian mental health and AOD focus groups specifically examining recent reforms and the role of specialist DFV practitioners in mental health and AOD services show that changing attitudes and practice in these health-related areas is possible but requires wider system as well as individual organisational commitment to the implementation of DFV reforms across service areas and locations.

Finally, our findings highlight the need for the consistent implementation of DFV specialist practitioner roles and multi-agency frameworks to generate integrated and holistic service responses to potential perpetrators of DFV. While these are emerging in some areas, they continue to be limited to specific locations and practice areas. Further, they remain predominantly victim-centred, which frequently leaves service areas that are increasingly focused on identifying and responding to DFV perpetration and related risk with limited options for referral pathways and shared risk monitoring and management. Australian state, territory and federal governments therefore need to commit to the resourcing of DFV specialist training, practitioner roles and service integration across all intersecting practice areas. This must extend beyond the practice areas captured in the current study and extend to other areas frequently responding to victim-survivors or perpetrators of DFV, including disability services, Centrelink, housing and homelessness services, non-statutory child and family welfare services, family law services, legal services, First Nations support services and culturally and linguistically diverse support services.

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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, Monash University.

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

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