

Safer Pathway Evaluation

Final report

Acknowledgments

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Abbreviations and acronyms

| | |
|---------------|--|
| Aboriginal | The term 'Aboriginal' is used to describe the many nations, language groups and clans in NSW including those from the Torres Strait ¹ |
| ADVO | Apprehended Domestic Violence Order |
| AVO | Apprehended Violence Order |
| BOCSAR | NSW Bureau of Crime Statistics and Research |
| CALD | Culturally and linguistically diverse |
| CRP | Central Referral Point |
| DFV | Domestic and family violence |
| DVSAT | Domestic Violence Safety Assessment Tool |
| DVLO | Domestic Violence Liaison Officer (NSW Police Force) |
| EAG | Evaluation Advisory Group |
| EWG | Evaluation Working Group (a sub-committee of the EAG) |
| FACS | NSW Department of Family and Community Services |
| IPV | Intimate partner violence |
| LAC | Local Area Command |
| LCP | Local Coordination Point |
| LGBTQI | Lesbian, gay, bisexual, transgender, queer, intersex |
| LSS | Local Support Service (male-LCPs) |
| NGO | Non-government organisation |
| NSWPF | NSW Police Force |
| PAC/PD | Police Area Command/Police District |
| POI | Person of interest |
| SAM | Safety Action Meeting |
| SAP | Safety Action Plan |
| SHLV | Staying Home Leaving Violence program |
| VP-SAFvR | Victoria Police Screening Assessment for Family Violence Risk |
| WDVCAS/WDVCAP | Women's Domestic Violence Court Advocacy Services/Program |

¹ The preference for the term 'Aboriginal' to 'Aboriginal and Torres Strait Islander' in NSW recognises that Aboriginal people are the original inhabitants of NSW. Source: NSW Ministry for Health. (2004). Communicating positively. *A guide to appropriate Aboriginal terminology*. Available from: <https://www.health.nsw.gov.au/aboriginal/Publications/pub-terminology.pdf>

Note on terminology

This report refers to people experiencing or alleged to be experiencing DFV and who are referred into Safer Pathway as 'victims of DFV'. This encompasses females and males who are referred, but may/may not also engage with services and receive supports as a client. This report also refers to people who have used or who are alleged to have used violence against an intimate partner, ex-partner or family member as a 'perpetrator'.

ARTD recognises that there is a wide range of views across both the DFV sector and within stakeholder agencies in Safer Pathway about reference terms for people who experience domestic and family violence. This terminology has been agreed with the Evaluation Working Group, in alignment with the language used by the NSW Police Force and Victims Services NSW.

Executive summary

Safer Pathway

The NSW Government's direction for domestic and family violence (DFV) service system reform is set out in the *NSW Domestic and Family Violence Blueprint for Reform 2016–2021: Safer Lives for Women, Men and Children*² (the Blueprint). Women NSW, within the NSW Department of Family and Community Services (FACS), has overall responsibility for leading the reform program across all the Blueprint domains.

Safer Pathway is a key initiative under Blueprint Action 3 – Supporting victims with timely and appropriate services that keep them safe, increase resilience and meet their needs. It is best understood as the system-wide, service system infrastructure for domestic and family violence victims in NSW, rather than an individual service or program. While led by Women NSW, the Department of Justice has responsibility for the Safer Pathway service model implementation and delivery platform as part of a whole-of-government approach. It was established in 2014 under *It Stops Here: Standing together to end domestic and family violence in NSW – The NSW Government's Domestic and Family Violence Framework for Reform*³ (It Stops Here).

Safer Pathway aims to ensure that all victims of domestic and family violence in NSW receive a timely, effective and consistent response, regardless of where they live. It works to offer victims tailored, coordinated services based on their needs and the level of threat to their safety, and reducing the need for victims to re-tell their story. Its overall objectives are to:

- reduce duplication and fragmentation in the DFV service system by streamlining referral pathways
- provide all victims of DFV across NSW with an effective, timely and consistent response, regardless of where they live, in order to secure their safety and support their recovery
- reduce the need for victims of DFV to re-tell their stories by helping them navigate the service system
- promote a shared understanding of DFV dynamics, indicators and threat levels
- provide victims of DFV at serious threat of further harm with prioritised, inter-agency responses through targeted information sharing.

Safer Pathway has five key components:

- **Domestic Violence Safety Assessment Tool (DVSAT)**—a common risk assessment tool that uses evidence-based criteria to assess the threat level to victims. Based on their responses, victims are assessed as 'at threat' or 'at serious threat'.

² Available at: https://www.women.nsw.gov.au/violence_prevention/blueprint

³ Available at: https://www.women.nsw.gov.au/.../It_stops_Here_final_Feb2014.pdf

- **Central Referral Point (CRP)**—an electronic platform managed by Victims Services that automatically refers incidents of DFV and DVSAT ratings uploaded by NSW Police Force (NSWPF) to Local Coordination Points, based on victim location and gender.
- **Local Coordination Points (LCPs) and Local Support Services (LSSs)**—LCPs/LSSs contact victims after referral from the CRP to re-administer the DVSAT and provide safety planning and case coordination. LCPs are for women victims and hosted by the Women's Domestic Violence Court Advocacy Services (WDVCAS). LSSs are for male victims and hosted by a range of non-government providers.
- **Safety Action Meetings (SAMs)**—fortnightly meetings attended by government agencies and local service providers to coordinate service responses for victims rated 'at serious threat' by the DVSAT. Members develop tailored, time-specific Safety Action Plans (SAPs) to prevent or reduce threat of further assault or harm to victims and their children.
- **Information sharing provisions**—the main legislation related to information sharing in Safer Pathway is Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007*⁴ and Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*⁵.

The Stage 2 evaluation

Purpose

The purpose of this evaluation was to examine whether and the extent to which Safer Pathway is being implemented as intended and meeting its stated objectives, and to identify opportunities for improvement.

Scope

The evaluation reviewed all five components of Safer Pathway and covered all CRP referrals, LCPs and SAMs in operating in Safer Pathway sites up to March 2018. It examined the program interactions and, where available, outcomes for female and male victims in situations of intimate and non-intimate partner violence, assessed as at threat or serious threat. Where data permits, the analysis reflects victims' diverse backgrounds and vulnerabilities.

Methods

The evaluation used a mixed-methods approach, drawing on and synthesising qualitative and quantitative data.

⁴ Available at: <https://www.legislation.nsw.gov.au/#/view/act/2007/80/full>

⁵ Available at: <https://www.legislation.nsw.gov.au/#/view/act/1998/157>

- **Stage 1 Scoping activities** to develop a program theory and outcomes hierarchy, and to inform stage 2 method selection. Methods involved a document review, literature scans, consultations with key stakeholders, a survey of LCP/LSS workers and NSWPF, and a quality review of CRP data.
- **Stage 2 Data collection and analysis** to assess Safer Pathway's implementation and outcomes. Methods included key stakeholder interviews, a survey of LCP/LSS workers and SAM members, analysis of CRP data, a survey of partner agencies and six site studies involving interviews and focus groups with LCP/LSS workers, SAM members, NSWPF members and victims, a review of LCP referral data, a validity review of DVSAT records, cognitive interviewing and scenario testing of DVSAT administrators. Reporting was done iteratively to enable stakeholders to validate or challenge emerging findings.

Approach

The evaluation was informed by realist theory, guided by twelve evaluation questions. Realist evaluations are theory-driven with a focus going beyond the question of 'what works?' to 'how or why does this work, for whom, in what circumstances?' They seek explanations of why programs work better with some groups than with others, or in some locations or circumstances than others.

This evaluation delivers a traditional analysis of findings and also, wherever evidence from data allows, a realist analysis that looks closely at what is working for different groups and in what circumstances. In this way the evaluation seeks to acknowledge and include the many variations and complexities that are part of the DFV landscape, and the variety of responses needed to meet the challenges.

Limitations

Limitations in this evaluation arise from five issues – the absence of outcome measures and tools, CRP data quality, sample size for some methods, sample bias in others, and the timing of the CRP data analysis. These are discussed below.

One of the key questions regarding the effectiveness of Safer Pathway concerns safety outcomes for DFV victims referred into the program. However, this and other outcomes for victims of DFV have not been clearly defined or specified through, for example, the development of a monitoring and evaluation framework, and tools or database fields to capture appropriate measures have not been developed.

This is a limitation because while we can describe program activity and intermediate program outcomes (such as engagement with victims of DFV in Safer Pathway processes, or referrals provided to other services) from quantitative data from the CRP, we can only talk about outcomes for victims of DFV from qualitative data based on interviews, focus groups and qualitative questions in surveys.

The evaluation draws quite heavily on CRP data to describe patterns of victim interactions with the Safer Pathway service system. As was noted in the CRP review conducted in stage 1 of the evaluation, there are gaps in contact and demographic fields. In order to undertake sup-group analysis, it has been necessary to assume that these gaps are consistent across service providers, so while absolute numbers may not be accurate, patterns within demographic and contact variables have been considered to be indicative of the experience of that group.

Data on Aboriginality in the CRP comes from WebCOPS; this data is 80% complete and considered by NSW Police to be relatively robust. We have also looked at patterns for people identified as culturally and linguistically diverse (CALD), having a disability, or lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI). These fields have high numbers of missing values in the CRP. The data does not capture all people in these groups who are referred to Safer Pathway, only those where this is identified to or by police or LCPs/LSSs. Patterns of victimisation and service engagement for these groups are often quite different than for victims of DFV overall and have been included for the illumination they provide.

Data capture of DVSAT re-administration by LCPs is incomplete. Except where a victim is assessed as at serious threat, LCPs are required to close CRP referrals after successfully establishing contact. LCPs then record case notes and other client information in hard copy files and in the WDVCAP database. This policy was implemented to reduce the administrative burden on LCPs, to ensure that client data is captured in a consistent manner, and to work around limitations in the CRP (e.g. the CRP was not developed to record court outcomes). The policy means that CRP data does not capture every DVSAT re-administration or referral/service provided to victims.

Data capture in the CRP for victims referred to SAMs is particularly weak. A sub-set of data was used from a period which Victims Services identified as containing the most robust data, but the results are not definitive.

The response rate for the partner agency survey was low, at 17 respondents. However, other surveys had good response rates. Qualitative (interview) data for different demographic groups was also limited to a small number of LCP/LSS staff working with people from these groups. These small sample sizes limit the strength of findings based on these methods, so these sources are not heavily relied on in the report or in findings and recommendations.

Victims of DFV interviewed were recruited through LCPs/LSSs, and the interviews may exhibit some positive bias due to this sampling method. This limits our qualitative understanding of where the program is not working, and who it is not working for.

The timing of analysis of administrative data (i.e. CRP data) in an evaluation is always difficult. Early analysis reveals patterns that can be interrogated in qualitative data collection, but those commissioning an evaluation want the most recent available data to inform findings and recommendations. There were not sufficient resources to analyse program data twice,

the most recent available data has been used, however this means there have been unexpected patterns identified that have not been explained by qualitative data.

Confidence in the findings

The evaluation investigated where Safer Pathways is working, for whom and under what circumstances from multiple perspectives and using different methods. Overall, there was strong consistency in the findings across the range of stakeholder groups and methods used, which gives a high level of confidence in the overall findings.

Key findings

Safer Pathway has been implemented largely as intended and is generally meeting its intended objectives of ensuring a consistent, effective and timely response to victims across NSW. All five components of the initiative have been implemented and work together.

As a result of Safer Pathway:

- Threat assessment is consistently undertaken by Police for every DFV victim (DVSAT), the DVSAT is completed by specialist domestic violence support services that receive Police referrals (LCPs/LSSs), DFV victims at serious threat are prioritised throughout Safer Pathway service response (including at SAMs), and the DVSAT is available for use by all service providers.
- A single streamlined referral pathway between NSWPF and LCPs/LSSs has replaced the previous service fragmentation and duplication that arose from different referral arrangements in each Police Area Command (PAC). The information sharing provisions (Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007*) mean all DFV victims are now automatically referred to LCPs/LSSs for support, and service providers can now share information in order to lessen or prevent a serious threat to a person's life, health or safety due to domestic and family violence (without consent in certain circumstances).
- There is now a standard level of service for DFV victims across NSW, with all female DFV victims referred to an LCP, and all male DFV victims referred to an LSS. DFV victims at high risk now receive a consistent, coordinated response across NSW and across service providers.

The early chapters of the report provide findings on Safer Pathway implementation (Chapter 3) and the DVSAT tool (Chapter 4). Subsequent chapters are structured using the Safer Pathway program logic which has four domains: the first three cover the client pathway from identification and assessment (Domain 1) to local contact and re-assessment (Domain 2) to referral and case coordination (Domain 3). The function of Safety Action Meetings (Domain 4) is a parallel structure to the support provided through Domain 3. The evaluation questions are addressed throughout the report (Table 1 lists the questions and the chapters where they are addressed).

Implementation

Safer Pathway is a NSW system level initiative engaging key partner agencies including NSWPF, Legal Aid NSW, Victim Services, FACS, Ministry of Health, Corrective Services NSW, Education and non-government organisations (NGOs). The importance of a system-wide program, with multiple entry points is critical given the broader evidence around help-seeking behaviours of victims and their low level of reporting to police.

Safer Pathway sites have been established as intended, with the staged roll out of 48 SAM sites across NSW from 2014–2018.⁶ Key components of Safer Pathway—the DVSAT, CRP, LCP and LSSs, and SAMs—have been implemented incrementally over five years.

Each agency has policy and program materials to support the implementation of their program. However, overall framing of the initiative has not been undertaken. Safer Pathway does not have an explicit theory of change, and documentation does not address re-referral. The initiative would be further strengthened by the development of a monitoring and evaluation framework which specified the expected outcomes for clients and the program as a whole at all levels of engagement and activity, and identifying available and needed data sources (e.g. CRP items, victim outcome measurement tools). This development would also support action area six of the Blueprint, improving the system by ensuring strong governance, planning and accountability mechanisms aligned to achieving outcomes.

CRP

The CRP was developed to securely transfer DFV incident data from NSWPF WebCOPS to LCPs/LSSs and has been upgraded continuously to increase its features and usability. Referrals by NSWPF into the CRP overall grew rapidly with the rollout of the DVSAT. However, the CRP as the main conduit for referral is not accessible to other partner agencies or service providers, although referrals can be made electronically into the CRP from courts.

The CRP functions effectively to streamline referrals from NSWPF to LCPs/LSSs. It is heavily used by LCP/LSS staff and is considered easy to use. Data completeness for existing variables is high overall, but there are gaps in contact and demographic fields.

The role and effectiveness of the CRP as a tool for monitoring and evaluation purposes is undermined the dual use of the CRP and WDVCAP databases by LCPs, and the lack of a monitoring and evaluation framework for Safer Pathway.

Training

The rollout was supported by information and training for LCP/LSS staff, Police and members of SAMs.

⁶ 43 of the 48 sites were operational at the time of this evaluation.

Legal Aid NSW implemented a comprehensive training program for LCP and LSS workers and SAM members, including development of a manual for LCPs.⁷ LSS workers and those in regional areas were less satisfied with training provided than LCP workers and those in metropolitan areas. Workers requested ongoing annual training, and training integrated with General Duties Police and Domestic Violence Liaison Officers (DVLOs).

Police described varying exposure to training in DFV, Safer Pathway and the DVSAT. There has not been formal training for Police in Safer Pathway or the DVSAT since a requirement to complete an online training module in 2015. With turnover of staff, this implies that most Police have minimal introduction to Safer Pathway and training in the use of the DVSAT, and poor understanding of its purpose is common. The priority role for Police attending a DFV incident is investigating whether an offence has occurred. A lack of training in the context and purpose of the DVSAT may undermine their role as assessors of risk in DFV incidents.

SAM members were positive about the training and support received in establishing Safer Pathway, including the manual to guide SAM operations. Regional SAM members had lower training completion rates and requested that training be made more available.

DVSAT

The evaluation assessed the extent to which the DVSAT is a valid, reliable and appropriate tool for assessing DFV threat. Findings from literature, interviews with police and LCP/LSS staff about their use of the DVSAT, and cognitive interviews were used to assess how victims respond to the questions in the DVSAT.

Views on best practice in risk assessment depend on how risk is understood and measured. The ANROWS' National Risk Assessment Principles⁸ argue that best practice risk assessment in DFV involves a structured professional judgement approach that incorporates:

- a well-tested actuarial tool (that has predictive validity) or a tool based on evidence-based risk factors
- victim statements and narratives that capture the victim's level of fear and self-perception of risk
- room for professional judgment by expert practitioners.

While the approach to risk assessment in Safer Pathway incorporates the three elements of a best practice risk assessment framework, there are limitations in both the design and practice of these.

The current DVSAT is a structured professional judgement tool. The items included in the DVSAT are largely based on risk factors associated with serious assault or homicide in intimate partner violence⁹ (IPV) risk assessment research. Police have been implementing the

⁷ NSW Government. (2015). *Local Coordination Point Manual*. Legal Aid NSW, Sydney.

⁸ Backhouse, C. & Toivonen, C. (2018). *National Risk Assessment Principles for Domestic and Family Violence: Companion resource*. ANROWS, Sydney.

⁹ An intimate relationship refers to people who are (or have been) in an intimate partnership whether or not the relationship involves or has involved a sexual relationship, i.e. married or engaged to be married, separated, divorced, de facto partners (whether of the same or different sex), couples promised to each other under cultural or religious tradition, or who are dating.

DVSAT state-wide since 2015. Use of the DVSAT is mandatory among NSW Police officers who respond to DFV incidents and mandated as standard practice among LCPs and LSSs. Since it was first introduced, there have been some developments to the tool and processes for using it.

The DVSAT used by police in Safer Pathway seeks to identify the level of risk of harm to a victim to prioritise the speed and level of response to higher risk matters. However, it lacks essential elements for best practice tools, the questions can be misinterpreted and can be answered incorrectly by victims, it is not reliably administered by police, and some victims are reluctant to answer some questions accurately.

The use of separate tools for police and DFV specialists in intimate partner risk assessment is standard in some other jurisdictions in Australia and internationally. Expanded definitions of DFV to include non-intimate relationships has required the development of new tools, including a valid actuarial tool for police in Victoria – Victoria Police Screening Assessment for Family Violence Risk (VP-SAFvR).

The development of a tool along the lines of the VP-SAFvR would mean:

- more effective and accurate prioritisation of high-risk cases
- victims of all forms of DFV in NSW, regardless of their relationship to a perpetrator, would receive a best practice risk assessment
- initial police risk assessment would be less reliant on the knowledge of an individual administrator.

The purpose of the LCP/LSS DVSAT is to facilitate a comprehensive risk assessment concerned with both the level and type of threat to a victim's safety, informing both the prioritisation of serious cases and an effective service response tailored to the needs of a victim.

The LCP/LSS DVSAT could be improved through some adjustments to formatting, weighting of items and wording of questions. However, it is a good practice tool for use by experienced DFV practitioners.

For victims that engage with police or LCP/LSS support workers, the administration of the DVSAT can have a profound effect. The administration of the DVSAT can enable victims to identify their experiences as DFV for the first time, especially in situations that did not fit victims' understanding of what comprises domestic or family violence. In other cases, victims may have recognised that there were 'elements' of domestic violence in their situation, but only when the DVSAT was administered did they register it as serious enough to change their circumstances. This is an unintended and positive effect of the DVSAT tool.

Domain 1: Victim identification and assessment

Safer Pathway guidelines are that DFV victims are identified through contact with NSW Police or another agency/service provider following an incident. The threat to victims is reliably assessed using a standard, valid tool as either 'at threat' or 'at serious threat', and the initial threat assessment and other relevant information is sent to the CRP database.

In practice, over 99% of the referrals into Safer Pathway since 2014 have come from NSWPF. Service providers other than police can make referrals directly to LCPs but these referrals are not recorded or processed in the CRP (and make up a very small number of overall referrals). The current role of police as the primary entry point for referral into Safer Pathway is a significant barrier for some victims of DFV to seek help with their situation.

The profiles of people referred into Safer Pathway broadly reflect population level data on DFV incidence:

- more female than male victims of intimate and non-intimate DFV
- lower rates of referral for non-intimate DFV than for intimate DFV
- high rates of referral for Aboriginal people.

Overall, almost two-thirds of referrals into Safer Pathway were for intimate partner violence. Police completed a DVSAT for almost 90% of these referrals, rating just under 8% at 'serious threat'.

Less than 5% of referrals for non-intimate DFV were rated at 'serious threat'. Overall, 48% of the non-intimate referrals were for child-parent DFV. The data does not indicate the proportion of perpetrators who were adult children, but this was raised in interviews as a common scenario.

Complex cases involving drug and alcohol use and/or where there are cross-accusations of violence sometimes presented challenges in identifying victims of DFV.

Approximately one-fifth of DFV victims have been re-referred into Safer Pathway since 2014 (19% of intimate DFV victims and 21% of non-intimate DFV victims). Re-referral occurred for all victim groups, but rates were higher for women, Aboriginal people, and those last referred at serious threat.

Domain 2: Victim contact and re-administration

Safer Pathway guidelines are for LCPs/LSSs to make timely contact with DFV victims referred through the CRP, with priority based on the initial threat assessment. The worker reassesses risk using a reliable, validated tool, as 'at threat' or 'at serious threat'.

LCP/LSS contact with victims of DFV was a positive feature of Safer Pathway, facilitating engagement of victims with the service system. LCPs/LSSs were successful in contacting two-thirds of victims referred through the CRP. They were unable to contact one in 10 victims due to no contact information being provided in the CRP, and the remaining quarter did not respond. This reflects population-level data on patterns of IPV victims seeking help and their willingness to engage with services.¹⁰

Most workers made contact with victims within one business day of referral. However, contacting victims within business hours was a problem for victims who did not want to receive these calls at work. Police informing victims to expect contact from a specialist DFV

¹⁰ Australian Bureau of Statistics. (2017). *Personal Safety, Australia, 2016*. Available at: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0>

worker enhanced victims' trust and engagement with LCP and LSS workers. DVLOs played an important role in facilitating contact through providing updated contact information.

Data analysis highlighted distinct patterns in LCP/LSS contact with victims. Women were more likely to be successfully contacted than men, and Aboriginal people were less likely to be successfully contacted than non-Aboriginal people.

LCP/LSS workers were very effective in engaging victims. Victims described workers as calm, compassionate, non-judgemental and receptive. While some DFV victims are initially unwilling to speak, willingness to engage can increase over time as their understanding of their situation and the way support is offered changes. Safety and safety planning were discussed with almost all victims during initial contact.

LCPs/LSSs re-administered the DVSAT with 30% of intimate and 26% of non-intimate DFV victims who were referred into Safer Pathway. Just over 10% of referrals for intimate DFV were upgraded to 'serious threat', with 3% of non-intimate referrals upgraded. Women victims were more likely than men to be upgraded from 'at threat' to 'at serious threat' after LCP/LSS re-administration of the DVSAT.

Domain 3: Victim referral and case coordination

Safer Pathway guidelines are for LCPs/LSSs to prioritise and coordinate responses according to reassessment and victim support needs.

Of those contacted, approximately half of intimate and non-intimate DFV victims received referrals for further support. This reflects population-level data on victim's reluctance to seek help from DFV services.¹¹

- Women were more likely to receive referrals than men, across all groups (64% of non-Aboriginal women and 61% of Aboriginal women)
- One-fifth of Aboriginal men and one-quarter of non-Aboriginal male victims of DFV who were contacted received a referral or information
- DFV victims in regional areas were more likely to receive referrals than metro areas.

Two-thirds of referrals for victims of intimate DFV were supported, or 'warm', referrals. For non-intimate DFV victims, half of the referrals were supported. LCPs made more warm referrals than LSSs, who reported a lack of local services to refer male victims to, and relied more on national support and advice lines than on local services to provide further support to victims. LCPs with an Aboriginal specialist worker were more likely to make warm referrals than those without, indicating that a specialist worker facilitates a greater degree of culturally appropriate service delivery for Aboriginal victims referred into Safer Pathway.

The type of referrals (i.e. supported versus information only) provided by LCPs appropriately matched victims' threat ratings, with those 'at serious threat' more likely to receive supported

¹¹ Australian Bureau of Statistics. (2017). *Personal Safety, Australia, 2016*. Available at: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0>

referrals than those rated 'at threat'. LCPs in small towns and remote areas made supported referrals at a higher rate than the LCPs in cities or large towns.

Most referrals made by LCPs connected DFV victims to a new service, suggesting a new or broader approach to their situation. Just over half (56%) of referrals made by LCPs were taken-up by victims.

Proactive contact with victims of DFV and the coordinated service response by LCPs/LSSs are significant factors leading to better safety outcomes, according to partner agencies. Safety outcomes included support with safety planning and fast access to security upgrades for homes (changing locks, installing cameras and alarms). Improving access to safe housing was a key intervention for many. Other support included obtaining Apprehended Violence Orders (AVOs), increased monitoring and compliance by Community Corrections, assistance and advocacy with the legal system. Child safety outcomes include school safety planning for children and upgrading the risk of significant harm responses.

Common service gaps were case management services (especially in small town and regional areas), mental health services (especially for LSSs) and housing or crisis accommodation. There were high rates of LCP workers continuing to provide or coordinate support for a victim after closing their case on the CRP.

Domain 4: Integrated support in response to serious threat

Safer Pathway guidelines are that LCPs place victims who are at serious threat on the SAM agenda for interagency discussion and problem solving. SAMs meet regularly to share information and make coordinated decisions. Agreed safety actions are implemented on time for victims 'at serious threat'.

SAMs are serving a valued and useful function within Safer Pathway in coordinating resources across agencies in complex cases. SAM members and external partner agencies described a changing culture that sees DFV as the responsibility of all agencies.

The majority of SAM members thought SAMs were appropriate for intimate and non-intimate cases of DFV. The higher number of services available for victims of intimate partner violence was commonly raised by those who reported that the SAM was more appropriate for these victims.

Data quality is not strong, but results suggest half of the referrals into Safer Pathway that were ultimately rated 'at serious threat' were listed and discussed on the SAM, along with a very small proportion of those graded 'at threat'. Most referrals down-graded to 'at threat' were listed, but not discussed at the SAM. The low rate of reassessment for men (18%) means it is not known how many are 'at serious threat', and few men, and very few Aboriginal men, are being referred to the SAMs.

Members were very positive about how SAMs coordinated interagency actions worked to reduce serious threats to victims. Information sharing was seen as key to the effectiveness of SAMs, supporting informed discussions and decision-making.

Conclusion

Overall, the evidence from the evaluation shows Safer Pathway providing a systematic, state-wide response to DFV in NSW, with the development of a shared understanding of DFV behavior and risks, and the language to describe it, by police, other government agencies and NGOs within the sector. This, in turn, is having an educative impact on people experiencing the DFV cycle of violence. Consistent threat assessment and support are leading to threat reduction for many victims of DFV.

However, challenges remain in reaching groups with a reluctance to engage in services, particularly where police are involved. Additionally, the relatively new inclusion of non-intimate DFV into the policy area means an understanding of and service delivery to victims of non-intimate DFV require further development.

Recommendations

The following recommendations are made on the basis of the evidence provided by the evaluation.

Implementation

1. In collaboration with Safer Pathway partner government agencies, Women NSW lead the refinement of the Safer Pathway scope and theory of change.
2. In collaboration with Safer Pathway partner government agencies, Women NSW lead the development and implementation of a Safer Pathway monitoring and evaluation framework, to enable ongoing monitoring, measurement and reporting by agencies for learning and accountability purposes. The monitoring and evaluation framework implementation plan should specify reporting requirements to the Domestic Violence Reforms Delivery Board,¹² and address:
 - 2.1 data development for improved monitoring and evaluation against identified outcomes
 - 2.2 monitoring of the proportion of victims assessed 'at serious threat' to ensure victims most at threat receive a prioritised, coordinated response
 - 2.3 monitoring of the rate of DVSAT completion by police across population groups
 - 2.4 monitoring of the number, proportion and profile of victims whose matters are referred to the SAMs
 - 2.5 monitoring of SAM participation to ensure appropriate local service participation, including case management service providers when their clients are listed on the agenda
 - 2.6 development of measures and tools to describe and quantify outcomes for victims from SAMs

¹² The Domestic and Family Violence Reforms Delivery Board is an interagency board providing governance and oversight to all DFV strategies and reforms in NSW.

2.7 development and monitoring of outcomes measures that reflect ongoing engagement of re-referred victims at all stages of Safer Pathway, including measures pertaining to victim engagement with LCPs, support, safety and links to the service system

2.8 outcome and economic evaluation.

3. Legal Aid NSW and Victims Services clarify the respective roles of the CRP and WDVCAP database for LCPs.
4. Continue to expand referral pathways to facilitate referrals to Safer Pathway from other agencies, funded services, and community and self-referral.
5. Continue to provide annual training for LCP and LSS workers and SAM members, accessible to staff across the state.
6. Legal Aid NSW and NSW Police consider providing joint local training for LCP/LSS staff, police and DVLOs to build local relationships and shared understandings of DFV and the roles of program components.
7. Strengthen the adequacy and availability of training in DFV, Safer Pathway and the DVSAT for police as part of ongoing training. The training should cover DFV dynamics and coercive control, provide support in developing skills and approaches to asking difficult questions, and make clear the role of the safety assessment in prioritising a multi-agency service response to victims of DFV.
8. Explore additional opportunities and mechanisms for information sharing and cross-learning for LCP/LSS staff, including reviewing and promoting participation in local DFV interagency meetings in the areas in which their clients live.
9. NSWPF review the monthly rotation of SAM chairs, and consider moving to a six-monthly rotation, to support SAM group dynamics.
10. As part of the next review of the SAM manual, include better practice information on working remotely with meeting participants, such as via tele-links, to support the effectiveness of SAMs in rural and remote areas.
11. Strengthen reference in SAM member training to the possible need for psychological support and its availability, e.g. through agency Employee Assistance Programs (EAPs).
12. Government agencies that are standing members on SAMs:
 - 12.1 prioritise SAM participation by reviewing SAM-related workload and resourcing
 - 12.2 seek to reduce rotation of staff representatives on SAMs
 - 12.3 provide adequate introduction, orientation and handover to incoming staff on SAM membership roles and responsibilities, and available psychological supports, such as EAPs.

DVSAT

13. Revise the Police DVSAT to enhance its predictive ability to assess the likelihood of further aggression by a perpetrator across intimate and non-intimate cases, ensuring its coherence with the LCP/LSS DVSAT. It is recommended the revised DVSAT include:
 - changes to the layout of the DVSAT to include parts A, B and C, where Part A involves an actuarial or itemised checklist, Part B involves victim of DFV self-assessment, and Part C involves professional judgment
 - guidance on the discretionary ability of police to increase, but not decrease, threat assessment, in line with other jurisdictions
 - reliability testing.
14. Revise the LCP/LSS DVSAT, ensuring its coherence with the police DVSAT. It is recommended the revised DVSAT include:
 - changes to the layout of the DVSAT to include parts A, B and C, where Part A involves an itemised checklist, Part B involves victim self-assessment, and Part C involves professional judgment in line with best practice protocols for DFV risk assessment
 - modified wording of questions to ensure a positive response by the victim of DFV means the presence of the evidence-based risk factor that the question seeks to assess is clear in each case
 - weighting of questions that the evidence base shows as most indicative of further risk of harm
 - reliability testing.
15. Legal Aid NSW and Victims Services develop explicit protocols and ensure LCP/LSS staff are sufficiently trained in the administration of sexual assault items in the LCP/LSS DVSAT.

Domain 1: Victim identification and assessment

16. NSWPF ensure that regular training for police includes:
 - the role of the safety assessment in investigation of an incident, and in referral into and prioritisation of victims within Safer Pathway
 - DFV dynamics and coercive control, identifying victims and perpetrators of DFV in complex situations, and identifying and assessing male victims of DFV.

Domain 2: Contact and re-administration

17. NSWPF and Victims Services work together to support more effective engagement with victims by LCP and LSS workers by:
 - 17.1 investigating strategies to address high rates of non-contact with some groups
 - 17.2 improving the accuracy of contact data for DFV victims in the CRP, and investigating reliable pre-population/updating of contact numbers in WebCOPS and the CRP
 - 17.3 improving the availability of incident and DFV victim demographic data in WebCOPS and the CRP.

18. NSWPF continue to reinforce to police the importance of providing information about LCP/LSS contact through DVSAT and Safer Pathway training.
19. Legal Aid NSW and Victims Services review the availability of Aboriginal Specialist Worker positions, and identify how to address availability gaps in areas with high Aboriginal populations to facilitate greater contact and engagement with Aboriginal victims of DFV.
20. Legal Aid NSW and Victims Services explore options to increase LCP/LSS DVSAT re-administration rates for vulnerable groups.

Domain 3: Referral and case coordination

21. Women NSW and Safer Pathway partner agencies identify any service gaps in availability of longer-term supports for victims, in particular services for Aboriginal victims, male victims and victims of non-intimate DFV.

Domain 4: Integrated support in response to serious threat

22. Victims Services ensure that planned or future developments of the CRP:
 - provide more information to SAM members about DFV victims who are re-referred to Safer Pathway
 - include systematic data capture about LCP/LSS DVSAT re-administration, including reasons for non-re-administration and outcomes for victims
 - include a mechanism for identifying and reporting on the completion of actions in safety action plans
 - enable accurate monitoring of the number, proportion and profile of victims whose matters are referred to SAMs, and provide training and direction to LCP and LSS staff to ensure SAM referral data is entered into the CRP.
23. Safer Pathway partner agencies ensure all existing and incoming SAM members are supported to attend SAM training as soon as possible in order that they understand SAM purpose and process, and appropriate use of the information provisions.

1. Background

1.1 The NSW policy context

The NSW Government's directions for domestic and family violence (DFV) service system reform are set out in the *NSW Domestic and Family Violence Blueprint for Reform 2016–2021: Safer Lives for Women, Men and Children* (the Blueprint). The Blueprint aims to establish a system that will make victims safer and better support their recovery. It sets out six areas of action:

1. **Preventing DFV**, with a focus on changes to attitudes, social norms and structures that underpin domestic and family violence
2. **Intervening early**, with a focus on vulnerable communities so that population groups at higher risk of DFV are identified and supported
3. **Supporting victims**, with timely and appropriate services that keep them safe, increase resilience and meet their needs
4. **Holding perpetrators to account**, by embedding accountability into the system with a focus on timely and effective behaviour change interventions
5. **Delivering quality services**, with a focus on services for victims and perpetrators that are evidence-based
6. **Improving the system**, by ensuring strong governance, planning and accountability mechanisms and are aligned to achieve outcomes.

Women NSW, within the NSW Department of Family and Community Services (FACS), has overall responsibility for leading the reform program across all the Blueprint domains.

Safer Pathway is a key initiative under Blueprint Action 3 – Supporting Victims. It involves system-wide changes to streamline and integrate approaches to victim safety assessment, referrals and service coordination. While led by Women NSW, the Department of Justice has responsibility for Safer Pathway service model implementation and delivery platform as part of a whole-of-government approach.

1.1.1 Rationale for Safer Pathway

Safer Pathway was established in 2014 under *It Stops Here: Standing together to end domestic and family violence in NSW - The NSW Government's Domestic and Family Violence Framework for Reform (It Stops Here)*.

This framework was developed in response to the recommendations of several key reports, including the NSW Legislative Council 2012 inquiry into *Domestic violence trends and issues* in

NSW,¹³ the NSW Auditor-General's 2011 *Responding to Domestic and Family Violence* report¹⁴ and Australian and NSW Law Reform Commission's 2010 *Family Violence – A National Legal Response* report.¹⁵

These reports found a need for agencies and services to build a stronger shared understanding of the dynamics of DFV including assessing risks of victimisation, and to coordinate and collaborate more effectively to enable more consistent responses.

National policy directions

Key national policies that inform the NSW response to DFV include:

- the *National Framework of Rights and Services for Victims of Crime 2013–2016*¹⁶ (The National Framework) represents a commitment by the Commonwealth, states and territories to improve national coordination of services to victims of crime. It identifies guiding principles to assist victims in recovery, and to minimise re-victimisation.
- the *National Plan to Reduce Violence Against Women and Their Children 2010–2022*¹⁷ (The National Plan) is a 12-year strategy that works towards Australian women and children living free from violence in safe communities. Governments have incorporated the key priorities of the National Plan into their policy-making which are: respectful relationships, strengthening Indigenous communities, ensuring that services meet the needs of women and children, the effectiveness of justice responses, stopping violence and holding perpetrators to account.

1.1.2 Defining domestic and family violence in NSW

Domestic and family violence is a crime. It is also a complex and diverse issue around which many definitions are used internationally and in Australian jurisdictions. In some settings, 'domestic and family violence' is employed interchangeably with 'domestic violence' and in others 'domestic violence' is used specifically to identify 'intimate partner violence' while 'family violence' has a broader reference. Often, definitions emphasise that there is no single type of domestic and family violence, but a central element is an ongoing pattern of

¹³ Available at: <https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=1687#tab-reportsandgovernmentresponses>

¹⁴ Available at: <https://www.audit.nsw.gov.au/publications/performance-audit-reports/2011-reports/responding-to-domestic-and-family-violence>

¹⁵ Available at: <https://www.alrc.gov.au/publications/family-violence-national-legal-response-alrc-report-114>

¹⁶ Available at: https://www.victimsservices.justice.nsw.gov.au/Pages/vss/vs_policy_tabled_documents/vs_policy_tabled_documents.aspx

¹⁷ Available at: <https://www.dss.gov.au/women/programs-services/reducing-violence/the-national-plan-to-reduce-violence-against-women-and-their-children-2010-2022>

behaviour, both criminal and non-criminal, through which power and control is exercised, including through fear.

There is little known about the extent to which the dynamics of coercive control seen in male perpetrated intimate DFV are the same in female-perpetrated DFV, or in child-parent or sibling violence. As more jurisdictions embrace wider definitions of DFV, with attendant research into issues and responses, more nuanced understanding of the differences between the nature, dynamics and drivers of various forms of violence under the DFV umbrella will be helpful in developing relevant and 'fit-for-purpose' tools and responses, such as risk assessment and safety planning.

The common policy definition in NSW

An agreed NSW Government policy definition of domestic and family violence was established in 2014 under *It Stops Here* and confirmed more recently during the development of the Blueprint.

Definition of DFV, intimate and family relationships in the Blueprint taxonomy

Domestic and family violence includes any behaviour, in an intimate or family relationship, which is violent, threatening, coercive or controlling, causing a person to live in fear. It is usually manifested as part of a pattern of controlling or coercive behaviour.

An intimate relationship refers to people who are (or have been) in an intimate partnership, whether or not the relationship involves or has involved a sexual relationship, i.e. married or engaged to be married, separated, divorced, de facto partners (whether of the same or different sex), couples promised to each other under cultural or religious tradition, or who are dating.

A family relationship has a broader definition and includes people who are related to one another through blood, marriage or de facto partnerships, adoption and fostering relationships, sibling and extended family relationships. It includes the full range of kinship ties in Aboriginal and Torres Strait Islander communities, extended family relationships, and constructs of family within LGBTIQ communities. People living in the same house, people living in the same residential care facility and people reliant on care may also be considered to be in a domestic relationship if their relationship exhibits dynamics which may foster coercive and abusive behaviours.

The behaviours that may constitute domestic and family violence include:

- physical violence including physical assault or abuse
- kidnapping or deprivation of liberty
- sexual assault and other sexually abusive or coercive behaviour
- emotional or psychological abuse including verbal abuse and threats of violence
- economic abuse e.g. denying a person reasonable financial autonomy or financial support
- stalking including through the use of electronic communication or social media
- harassment, intimidation or coercion of the other person's family to cause fear or ongoing harassment
- unreasonably preventing the other person from making or keeping connections with her or his family or kin, friends, faith or culture.¹⁸

¹⁸ NSW Government. (2014). *It Stops Here: Standing together to end domestic and family violence in NSW – The NSW Government's Domestic and Family Violence Framework for Reform*, p. 7.

The criminal definition in NSW

It is relevant to note that the criminal definition of DFV in NSW is different to the common policy definition above – as is the case in other jurisdictions. NSW legislation does not define family violence, but defines ‘domestic violence offences’ by referring to ‘personal violence’ offences in the *Crimes Act 1900 (NSW)* where those offences are committed by persons in defined domestic relationships against other persons.

NSW legislation also provides that non-physically violent offences such as stalking, intimidation with intent to cause fear of physical or mental harm, and attempts to commit these, can amount to ‘domestic violence’.¹⁹

1.2 Victims of domestic and family violence

The most common form of DFV is intimate partner violence perpetrated by a male against a current or former female partner. However, the range of victims also includes male victims, female victims of violence perpetrated by children or other family members, and elder abuse. Aboriginal communities and families are disproportionately affected by DFV. People who experience forms of social exclusion, including people living with disability, people who identify as LGBTQI, Aboriginal and Torres Strait Islander people, and people from cultural and linguistically diverse (CALD) backgrounds are particularly vulnerable to DFV.²⁰

Children are also highly vulnerable to DFV, both directly and indirectly: directly when they are the victims of emotional, physical or sexual abuse; indirectly when they are living in a home in which DFV is occurring and exposed to the trauma effects this can have.

1.3 Prevalence of domestic and family violence

According to the 2016 *Australian Personal Safety Survey*,²¹ approximately one in four women and one in 13 men have experienced violence by an intimate partner in Australia. One in six women experienced physical violence by a partner, compared with one in 17 men, and women were eight times more likely to have experienced sexual violence by a partner than men. Both women and men were more likely to have experienced violence by a previous partner than by a current partner. Over half of those who experienced partner violence had experienced more than one incident of violence by that partner. Almost one in four women

¹⁹ Australian Law Reform Commission. (2010). A Common Interpretative Framework—Definitions in Family Violence Legislation. *Family Violence—A National Legal Response*. Available at: https://www.alrc.gov.au/sites/default/files/pdfs/publications/ALRC114_WholeReport.pdf

²⁰ Australia Bureau of Statistics. (2013). Describing behaviours and relationships. *Defining the Data Challenge for Family, Domestic and Sexual Violence*. Available at: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4529.0main+features172013>

²¹ Australian Bureau of Statistics. (2017). *Personal Safety, Australia, 2016*. Available at: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4906.0>

experienced emotional abuse, compared to just over one in six men. Of those women, they were more likely than men to experience being shouted at with intent to intimidate or being constantly insulted. Women were also more likely than men to experience fear and anxiety due to partner violence.

Both women and men experienced violence by other non-intimate persons at similar rates, with one in six experiencing either physical or sexual violence.²² Women were nearly four times more likely to experience sexual violence by a non-intimate known person than men. Men were more likely to experience physical violence by a non-intimate known person than women, with nearly one in six men experiencing physical violence by a non-intimate known person compared to one in ten women.

1.4 Victim help-seeking responses

Victims of DFV take many actions to make themselves, children and other family members safe, but most victims of DFV do not report their experiences to police or seek professional or other support services. National data from the Australian Bureau of Statistics (ABS) *Personal Safety Survey* shows that, although 54% of women who experienced current partner violence sought advice or support, for two of every three of these women it was from friends or family. Similarly, while 63% of women who had experienced previous partner violence sought advice or support, for two of every three of these women it was from friends or family. Only an estimated 18% of women experiencing current partner violence and 35% of women experiencing previous partner violence sought support from police.²³

Common barriers to help-seeking for female victims of intimate partner violence include self-blame and low self-esteem, normalisation of violence in past relationships, fear of repercussions including further abuse, involvement of child services, ridicule; a lack of faith in resources including police and health professionals; and a lack of information about available resources.²⁴ Some of these barriers are themselves expressions of intimate partner violence, or its long-term effects. Aboriginal women can face additional barriers of discrimination, lack of culturally appropriate responses and geographical remoteness.²⁵

Male victims of intimate partner violence were less likely to seek help. Approximately 32% of men who experienced current partner violence and 41% of men who experienced previous partner violence sought advice or support, mostly (54%) from friends or family.²⁶ Only an estimated 3% of men experiencing current partner violence and 24% of men experiencing previous partner violence sought support from police, principally because they had already

²² Australian Bureau of Statistics. (2017).

²³ Australian Bureau of Statistics. (2017).

²⁴ Evans, M.A. & Feder, G.S. (2016). Help-seeking amongst women survivors of domestic violence: a qualitative study of pathways towards formal and informal support, *Health Expectations*, 19(1): 62-73.

²⁵ Blagg, H., Bluett-Boyd, N. & Williams, E. (2015). *Innovative models in addressing violence against Indigenous women: State of Knowledge paper*. ANROWS, Sydney.

²⁶ Australian Bureau of Statistics. (2017).

left the relationship so faced less barriers to disclosure. This is reflected in the literature, which shows help-seeking is typically considered a feminine behaviour.²⁷

Male victims of intimate partner violence are more likely than females to minimise violence and less likely to disclose and seek formal or informal support²⁸ due to a greater desire for privacy²⁹ or a perception that help-seeking threatens 'manhood' and may result in social ridicule.³⁰ Having another male disclose violence can facilitate male disclosure, and gay men often prefer disclosing intimate partner violence at a sexual health clinic, rather than to a GP or police, reflecting a perception of homophobia in traditionally heteronormative institutions.³¹

Given a historic focus on intimate partner violence, there is little evidence in the literature to explain help-seeking behaviours for victims of other forms of DFV.

These data underline the importance of a system-wide program, with multiple entry points, and draw attention to patterns of low engagement by victims of DFV with police and other services when seeking help with violence. The patterns revealed in population level data and research into help-seeking behaviour are reflected in Safer Pathway referrals and when victims of DFV engage with formal support services.

1.5 Safer Pathway

Safer Pathway intends to facilitate streamlined referrals and to help victims of DFV receive a timely and consistent approach that secures their safety and supports their recovery. The approach seeks to ensure that the system identifies victims of DFV who are at risk from the initial point of contact, and prioritises responding to those at most serious threat, while promoting information sharing between agencies to avoid victims of DFV having to re-tell their stories and to prevent re-victimisation. In summary, its objectives are to:

- reduce duplication and fragmentation in the DFV service system by streamlining referral pathways
- provide all victims of DFV across NSW with an effective, timely and consistent response, regardless of where they live, in order to secure their safety and support their recovery
- reduce the need for victims of DFV to re-tell their stories by helping them navigate the service system

²⁷ Vandello, J.A. & Bosson, J.K. (2013). Hard Won and Easily Lost: A Review and Synthesis of Theory and Research on Precarious Manhood, *Psychology of Men & Masculinities*, 14(2): 101-113.

²⁸ Arnocky, S. & Vaillancourt, T. (2014). Sex Differences in Response to Victimization by an Intimate Partner: More Stigmatization and Less Help-Seeking among Males, *Journal of Aggression, Maltreatment and Trauma*, 23(7): 705-724.

²⁹ Morgan, K., Buller, A.M., Evans, M., Trevillion, K., Williamson, E. & Malpass, A. (2016). The role of gender, sexuality and context upon help-seeking for intimate partner violence: A synthesis of data across five studies, *Aggression and Violent Behavior*, 31: 136-146.

³⁰ Hines, D.A. & Douglas, E.M. (2016). Relative Influence of Various Forms of Partner Violence on the Health of Male Victims: Study of a Help Seeking Sample, *Psychology of Men and Masculinity*, 17(1): 3-16.

³¹ Morgan et al. (2016).

- promote a shared understanding of DFV dynamics, indicators and threat levels
- provide victims of DFV at serious threat of further harm with prioritised, inter-agency responses through targeted information sharing.

1.5.1 Key Components

A rapid realist literature scan of current national and international DFV research found that Safer Pathway is designed with many of the key features of a strong, coordinated and inter-agency response to DFV and is well-grounded in the evidence base.

The five key components of Safer Pathway build on the existing domestic violence service system to implement robust and consistent standards and practices, and strengthen inter-agency collaboration. These components are described below.

Domestic Violence Safety Assessment Tool (DVSAT)

The DVSAT is a domestic violence risk assessment and identification tool, which uses evidence-based criteria to assess risk to victims through the consideration of risk factors. In the Safer Pathway context, there are three versions of the tool: a Police DVSAT, a Local Coordination Point (LCP) DVSAT and a non-police DVSAT. The three versions are very similar with minor differences in language to cater for the different contexts. Use of the DVSAT is mandatory among NSW Police officers who respond to DFV incidents and mandated as standard practice among LCPs and Local Support Services (LSSs) (see below). The DVSAT is applied twice in Safer Pathway.

- First, the Police DVSAT is applied when police attend an incident of DFV or receive a report of DFV. This information triggers the Central Referral Point (CRP) referral. Other first responders would use the non-police DVSAT for this first assessment.
- Second, the LCP DVSAT is applied when the LCP/LSS contacts victims to ascertain if there has been a change in the risk rating, or if victims of DFV may be willing to provide more information than they did to police (or another first responder), which function to prioritise appropriate service responses.

After assessment, victims of DFV are rated either 'at threat' or 'at serious threat', based on the number of items to which they answered 'yes' and the use of professional judgement by the tool administrator. Victims of DFV rated 'at serious threat' receive a prioritised and more intensive service response in Safer Pathway.

Central Referral Point (CRP)

The CRP is an electronic platform managed by Victims Services and is a key part of the streamlined referral pathway. Information from police (entered into WebCOPS) about DFV incidents and DVSAT grading of victims of DFV is uploaded to the CRP. Referrals are then

allocated electronically to LCPs based on the location and gender of victims of DFV. This process is fully automated.

The CRP supports monitoring of system responsiveness to the needs of victims of DFV from referral to case closure and provides real time, de-identified data on DFV referrals and the timeliness of service provision.

Local Coordination Points (LCP) and male-LCPs (local support services – LSS)

LCPs for female victims are hosted by Women's Domestic Violence Court Advocacy Services (WDVCAS), which are specialist DFV services for women. LCPs for male victims are hosted by a range of NGO providers (e.g. Relationships Australia) through LSSs. Prior to January 2018, support for male victims was provided by Victims Services and various non-government providers through a two-stage model.

Within Safer Pathway, LCPs contact victims of DFV after referral and seek consent to provide threat assessment, safety planning and case coordination. Case coordination means making referrals to appropriate local services for a DFV victim's key needs (e.g. housing, legal advice, counselling). LCP and LSS workers are also system navigators for victims.

The LCP use the DVSAT to reassess the risk of victims of DFV. They can re-grade a DFV victim's threat rating where appropriate, but can only re-grade from 'at serious threat' to 'at threat' if the relevant Domestic Violence Liaison Officer (DVLO) agrees.

LCPs also provide liaison for victims of DFV in relation to Safety Action Meetings (SAMs) (see below), and the LCPs for female victims of DFV provide secretariat support for SAMs.

If a victim of DFV chooses not to engage with supports offered by the LCP then they are given the option of re-contacting the service at a later point. No further contact is initiated by the service, except for victims of DFV assessed as 'at serious threat' who are referred to the SAM.

Safety Action Meetings (SAM)

Victims of DFV who are assessed to be 'at serious threat' have their case referred to a SAM. SAMs are regular, fortnightly meetings attended by a range of government agencies and local service providers that aim to prevent or lessen serious threats to the safety of victims of DFV and their children through targeted information sharing and rapid safety action planning, rather than case management.

Members share information to develop tailored, time-specific Safety Action Plans (SAPs) for victims of DFV 'at serious threat' and their children. A SAP is a list of actions for SAM members to complete that are aimed at reducing current threat to a victim of DFV's safety.

SAMs are chaired by a senior police officer, and LCP staff provide secretariat support. In addition to police and the LCP provider, the following government agencies regularly attend as standing members:

- NSW Health including, where possible, representation from drug and alcohol and mental health services
- FACS including officers able to speak about child protection and housing assistance
- Department of Education and Communities
- Corrective Services NSW.

If a male victim is listed on a SAM, an appropriate male-LCP (LSS) will attend. NGO members of SAMs are decided locally in consultation with stakeholders and occasionally attendees are invited if their service is relevant to a particular case. Agencies and service providers (other than LCP providers and LSSs) do not receive specific funding to participate in SAMs.

Information sharing provisions

The main legislation related to information sharing in Safer Pathway is Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007*³² and Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*,³³ Part 13A. A related *Domestic Violence Information Sharing Protocol*³⁴ commenced on 15 September 2014 which make exceptions to NSW privacy laws. These exceptions, in conjunction with 16A, allow Safer Pathway responses to:

- facilitate access to support services for victims of DFV – there is an automatic referral of victims' details from police and local courts to support services via the CRP. Victims' details are also sent to support services via the CRP by NSW Local Courts, except where a victim expressly objects to the referral. Victims can choose to accept or decline the assistance offered by services.
- prevent or lessen a serious threat to the life, health or safety of a person – consent should be sought unless impractical or unreasonable, but a lack of or refusal to consent can be overridden when a victim of DFV is assessed as 'at serious threat.'

1.5.2 Previous evaluations

In 2015, the NSW Bureau of Crime Statistics and Research (BOCSAR) conducted a process evaluation of the effectiveness and efficiency of the implementation of all the components of Safer Pathway in the two launch sites.³⁵ The evaluation noted that Safer Pathway provides a structured and coordinated response to victims of DFV that improves on the earlier, fragmented system. The evaluation indicated that, broadly, the following elements were working well:

³² Available at: <https://www.legislation.nsw.gov.au/~view/act/2007/80>

³³ Available at: <https://www.legislation.nsw.gov.au/~view/act/1998/157>

³⁴ Available at: <https://www.facs.nsw.gov.au/download?file=583245>

³⁵ The launch sites were Waverly and Orange.

- all victims of DFV were being assessed through the Police DVSAT and contacted by LCPs
- the *Domestic Violence Information Sharing Protocol* was encouraging agencies to share information
- the LCP process was effective in providing victims of DFV with information, support and referral to services shortly after the incident
- most government and service providers regularly attended SAMs and they saw these as effective forums for sharing information and collaboration
- the DVSAT was considered easy to use and providing a shared understanding of threat levels, and a common language for discussing victims of DFV.

The process evaluation also identified that some elements of Safer Pathway may need refinement and proposed:

- DVSAT adjustments or processes for reviewing victims of DFV referred to SAMs to ensure prioritisation of those 'at serious threat'
- enhancements to the speed of the CRP database, and improvements to the completeness of information being recorded
- considerations of any additional background/ demographic questions to be included in the DVSAT
- greater collaboration at the local level and enhanced transparency about LCP decisions around referrals/ working with other service providers
- consideration of ways to enhance the consistency of decision-making at SAMs about retiring victims of DFV from the agenda, and accountability for reporting on Safety Action Plans.

Comprehensive review of the implementation of the recommendation of the 2015 BOCSAR evaluation was out of scope for this evaluation. However, this evaluation found some of these refinements have been addressed, while others have not been implemented, as discussed in this report where relevant.

Since the 2015 evaluation, BOCSAR has published five papers of relevance to Safer Pathway as part of an ongoing program of monitoring and evaluating trends and policy developments in domestic violence. In 2016, the factors that best predict re-conviction were identified for a cohort of people convicted of a DFV offence and given a non-custodial penalty.³⁶ In 2017, the experience of proscribed behaviours by women at serious threat was compared in fully operational and partially operational Safer Pathway sites; no difference in the reduction of re-victimisation was found.³⁷ A second 2017 paper found a high rate of police administration of the DVSAT, with the use of professional judgement and the 'repeat victim trigger' influencing

³⁶ Fitzgerald, R. & Graham, T. (2016). Assessing the risk of domestic violence recidivism. *Crime and Justice Bulletin*. No. 189. NSW Bureau of Crime Statistics and Research, Sydney.

³⁷ Trimboli, L. (2017). Outcome evaluation of NSW's Safer Pathway Program: Victims' Experiences. *Crime and Justice Bulletin*. No. 202. NSW Bureau of Crime Statistics and Research, Sydney.

serious threat ratings.³⁸ A 2018 paper found the predictive accuracy of the Police DVSAT to be poor, recommending further review and highlighting the importance of empirical validation.³⁹ A second 2018 paper compared the reduction in DFV re-victimisation between sites with and without Safer Pathway fully implemented, finding evidence of some improvement in several DFV indicators in some Local Area Commands (LACs).⁴⁰ The findings of this evaluation are largely congruent with those of BOCSAR, where there is crossover in focus and method.

1.6 Program logic

Figure 1 shows how the five components interact in Safer Pathway. The logic is read from bottom to top. Safer Pathway begins when victims of DFV contact or are contacted by police or another agency following a DFV incident. The police first responder conducts a threat assessment using the DVSAT, arriving at a rating of 'at threat' or 'at serious threat'. The assessment, demographic and contact data are entered by police into the CRP (via Web-COPS).

The CRP operates continuously and automatically refers victims of DFV to their local LCP/LSS. These services attempt to contact victims by phone within one business day of referral, with at least three attempts in a five-day period. Referrals 'at serious threat' are prioritised by the LCP/LSS. If the victim is assessed as 'at serious threat' and phone contact has not been possible, LCP/LSS services may seek police assistance in contacting the victim of DFV.

Where the LCP/LSS has been able to contact the victim of DFV, and the victim consents to receiving support, the LCP/LSS will re-administer the DVSAT, to confirm the information provided to police (or other first responder) at a less stressful time than immediately after the incident, and to assess if the threat has changed since the referral was made. Following reassessment, the LCP/LSS will confirm, upgrade or downgrade the victim of DFV's threat level, again arriving at a rating of 'at threat' or 'at serious threat'. An LCPs/LSSs can only downgrade a victim's threat level if the relevant DVLO agrees.

Victims of DFV reassessed 'at threat' are provided with case coordination (if they consent). After discussing the needs and supports of victims of DFV, and providing safety planning tips and resources, the LCP/LSS make referrals to a range of service providers to address a victim of DFV's ongoing needs. Warm referrals, where the LCP/LSS introduces the victim of DFV to the services, are preferred. The LCP/LSS will follow up with victims of DFV 'at threat' to ensure

³⁸ Agnew-Pauley, W. & Poynton, S. (2017). The Domestic Violence Safety Action Tool (DVSAT): Results from the first 12 months of implementation. *Bureau Brief. No. 128*. NSW Bureau of Crime Statistics and Research, Sydney.

³⁹ Ringland, C. (2018). The Domestic Violence Safety Assessment Tool (DVSAT) and intimate partner repeat victimisation. *Crime and Justice Bulletin. No. 213*. NSW Bureau of Crime Statistics and Research, Sydney.

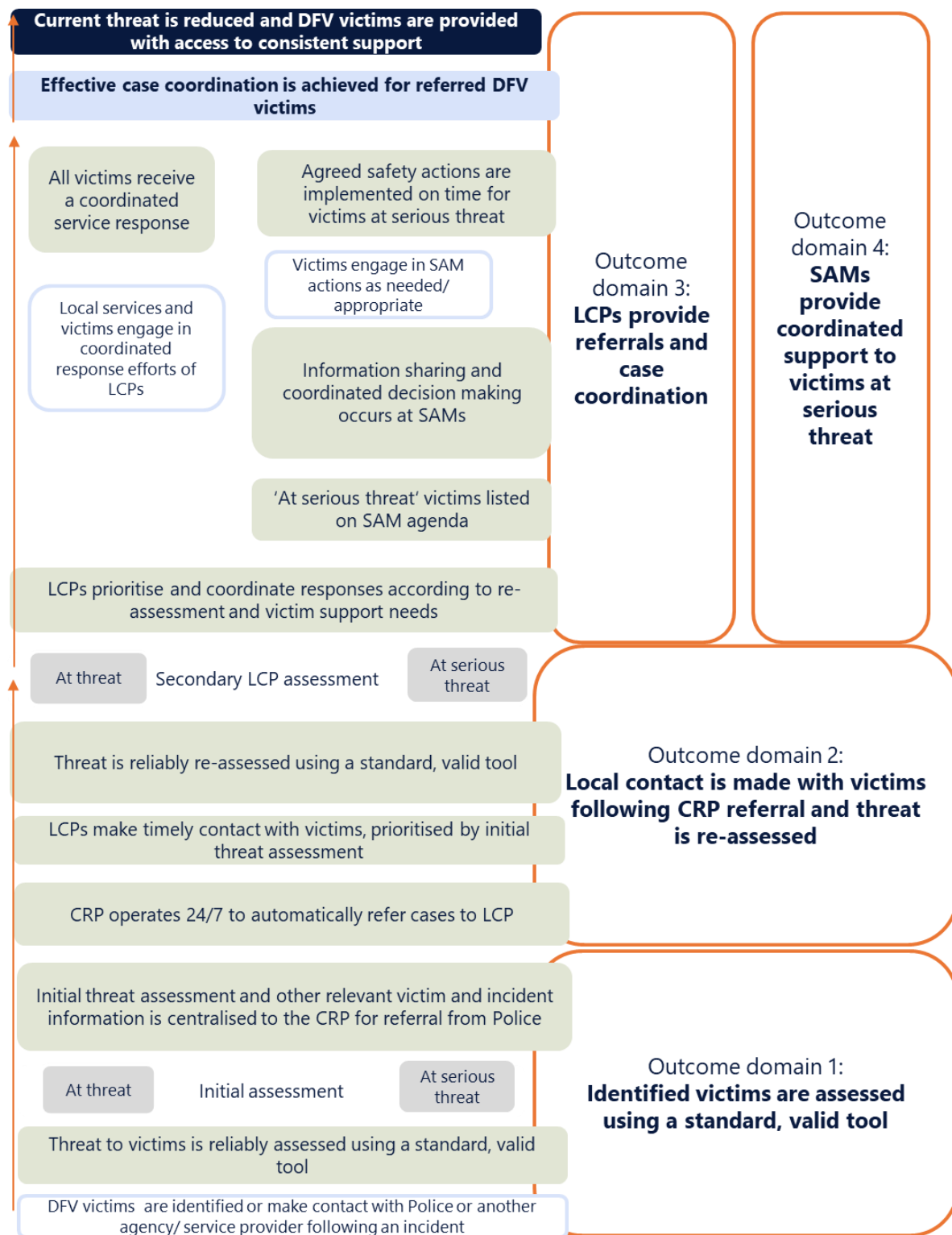
⁴⁰ Wan, W.Y., Thorburn, H., Poynton, S. & Trimboli, L. (2018). Assessing the impact of NSW's Safer Pathway Program on recorded crime outcomes – an aggregate-level analysis. *Crime and Justice Bulletin. No. 210*. NSW Bureau of Crime Statistics and Research, Sydney.

the referrals made have been successfully, and the victim of DFV is supported, before closing the case.

Victims of DFV assessed 'at serious threat' are listed on the SAM agenda, and receive case coordination through the LCP/LSS, as described above if they consent to receiving services. SAM members will share information they know about the victim of DFV, the perpetrator, and involved children, and will nominate actions they can take to prevent or lessen serious threats to the victim of DFV and their family. Agreed safety actions will be implemented on time by the responsible agency, reporting back to the SAM until all actions are complete and the victim of DFV is removed from the SAM agenda. The LCP/LSS will follow-up with these victims of DFV to ensure the referrals made have been successful, and the victim of DFV is supported, before closing the case.

Through this sequence of actions, it is expected that referred victims of DFV receive effective case coordination, resulting in a reduction of current threat and access to consistent support.

Figure 1. Program logic for Safer Pathway



2. Evaluating Safer Pathway and the DVSAT

This section outlines the purpose and approach to evaluating Safer Pathway and assessing the Domestic Violence Safety Assessment Tool (DVSAT) as a threat assessment tool and key component of Safer Pathway.

2.1 This report

This is the final report of the Stage 2 evaluation of Safer Pathway. We have structured the report largely from the perspective of the journey of a victim of domestic and family violence (DFV) by assessing the program activities and outcomes of the four domains, rather than structuring it by program elements or evaluation questions. Recommendations are provided in the relevant sections throughout.

- **Chapter 3: Implementation**—describes the implementation of Safer Pathway in NSW, including the Central Referral Point (CRP), training, and profiles of the Local Coordination Points (LCPs)/Local Support Services (LSSs) and Safety Action Meeting (SAMs).
- **Chapter 4: Evaluation of the DVSAT**—reviews the DVSATs against current evidence, including the validity and reliability of the tools and their administration.
- **Chapter 5: Domain 1 – Identification and assessment**—assesses the identification and assessment of DFV by police, engagement with victims of DFV by police, and referrals and re-referrals to Safer Pathway.
- **Chapter 6: Domain 2 – LCP/LSS contact and reassessment**—assesses the initial contact with victims of DFV by services, engagement with victims of DFV, and re-administration of the DVSAT.
- **Chapter 7: Domain 3 – LCP/LSS case coordination and referrals**—assesses the referral and case coordination processes.
- **Chapter 8: Domain 4 – Integrated support through the SAMs**—assesses the SAMs, including outcomes for victims of DFV and key success factors.

2.2 Purpose

The Stage 2 Evaluation of Safer Pathway is a process evaluation that aims to examine whether, and the extent to which, Safer Pathway is being implemented as intended and meeting its stated objectives, and to identify opportunities for improvement.

2.3 Scope and focus

The evaluation focuses on the current implementation and outcomes of Safer Pathway, as it is operating in 2017–18. It covers all CRP referrals, LCPs and SAMs in operating Safer Pathway sites up to March 2018. All five components of Safer Pathway are reviewed.

- The DVSAT tool (Police and LCP versions)
- The CRP data and referral processes
- The LCPs and LSS (WDVCAS services and LSS providers)
- The SAMs
- Information sharing provisions

We examine the program interactions and outcomes for female and male victims of DFV in situations of intimate and non-intimate partner violence, assessed as 'at threat' or 'at serious threat'. Where data permits, the analysis incorporates the diverse backgrounds and vulnerabilities of victims of DFV. This includes Aboriginal people, people with disability, people from CALD backgrounds, and people in same-sex relationships. These factors are explored to understand experiences, interactions with processes and outcomes to the extent that data quality and completeness allows.

2.4 Evaluation questions

The following questions were developed based on the tender specifications and agreed in consultation with the Evaluation Working Group.

Note on terminology

The term 'context' in the questions below (e.g. 'in what context') is used in the realist sense and generally includes individual and interpersonal dynamics, institutional features or settings, and infrastructure.

Table 1. Evaluation questions by report chapter

| Evaluation question | Report reference |
|--|--|
| Implementation, processes and experiences | |
| 1 To what extent, and in what ways, are the following components of Safer Pathway reflected in the research literature? <ul style="list-style-type: none"> ▪ the DVSAT in relation to valid, reliable and appropriate DFV threat assessment tools ▪ the CRP data collection and processes in relation to good practice information management systems ▪ Safer Pathway as a whole, in particular LCPs and SAMs, in relation to effective inter-agency coordination and service responses | Chapter 4, Appendix 2 and 3 Chapter 3 and 5 Chapter 6, 7 and 8 |
| 2 What is the reach of Safer Pathway in terms of victims of DFV assessed, referred and receiving coordinated support? How does this differ by location and according to groups of victims of DFV, and why? | Chapter 3, 5, 6, 7 and 8 |
| 3 In what contexts are the components of Safer Pathway (including the Police and non-Police DVSAT) being implemented as intended? In what circumstances is there variation, and why? | Chapter 4, 5, 6, 7, 8 |

| | | |
|--------------------------------------|--|----------------------------|
| 4 | In what ways do victims of DFV experience their interactions with Safer Pathway (including the DVSAT)? In what contexts and for what groups of victims of DFV does this differ, and why? | Chapter 4, 6, 7 and 8 |
| 5 | How do agencies/ service providers experience their involvement in Safer Pathway? How does this differ and for what organisation types, and why? | Chapter 6, 7 and 8 |
| Outcomes and impacts | | |
| 6 | In what contexts is Safer Pathway meeting its intended objectives for victims, considering current threat reduction and access to consistent support? To what degree are these outcomes achieved, and why? | Chapter 6,7 and 8 |
| 7 | In what contexts do victims of DFV feel safer as a result of their interactions with Safer Pathway, and why? In what contexts do victims of DFV not feel this way, and why? | Chapter 7 and 8 |
| 8 | In what contexts has Safer Pathway established a more coordinated and consistent service response to DFV, to what degree, and why? | Chapter 4, 5, 6, 7 and 8 |
| 9 | Are there any unintended impacts of Safer Pathway (including the DVSAT administration), positive or negative, for victims of DFV, agencies and/or service providers? In what contexts do these occur, and why? | Chapter 6 |
| Opportunities for improvement | | |
| 10 | What opportunities are there for Safer Pathway to better meet its intended objectives? In what context are these opportunities most applicable, and why? | Recommendations throughout |
| 11 | What scope is there to enhance the DVSAT tool (its design) and how is it applied? What contexts are relevant when considering potential enhancements, and why? | Chapter 4 |
| 12 | In what ways are opportunities for improvement related to the broader DFV reforms and service system context, and what is the relevance of this for recommendations? | Chapter 3, 4 and 5 |

2.5 Methods

The evaluation used a mixed-methods approach, drawing on and synthesising qualitative and quantitative data sources, and was conducted in two stages.

Stage 1 consisted of scoping activities including literature reviews, interviews and a survey. This led to the development of hypotheses which were developed into tables of program theory and simplified into an outcomes hierarchy, and informed the development of tools and approaches utilised in stage 2. Stage 1 also included a review of the CRP, developing an understanding of the primary quantitative data source and providing draft recommendations for its further development.

Stage 2 consisted of data collection and analysis. Data was collected through key informant interviews, a stakeholder survey, and studies of Safer Pathway activities and outcomes in six sites. Detailed analysis was undertaken of program outcomes and patterns of engagement in Safer Pathway processes for different groups of victims of DFV. The methods used in each stage are described in brief below, with achieved sample sizes and estimated response rates where relevant. The methods are described in more detail in Appendix 1.

Stage 1

- Review of policy and program documents
- Literature scan of integrated DFV responses
- Literature scan of DFV data collection and information systems
- Literature scan of the DVSAT evidence base
- Scoping consultations with key stakeholders n=8
- Scoping survey – response rate 151/278 (54%) for LCP/LSS; and 50/120 (42%) for police
- Quality review of CRP data and process January to December 2017 – n= 128,869 combined records

Stage 2

- Key informant and stakeholder consultations with expert practitioners n=15
- Analysis of CRP data September 2014–March 2018 n=365,456 combined records
- Workforce survey n= 273 respondents/520 distributed links (53%) (estimated based on 29 WDVCS with 4 staff, 9 LSS with 7 staff, 43 SAM coordinators with 8 SAM members per SAM⁴¹)
- Site studies n=6
 - Review of LCP referral data n= ~50 records from each of 6 sites
 - Victim of DFV interviews n=22 victims at 6 sites
 - Focus groups with LCP workers n= 20 workers at 6 sites
 - Focus groups with LSS workers n= 14 workers at 6 sites
 - Interviews with SAM Chairs n= 6 Chairs at 6 sites
 - Focus group with SAM members n= 56 workers at 6 sites
 - Validity review of sample of DVSAT records n= 27 records, 21 LCP/LSS workers at 5 sites
 - Focus groups with Police DVSAT administrators n= 33 Police at 6 sites
 - Cognitive interviews and scenario testing with Police and LCP-DVSAT administrators n= 8 Police and 12 LCP/LSS workers at 6 sites
 - Partner agency survey n= 17/46 (37%) respondents from 6 sites

⁴¹ Estimates based on workforce survey data.

2.6 A realist-informed approach

We have conducted the evaluation using a realist-informed approach. Realist evaluations are theory-driven. A realist evaluation asks not ‘what works?’ but ‘how or why does this work, for whom, in what circumstances?’ and provides explanations of ‘why programs work better with some groups than with others or work better in some locations or circumstances than others?’.⁴²

Realist evaluation methods acknowledge that interventions do not ‘cause’ change. Instead, behavioural outcomes occur through the interactions between the resources provided by Safer Pathway and the choices participants make in response to them, based on factors such as their own personal histories or the circumstances in which they encounter Safer Pathway resources.

In realist evaluation, explanations of change are formalised in a particular way – typically referred to as Context-Mechanism-Outcome (CMO) configurations – so that data collection and analysis can be structured to ‘test’ if, when and how the program operates as expected. CMOs can be written in any order. In this report, tables have been inserted in a CMO format, i.e. **‘this outcome occurred in this context, because of...’**. The tables display how the same program activity can lead to different outcomes in different circumstances.

These sorts of explanations were not possible for every aspect of Safer Pathway, but focused on the decisions of victims of DFV about whether to engage with police and with services, and on how staff in services engaged with each other at SAMs.

2.7 Limitations

Limitations in this evaluation arise from five issues – the absence of outcome measures and tools, CRP data quality, sample size for some methods, sample bias in others, and the timing of the CRP data analysis. These are discussed below.

One of the key questions regarding the effectiveness of Safer Pathway concerns safety outcomes for DFV victims referred into the program. However, this and other outcomes for victims of DFV have not been clearly defined or specified through, for example, the development of a monitoring and evaluation framework, and tools or database fields to capture appropriate measures have not been developed.

This is a limitation because while we can describe program activity and intermediate program outcomes (such as engagement with victims of DFV in Safer Pathway processes, or referrals provided to other services) from quantitative data from the CRP, we can only talk about outcomes for victims of DFV from qualitative data based on interviews, focus groups and qualitative questions in surveys.

⁴² Westhorp, G. (2014). *Realist Impact Evaluation – A Guidance Note*. Overseas Development Institute, London.

The evaluation draws quite heavily on CRP data to describe patterns of victim interactions with the Safer Pathway service system. As was noted in the CRP review conducted in stage 1 of the evaluation, there are gaps in contact and demographic fields. In order to undertake sup-group analysis, it has been necessary to assume that these gaps are consistent across service providers so, while absolute numbers may not be accurate, patterns within demographic and contact variables have been considered to be indicative of the experience of that group.

Data on Aboriginality in the CRP comes from WebCOPS; this data is 80% complete and considered by NSW Police to be relatively robust. We have also looked at patterns for people identified as CALD, having a disability or LGBTQI. These fields have high numbers of missing values in the CRP; the data does not capture all people in these groups who are referred to Safer Pathway, only those where this is identified to or by police or LCPs/LSSs. Patterns of victimisation and service engagement for these groups are often quite different than for victims of DFV overall and have been included for the insight they provide.

Data capture of DVSAT re-administration by LCPs is incomplete. Except where a victim is assessed as at serious threat, LCPs are required to close CRP referrals after successfully establishing contact. LCPs then record case notes and other client information in hard copy files and in the WDVCAP database. This policy was implemented to reduce the administrative burden on LCPs, to ensure that client data is captured in a consistent manner, and to work around limitations in the CRP (e.g. the CRP was not developed to record court outcomes). The policy means that CRP data does not capture every DVSAT re-administration or referral/service provided to victims.

Data capture in the CRP for victims referred to SAMs is particularly weak. A sub-set of data from a period Victims Services identify as containing the most robust data was used, but results are not definitive.

The response rate for the partner agency survey was low, at 17 respondents. However, other surveys had good response rates. Qualitative (interview) data for different demographic groups was also limited to a small number of LCP/LSS staff working with people from these groups. These small sample sizes limit the strength of findings based on these methods, so these sources are not heavily relied on in the report or in findings and recommendations.

Victims of DFV interviewed were recruited through LCPs/LSSs, and the interviews may exhibit some positive bias due to this sampling method. This limits our qualitative understanding of where the program is not working and who it is not working for.

The timing of analysis administrative data (i.e. CRP data) in an evaluation is always difficult. Early analysis reveals patterns that can be interrogated in qualitative data collection, but those commissioning an evaluation want the most recent available data to inform findings and recommendations. There were not sufficient resources to analyse program data twice, the most recent available data has been used, however this means there have been unexpected patterns identified that have not been explained by qualitative data.

2.8 Confidence in the findings

Despite the limitations detailed above, we are confident the evaluation has collected a sufficiently robust set of evidence to support the conclusions made. The evaluation investigated where Safer Pathways is working, for whom and under what circumstances, from multiple perspectives and using many different methods. Overall, there was a strong consistency in the findings across the range of stakeholder groups and methods used, which gives a high level of confidence in the overall findings.

3. Implementation

Key components of Safer Pathway – the Domestic Violence Safety Assessment Tool (DVSAT), Central Referral Point (CRP), Local Coordination Point (LCP) and Local Support Services (LSSs), and Safety Action Meetings (SAMs) – have been implemented incrementally over five years. However, the CRP referral system is not yet accessible to agencies other than NSW Police and Courts.

Key findings

- Safer Pathway sites were established as intended, with the staged roll out of 48 SAM sites across NSW from 2014–18.
- Overall framing of the initiative has not been undertaken. Safer Pathway does not have an explicit theory of change, and documentation does not address re-referral.
- The development of a monitoring and evaluation framework would strengthen the program.
- The CRP was developed to securely transfer DFV incident data from Police WebCOPS to LCPs/LSSs and has been upgraded continuously to increase its usability and add additional functions. However, the CRP as the main conduit for referral is not accessible to agencies other than Police and Courts.
- The role and effectiveness of the CRP as a tool for monitoring and evaluation purposes is undermined by the dual use of the CRP and Women's Domestic Violence Court Advocacy Program (WDVCAP) databases by LCPs, and the lack of a monitoring and evaluation framework for Safer Pathway.
- Referrals by Police into the CRP overall grew rapidly with the rollout of the DVSAT.
- Procedural changes to the use of the DVSAT have decreased the proportion of victims assessed by police at serious threat to 6%, below the expected proportion of 10%.
- The caseload workflow of referrals of victims of intimate and non-intimate DFV through the stages and processes of Safer Pathway show the triaging, reclassification and service provision through LCPs/LSSs and SAMs in line with program guidelines to victims who engage, and also the reluctance of some victims to engage.
- The rollout was supported by information and training for LCPs/LSSs, police and SAMs.
 - Legal Aid NSW implemented a comprehensive training program for LCPs/LSSs, which was well-received by workers who were mainly positive about the training and support they received, including the LCP Manual. LSS workers and those in regional areas were less satisfied than LCP workers and those in metropolitan areas. Workers requested ongoing annual training, and training integrated with General Duties Police and Domestic Violence Liaison Officers (DVLOs).
 - Police described varying exposure to training in DFV, Safer Pathway and the DVSAT. There has not been formal training for police in Safer Pathway or the DVSAT since a requirement to complete an online training module in 2015.
 - SAM members were positive about the training and support received in establishing Safer Pathway, including through the SAM Manual. Regional SAM members had lower training completion rates and requested that training be made more available.
- LCPs and LSSs are funded and structured differently, but issues in service delivery are related more to metropolitan/rural location.
- There is some variability in how SAMs are constituted and managed, but members find them effective. Participation and workload are issues for some members.
- SAM functioning improves with maturity and member consistency.

3.1 Establishment of Safer Pathway

3.1.1 Framing Safer Pathway

Safer Pathway was developed and is delivered as a multi-agency initiative. Each agency has completed policy and program materials to support the implementation of their program. However, overall framing of the initiative has not been undertaken. Safer Pathway does not have an explicit theory of change, and documentation does not address re-referral. The initiative would be further strengthened by the development of a monitoring and evaluation framework, which specified the expected outcomes for clients and the program, and identified available and needed data sources (e.g. CRP items, victim outcome measurement tools). This development would also support action area six of the Blueprint, improving the system by ensuring strong governance, planning and accountability mechanisms aligned to achieving outcomes.

Following the development and implementation of the outcomes measures and tools, it will be possible to undertake an outcomes and cost effectiveness evaluation of Safer Pathway.

3.1.2 Key CRP developments and upgrades

In 2014, work was completed by Victims Services and NSW Police to ensure DFV incidents entered into the Police WebCOPS system were securely forwarded to the newly created CRP database so LCP users could have direct access to this data to provide support services to victims of DFV. Key developments and upgrades since this time are listed below.

CRP Project 1 (re-platform)

In April 2016, CRP Project 1 commenced to move the CRP database from the original platform (VisiCase) to a new, more stable platform (PEGA). This project consisted of five development sprints (time-limited development phases) with a focus on end-user operational functionality to replicate the former VisiCase functionality in the new PEGA system.

The build was completed in September 2016 and deployed in November 2016, including basic reporting functionality and a total of 79 enhancements.

CRP Project 2 (additional functionality improvements)

In March 2017, CRP Project 2 commenced with a primary focus to improve on functionality from the re-platform project. A dedicated CRP Technical Support Officer was hired as part of the Safer Pathway team at Victims Services to facilitate this project and formally administer the CRP to further support the roll out of Safer Pathway.

CRP Project 2 consisted of three development sprints in which a total of 22 enhancements were built into the CRP. Key functionalities included:

- introducing a single logon to multiple sites
- expanding the SAM functionality to include SAM agendas
- introducing contact attempt icons to facilitate better data capture for monitoring and to assess KPI achievement
- introducing the ability to view the history of parties to a referral (including both perpetrator and victim history).

Many of these features were identified by Safer Pathway stakeholders as improvements needed in the CRP prior to the commencement of the project. The final sprint was completed in November 2017.

CRP Project 3

CRP Project 3 was earmarked for development in 2018 after initial scoping and costing in December 2017.

The project is shaped by feedback from end users and is expected to increase sophistication of reporting functions to meet the growing demand for consistent reporting, with the expansion of Safer Pathway state-wide in 2018. Preliminary focus areas for enhancements include expanding the reporting functionality, introducing best practice CRP account auditing, and introducing administrator functions to streamline internal CRP processes.

It is anticipated Project 3 will be completed in 2019.

CRP data review

ARTD's early review of the CRP data in July 2018 found that the system reflects many of the expected characteristics of an effective Information Management System (IMS) in a human services context. It also fulfils the purpose of streamlining and prioritising DFV referrals from the frontline agency to the response service, i.e. from NSW Police to the LCP. Key findings were that the CRP:

- is heavily used by LCP staff and widely considered to be easy to use
- functions at a high speed with quick response times
- ensures a high level of data accuracy and integrity through mandatory fields and set selection lists, and shows a high degree of data completeness, though contact numbers and demographic data were the main areas of data incompleteness
- provides data that is relevant and useful overall, though more so for intake and referral officers than SAM coordinators.

The review identified some broader issues related to how and how well the CRP may be operating to enable the Safer Pathway approach.

- Whether, and if so the extent to which, inaccurate contact information, incomplete demographic data and the lack of WebCOPS narratives for some matters is impacting on

the ability of intake and referral officers to engage victims of DFV in DVSAT assessments and service responses. This is discussed in Chapters 5 and 6.

- The extent to which the CRP (particularly the SAM portal) is providing sufficient and easy access to information for SAM Coordinators to facilitate their role in developing SAM agendas, planning for meetings and identifying re-referred victims. These will need to be reviewed following the finalisation of CRP enhancement Projects 2 and 3, described above.
- The role of the CRP in capturing and reporting outcome data for monitoring and evaluation purposes needs to be clarified. If the CRP is to provide this data, some additional variables and more stringent rules will need to be developed, in-line with a monitoring and evaluation framework that defines client and service outcomes at several levels.

The role and effectiveness of the CRP as a tool for monitoring and evaluation purposes is undermined the dual use of the CRP and WDVCAP databases by LCPs, and the lack of a monitoring and evaluation framework for Safer Pathway. The dual use of the CRP and WDVCAP databases means data on victims of DFV in the CRP is incomplete as LCPs either close cases after initial contact attempts and continue case coordination in the WDVCAP database, or continue data entry in two systems, which is inefficient. Clarifying the respective roles of the CRP and the WDVCAP database would bring greater consistency of use by all LCPs and reduce the duplication of data collection for staff while ensuring the completeness of data availability for the program as a whole.

Enhancements to support monitoring, reporting and evaluation would probably involve some new data items to describe actions within the program, such as whether the LCP DVSAT was administered, which cases were listed and discussed on the SAM, and what actions were committed to by which agencies in the SAP. The monitoring and evaluation framework would clarify the optimal role of CRP data in process and outcomes measurement, and provide further direction for development. It would also provide clarity on the respective roles of the CRP and the WDVCAP database in case coordination and data capture.

Recommendations

In collaboration with Safer Pathway partner government agencies, Women NSW lead the refinement of the Safer Pathway scope and theory of change.

In collaboration with Safer Pathway partner government agencies, Women NSW lead the development and implementation of a Safer Pathway monitoring and evaluation framework to enable ongoing monitoring, measurement and reporting by agencies for learning and accountability purposes. The monitoring and evaluation framework implementation plan should specify reporting requirements to the Domestic Violence Reforms Delivery Board, and address:

- data development for improved monitoring and evaluation against identified outcomes
- monitoring of the proportion of victims assessed 'at serious threat' to ensure victims most at threat receive a prioritised, coordinated response
- monitoring of the rate of DVSAT completion by police across population groups
- monitoring of the number, proportion and profile of victims whose matters are referred to the SAMs
- monitoring of SAM participation to ensure appropriate local service participation, including case management service providers when their clients are listed on the agenda

- development of measures and tools to describe and quantify outcomes for victims from SAMs
- development and monitoring of outcomes measures that reflect ongoing engagement of re-referred victims at all stages of Safer Pathway, including measures pertaining to victim engagement with LCPs, support, safety and links to the service system
- outcome and economic evaluation.

Legal Aid NSW and Victims Services clarify the respective roles of the CRP and WDV CAP database for LCPs

3.1.3 System level gateway not yet developed

Safer Pathway is a NSW system level initiative engaging key partner agencies including NSW Police, Victims Services, FACS, Ministry of Health, Corrective Services NSW, NSW Department of Education and Communities and NGOs. The importance of a system-wide program, with multiple entry points is critical given the broader evidence around help-seeking behaviours of victims of DFV and their low level of reporting to police (see section 1.4).

Safer Pathway was designed to provide an immediate and consistent response for victims of DFV regardless of how they enter the system, for example through their general practitioner, housing provider or health service. Responses to the partner agency survey revealed a high level of use of safety assessment tools (94%) by partner services, predominantly the DVSAT (75%). However, no formal mechanism exists for referring these victims of DFV into Safer Pathway for the planned service response. Service providers other than police and courts can refer directly to LCP/LSSs by phone, fax or email. However, these referrals are not processed in or recorded by the CRP and make up a very small number of overall referrals. Between July 2014 and March 2018, there were 138,048 referrals to Safer Pathway, over 99% of which have come from NSW Police (CRP 2014–18 data).

Given that many victims of DFV do not report their experiences to police, there is a need to expand the referral pathways to other agencies to complete the development of Safer Pathway as a system-wide initiative, while recognising the right of victims of DFV to choose not to seek support. This would ensure victims of DFV who do not come to police attention, or who do not wish to have police involvement, can receive the appropriate system response and reduce expectations that police alone are responsible for responding to DFV. Expanding referral pathways also contributes to action area 2 of the *NSW Domestic and Family Violence Blueprint for Reform 2016–2021* – intervening early, by referring victims in to a coordinated response before conflict has escalated to the point where police are called.

To date, the CRP referral pathway is only available to police and courts, which has significantly undermined the intent of Safer Pathway as a multi-agency system.

Recommendation

Continue to expand referral pathways to facilitate referrals to Safer Pathway from other agencies, funded services, and community and self-referral.

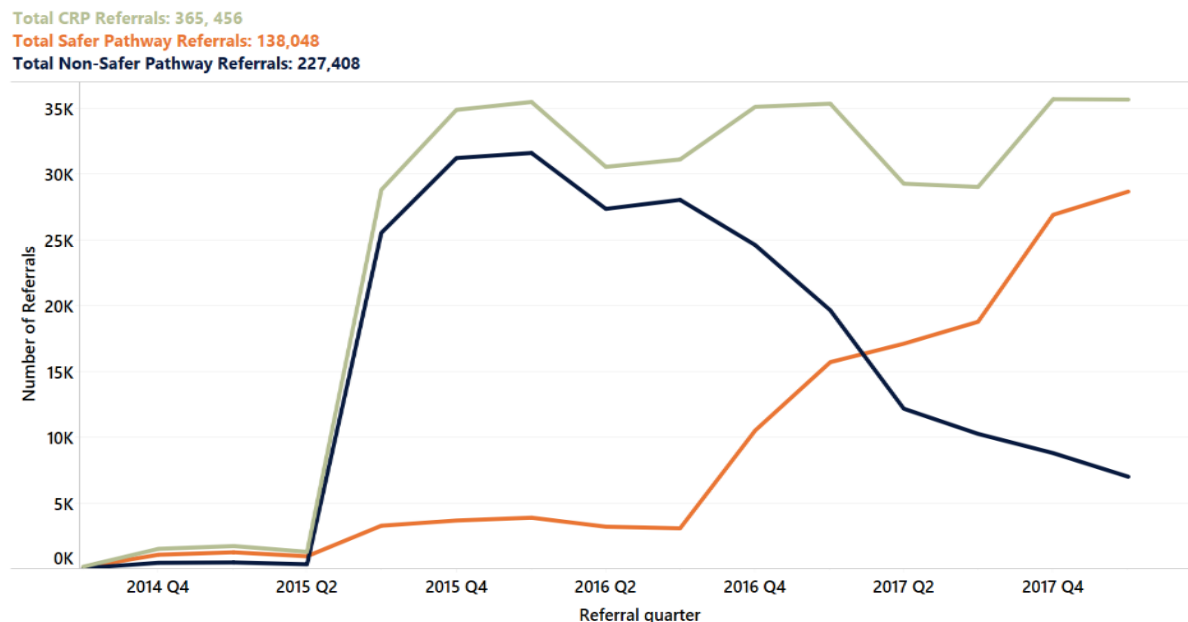
3.2 Establishment of Safer Pathway sites

The establishment of Safer Pathway sites across NSW occurred largely as planned. Safer Pathway commenced with the establishment of the CRP and launch of two sites in September 2014. The state-wide operation of Safer Pathway in July 2015 was marked by the mandatory use of the DVSAT at all DFV incidents attended by police, automatic referrals through the CRP and contact with victims of DFV by the LCP.

The implementation of SAMs has been incremental and staged over five years. Orange and Waverley were chosen as launch sites to pilot SAMs as they provided the opportunity to test the approach in a metropolitan and rural setting with different service systems, demand and demographics. By the end of March 2018, there were 43 SAM sites across the state. The establishment of SAMs in the last five sites occurred in the last quarter of 2018, bringing total SAM rollout by 2019 to 48 locations.

As shown in Figure 2, referrals into the CRP overall grew rapidly with the rollout of the DVSAT. As the Safer Pathway sites have been activated, the proportion of referrals in Safer Pathway has grown. In March 2018, 91% of all referrals were into Safer Pathway sites.

Figure 2. Incoming referrals to the CRP by Safer Pathway and non-Safer Pathway referrals



Source: CRP data 2014-17.

3.2.1 Key procedural changes

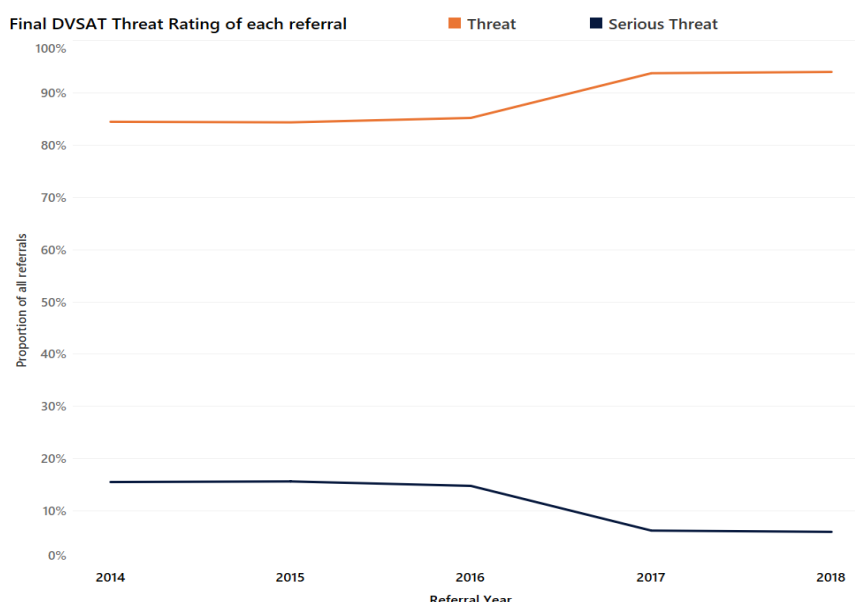
Several procedural changes have been made to Safer Pathway since it was first implemented in 2014. These were largely to help manage demand and included:

- February 2015, the DVSAT threshold for a serious threat assessment was increased from 10 to 12 positive responses to questions
- February 2015, the LCP was given the ability to re-grade a threat assessment from 'at serious threat' to 'at threat' where appropriate and in consultation with the relevant Police DVLO (LCPs could already re-grade up to 'at serious threat')
- July 2015, police implemented the DVSAT state-wide
- Between August and December 2016, the automatic 'trigger' for an 'at serious threat' assessment after three referrals within six months was removed from the DVSAT
- Early 2018, the Safer Pathway referral process for male victims changed from a two-stage model to a single stage model, in which initial contact, assessment and SAM representation is conducted by LSSs (male-LCPs).

Impact of procedural changes on threat ratings

The increase from 10 to 12 positive responses in the serious threat assessment and the removal of the automatic trigger are shown below to have decreased the proportion of victims assessed 'at serious threat' to 6% (Figure 3). This is below the expected proportion for 10% of assessments to be at the serious level, meaning there may be some underutilised capacity in the system to be working with more victims assessed at a higher risk of harm.

Figure 3. Final DVSAT threat ratings 2014-2018



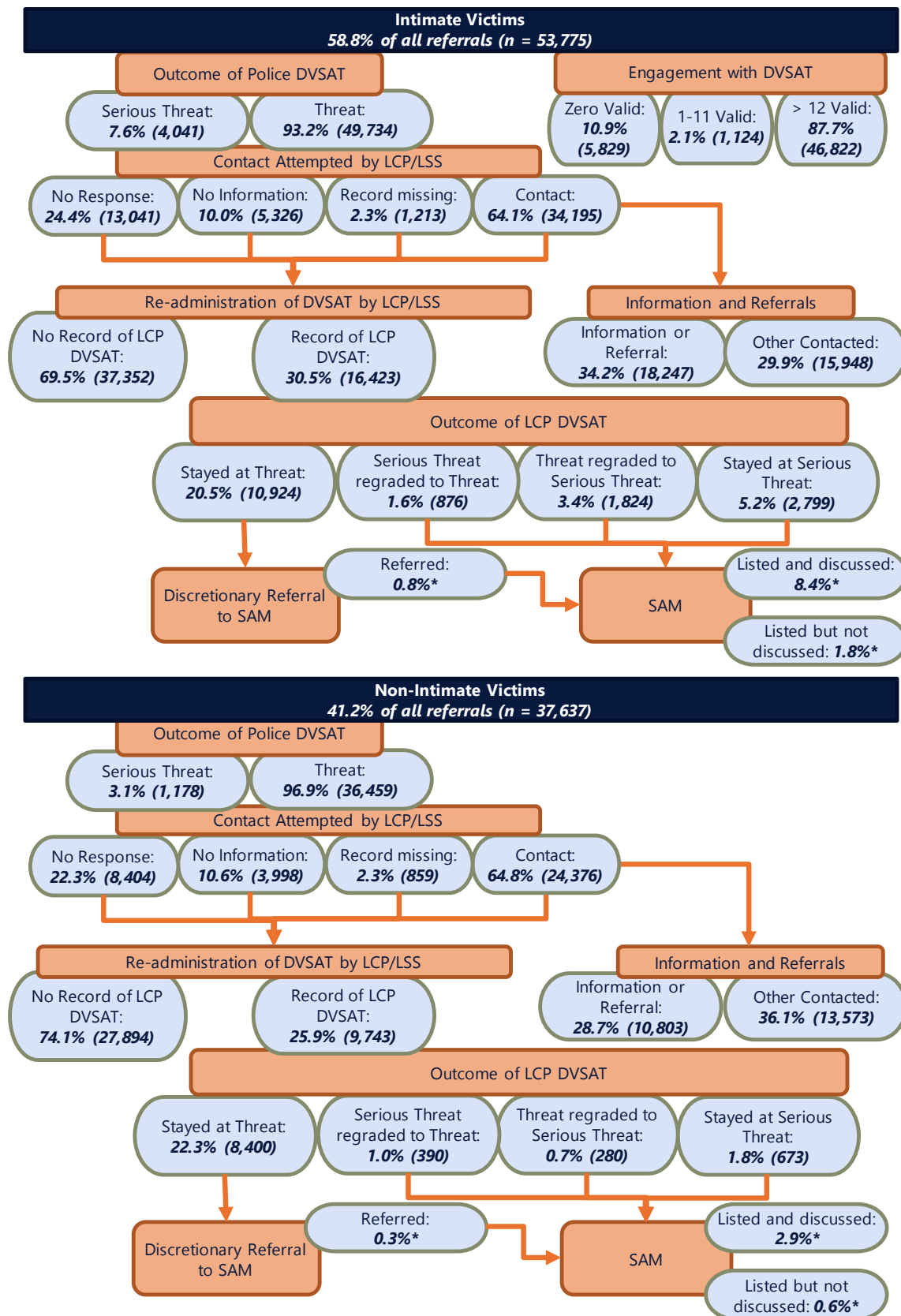
Source: CRP data 2014–18.

3.3 Safer Pathway caseload

The caseload workflow of referrals of victims of intimate and non-intimate DFV through the stages and processes of Safer Pathway are summarised in Figure 4. The data are discussed in

detail in Chapters 5 to 8. Overall, the diagrams show the triaging, reclassification and service provision through LCPs/LSSs and SAMs in line with program guidelines to victims of DFV who engage, and also the reluctance of some victims to engage (see section 1.4), through a lack of valid responses to the Police DVSAT, no response to contact with the LCPs/LSSs, and a lack of completion of LCP/LSS DVSATs.

Figure 4. CRP data showing caseload workflow for victims of intimate and non-intimate DFV in Safer Pathway



Source: CRP data 2017/18

*data for referral to SAM based on 6 months only so numbers are not provided, see Chapter 8.

3.4 Rollout supported by information and training

3.4.1 Training and support for SAMS and LCPs/LSSs⁴³

Legal Aid NSW implemented a comprehensive program of training since the commencement of Safer Pathway, which was well received. From November 2016, Legal Aid provided Safer Pathway information or training to over 3,600 people across NSW, through pre-launch and refresher training and information sessions for SAM members, LCP/LSS workers and other local stakeholders. SAM members, and LCP and LSS workers were also provided with policy and procedure manuals.

SAM training was provided in each Safer Pathway site in the month prior to launch. The five-hour training session covered the aims and operation of SAMs, as well as the roles and expectations of all members. For the Safer Pathway sites that commenced between September 2014 and November 2016, Legal Aid provided SAM refresher training six months after commencement. For sites that commenced in 2017 and 2018, Legal Aid conducted a SAM 'check-in' with members six months after commencement. From 2017, Legal Aid NSW also provided general SAM training sessions for members or proxies involved in any SAM that did not complete the original training in their area. The five-hour training sessions were held in Sydney and several regional sites each year to maximise opportunities for members from across NSW to attend. From November 2018, Legal Aid NSW is continuing to provide SAM general training across the state each year.

For Safer Pathway sites that commenced between 2014 and March 2018, Legal Aid NSW provided LCP training for new WDVCS workers, workers from Victims Services and other organisations working with male victims. The training covered the aims and operation of Safer Pathway, with a focus on using the DVSAT with clients, safety planning and case coordination. From November 2018, LCP training has been included in general WDVCS training. The training program includes mandatory foundation training for new workers and a continuing education session with a different focus each year.

The Department of Justice provided training on Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007* in several locations in 2014. Information sharing was also included in WDVCS continuing education sessions in 2016 and every SAM training session.

Satisfaction with training and support for LCPs

Respondents to the LCP/LSS component of the workforce survey (n=53), indicated they were mainly positive about the training and support received in establishing Safer Pathway. Almost all (88%) of these respondents had completed LCP training, with similar proportions across respondents from LCPs and LSSs, from metropolitan and regional areas. Training was reported to support the LCP role very well (58%) or somewhat well (38%) by respondents.

⁴³ Summary of description provided by Legal Aid NSW.

Most respondents reported that the LCP manual supported their role somewhat well (51%), or very well (31%). The range of reported satisfaction levels was greater in both LCPs and metropolitan regions than their LSS or regional counterparts – though reasons for this were not clear.

Respondents generally requested more frequent training and further training with process issues to support their work. Ongoing yearly training, more background information about relevance of DVSAT questions for client safety, and clearer practice questions and case scenarios during training were proposed as ways that staff could be supported to work better. Some noted that integrated training with police and DVLOs would support staff to work better.

Recommendations

Continue to provide annual training for LCP and LSS workers, and SAM members, accessible to staff across the state.

Legal Aid and NSW Police consider providing joint local training for LCP/LSS staff, police and DVLOs to build local relationships and shared understandings of DFV and the roles of program components.

Satisfaction with training and support for SAMs

SAM members were positive about the training and support received in establishing Safer Pathway, assessed through the workforce survey. Of the 273 SAM members who responded, almost all (88%) had completed SAM training. The proportion of SAM members completing training was lower for those working for the Department of Education (57%) and in regional areas. Respondents from regional areas requested that training be made more available. More than half of respondents (58%) reported that most SAM members had completed SAM training. Some respondents thought it important to ensure all SAM members had attended SAM training.

Almost all respondents reported training supported their role, with 50% reporting it supported their role very well (50%), and 45% somewhat well (45%). Respondents reported that all (51%) or most (47%) SAM members had a common understanding about the processes and procedures of the SAMs. Respondents reported that the SAM manual supported their role very well (45%) or somewhat well (49%). Newer SAMs were less positive about the SAM manual.

One third of respondents reported that SAM members need more support to work better, with newer SAMs and those with a rotating chair more likely to report a need for more support. Respondents suggested more guidance on drawing the line between case management and threat reduction would help SAMs work better. There was a desire to clarify what was expected from the SAM coordinator role, and to appropriately acknowledge their work and contributions.

3.4.2 Training and support for police⁴⁴

Training for police has been less consistent and intensive than for LCPs and SAMs. The implications of this are evident in the evaluation findings about understanding by the police of DFV related issues (see below) and the use of the DVSAT by police (see chapters 4 and 5). The findings indicate more training is needed for police around issues of DFV dynamics and coercive control, as well as in the use of the tool.

Safer Pathway training for police commenced in 2014 with the commencement of the two pilot sites. Police in the four (then) LACs, that provided referrals to the Waverley and Orange LCPs and SAMs, received three hours face-to-face comprehensive training on the DVSAT and how to apply it. This training included an overview of Safer Pathway so they understood the context of where the DVSAT sits in the referral pathway process.

When the DVSAT was implemented state-wide in July 2015, a NSW Police Commissioner's directive was issued that all police were required to complete an online training module prior to implementation. There has been no formal ongoing training since. Each PAC/Police District (PD) is responsible for ensuring local training is provided to their operational police as required.

As each new SAM site has been rolled out, the NSWPF chairperson, their proxies and DVLOs have attended the SAM training and/or information sessions.

Police experience of training

Police in focus groups described training in DFV and in the DVSAT. Training about both topics appears to have differed in type and frequency across different sites.

Police in three of six focus groups said they received training on DFV theory (the cycle of violence) and dynamics (coercive control, escalation etc) during their time at the Police Academy. At two sites, officers received some face-to-face training during a training day. Officers at one site received regular online training. It was commonly mentioned across different sites that training often occurred in response to a change in NSW legislation.

We also have DFV training when there are changes to DFV [laws]. (NSW Police Officer, police focus group)

There was a prevailing attitude across five out of six sites that more training in DFV theory and dynamics was not required. Officers tended to explain this by appealing to the value of 'learning on the job'.

... it [DFV] is our bread and butter (NSW Police Officer, police focus group)

⁴⁴ Summary of description provided by NSW Police Force.

At the sixth site a senior officer stated their desire for general duty police to receive more DFV training to change the way that they respond to an incident.

I'd like to see the GD police get more training around the dynamics of domestic violence relationships and understand a bit more about power and control, and what's going on in that environment and not just about the 'investigative head' that goes in there often ...
(DVLO, police focus group)

Focus group participants described five different methods of training they received in the use of the DVSAT. At two sites, police received face-to-face training. One site reported seeing videos on administering the DVSAT. Officers at another site suggested that younger officers had received some training in the academy, and that older officers had received face-to-face instruction via a workshop looking at administration across a range of different scenarios.

Officers at one site appeared to have received very little training; when asked about the extent of their training around the use of the DVSAT, an officer replied:

Five minutes in parade. (NSW Police Officer, police focus group)

Attitudes to further training were mixed. Officers at three sites thought the DVSAT is 'self-explanatory' and that they did not need further training around administration.

I have been doing the job long enough to ask questions like a counsellor. (NSW Police Officer, police focus group)

It's pretty straightforward. (NSW Police Officer, police focus group)

Officers at one site suggested provision of more refresher training, potentially online.

Maybe some online training, or workplace training. Perhaps a refresher every now and then. (NSW Police Officer, police focus group)

Recommendation

Strengthen the adequacy and availability of training in DFV, Safer Pathway and the DVSAT for police as part of on-going training. The training should cover DFV dynamics and coercive control, provide support in developing skills and approaches to ask difficult questions and make clear the role of the safety assessment in prioritising a multi-agency service response to victims of DFV.

3.5 Profile of LCPs/LSSs

LCPs and LSSs are funded and structured differently, and issues in service delivery are related more to metropolitan/rural location than funding or auspice mechanisms.

LCPs – the services for women referred through Safer Pathway – are funded through Legal Aid and hosted by Women's Domestic Violence Court Advocacy Services (WDVCAS).

WDVCAS are auspiced by a range of NGOs and provide locally-based information, referral and court support at 117 local courts across NSW. When the rollout of Safer Pathway is complete, each WDVCAS will include between one and three LCP services. Respondents to the workforce survey reported that individual LCPs have an average of four intake and referral officers (ranging from 1 to 13), with 58% of respondents reporting there was currently an Aboriginal specialist worker at their service.

LSSs – the services for men referred through Safer Pathway – are funded through Victims Services, auspiced by five large NGOs and managed through nine regional offices across NSW. The number of LSSs auspiced by each NGO varies widely (between four and 21). Respondents to the workforce survey reported an average of seven intake and referral officers in their LSS (ranging from 2 to 14), with none reporting Aboriginal specialist workers; participants in LSS focus groups included a culturally and linguistically diverse (CALD) and a LGBTQI specialist worker. LSS workers interviewed described working in several different ways, with some covering one LGA, others working in as many as five LGAs in metro areas and some working across multiple rural towns and regions.

LCP/LSS respondents to the workforce survey in regional areas suggested that flexibility in job titles and roles would be helpful, due to 'different demands' on staff from metropolitan regions, although the nature of the different demands was not specified. Regional LCP/LSS staff also reported a limited ability to share information regarding best practice and processes with other LCPs/LSSs due to their geographical isolation.

Recommendation

Explore additional opportunities and mechanisms for information sharing and cross-learning for LCP/LSS staff, including reviewing and promoting participation in local DFV interagency meetings in the areas in which their clients live.

3.6 SAM membership and functioning

SAMs are mostly being implemented as intended. There is a high level of commitment to the SAMs and they are well attended by people at the correct level of agencies/ organisations, with many having stable membership over time. Meetings have a formal format, with the aim of increased safety for victims of DFV and children. They are generally well-focused without getting into details not relevant for SAM discussion, such as case management. SAM respondents to the workforce survey revealed some variation in how SAMs are constituted and managed, and in the workload of and supports available for SAM participants at different agencies.

Chairing

SAMs are chaired by police, which many informants believe sends a clear message about the commitment of police to the Safer Pathway process. The literature suggests this model is appropriate, indicating that strong and stable leadership is crucial to the effectiveness of

inter-agency responses. This is with the proviso that there are ways to share decision-making responsibilities and any differences in 'power' do not inhibit agencies' capacity to listen and be heard.⁴⁵ The majority (94%) of workforce survey respondents described their SAMs as effectively chaired. The most effective chairs were described in interviews as seeking everyone's input and acknowledging the value of all perspectives.

When the chairs ask us what we think, when they are down to earth, on the same level as us, then they seek our opinion and talk to us like a person. They are able to acknowledge that they might not know everything about what is going on, and they trust that we do. This means everyone feels comfortable sharing their information and speaking up. (SAM focus group)

On the other hand, chairs who are overly formal or authoritarian and appear dismissive of views other than those of the police can shut down some of the discussion and preclude alternative views from being expressed.

Where SAMs are constituted across PAC boundaries, the chair rotates between crime managers of the PACs. Almost half of respondents (42%) reported their SAM had a rotating chair, and this did not impact on assessments of effectiveness. Two-thirds of SAM members (68%) reported their SAM took between 1–2 hours. One fifth (20%) reported meetings took 2–3 hours, and approximately 5% had very short (less than 1 hour) or very long (3–4 hours) meetings. The length of SAMs did not differ between metropolitan and regional/rural areas.

Group dynamics

SAM members were positive about discussion and group dynamics within SAMs. Most (81%) SAM members reported that the SAM group dynamic supported contributions to discussions about safety actions. SAM members from small towns or remote areas, and members attending SAMs with rotating police chairs were less positive about the impact that the group dynamic of the SAM had on discussion. The reasons for these differences are not clear. Rural SAM members stressed the need for understanding that some remote services require tele-links and need to contribute without physical attendance. This could impact on group dynamics. While different chairs can be equally effective at chairing a meeting, the different styles of the chairs could impact on the group dynamic.

Recommendation

NSWPF review the monthly rotation of chairs and consider moving to a six-monthly rotation to support SAM group dynamics.

⁴⁵ Allen, N.E. (2006). An Examination of Domestic Violence Coordinating Councils. *Violence Against Women*, 12(1): 62; ACT Government. (2015). *Gap Analysis Project*. Community Services, Canberra; Breckenridge, J., Rees, S., Valentine K, & Murray, S. (2015). *Meta-evaluation of existing inter-agency partnerships, collaboration, coordination and/or integrated interventions and service responses to violence against women: State of knowledge paper*, ANROWS, Sydney.

As part of the next review of the SAM manual, include better practice information on working remotely with meeting participants, such as over tele-links, to support the effectiveness of SAMs in rural and remote areas.

Membership

DVLOs commonly attend SAMs, with all respondents bar one reporting there was at least one DVLO at most SAMs. Specialist DFV services and other NGOs were also frequent attendees of SAMs. Eighty-six per cent of respondents reported specialist DFV services attended most SAMs, and 77% of respondents reported other NGOs (excluding LCPs/LSSs) commonly attended SAMs. FACS and Housing were most often (one in eight respondents) cited as organisations that did not attend regularly.

SAM members who responded to the workforce survey expressed a desire for NGOs to attend meetings more regularly and for greater input from FACS during meetings to improve the SAM effectiveness.

One third of respondents are standing members on more than one SAM. Of these, 31% reported regularly attending one SAM, 39% regularly attend two, 28% regularly attend three SAMs and two respondents regularly attend four SAMs. Monitoring of patterns of attendance would show if some members are unable to meet the requirements of attending and resourcing multiple SAMs.

Associated workload

The workload associated with SAM membership varied by agency, and some agencies reported more resources available than others. However there was also considerable variation within agencies. Most respondents (86%) reported they had overall responsibility for ensuring that required information is collected each fortnight about victims of DFV on the SAM agenda. This was relatively consistent across organisations, with the highest proportions of respondents who had another person in their organisation responsible for collecting information found in the NSWPF (24%) and Corrective Services (21%).

While most SAM members had responsibility for information collection, fewer collected the information themselves without support. Most SAM members from NSW Health, FACS and the Department of Education were involved in the collection of information, with approximately 48% collecting the information themselves alone and about 40% collecting the information with additional support from others in their organisation.

LCPs and LSSs differed in organisational support in collecting information for SAMs, with 38% of LCP workers collecting the information themselves compared to 59% of LSS workers. Fifty-three per cent of NSW Police collected information themselves. However, 29% had the information collected by someone else in their organisation.

Just over half of respondents (57%) reported that collecting the information and preparing for each fortnightly SAM takes less than half a day, with 20% reporting that it takes less than an hour, and another 37% reporting that it takes between one hour and half a day. There was a large collection time reported for LCP workers, with only 5% of workers reporting that it took less than half a day to prepare for SAMs. NSW Police and Health had the longest collection time reported out of SAM members, with 47% and 51% respectively reporting that preparing for each SAM took between half a day to one day each fortnight.

Some respondents suggested more allocated/funded hours for SAM members, and administrative support to meet information collection requirements to help SAM members work better. This is reflected in the literature, which suggests adequate recognition and funding for the time staff spend at inter-agency meetings, as well as appropriate staffing for administrative support, would help increase attendance at meetings.⁴⁶

Recommendation

Government agencies that are standing members on SAMs should:

- prioritise SAM participation by reviewing SAM-related workload and resourcing
- seek to reduce rotation of staff representatives on SAMs
- provide adequate introduction, orientation and handover to incoming staff on SAM membership roles and responsibilities
- ensure staff who are SAM members have access to and know about available psychological supports, such as EAPs.

SAM maturity and consistency

SAM effectiveness in information sharing and collaboration in safety planning for victims of DFV (discussed in Chapter 7) were reported to be greater by members of longer running SAMs. Information sharing and collaborative service planning could be new ways of working for some agencies or staff, and it could take time for them to become comfortable and confident in that new working environment.

Informants described in interviews the disruption to the SAMs and effectiveness of high rotation of staff through positions responsible for attending the SAM, and how this could be ameliorated through planned, supported handover by staff within the agency, such as incoming staff attending one or two meetings in the company of outgoing staff.

Psychological well-being

Workforce survey respondents highlighted the confronting content that members commonly encounter during SAMs, and suggested the need for post-session debriefs and informal supports for SAM members.

⁴⁶ Marshall, J., Ziersch, E. & Hudson, N. (2008). *Family Safety Framework: Final Evaluation Report*. Government of South Australia, Office of Crime Statistics and Research, Adelaide; State of Tasmania. (2009). *Review of the Integrated Response to Family Violence: Final Report*, Department of Justice, Hobart.

Recommendations

Strengthen reference in SAM member training to the possible need for psychological support and its availability, e.g. through agency Employee Assistance Programs (EAPs).

The table below sets out outcome patterns related to SAM characteristics:

| Outcome | Context | Mechanism (because) |
|---|--|--|
| Diverse relevant information discussed, consideration of alternative approaches | Effective chairing | Mutual respect between members at meetings |
| Less effective discussions at meetings | Rotating chairs Overly formal or authoritarian chairing | Less open discussion at meetings |

4. Evaluation of the DVSAT

The evaluation assessed the extent to which the Domestic Violence Safety Assessment Tool (DVSAT) is a valid, reliable and appropriate tool for assessing domestic and family violence (DFV) threat. The assessment used findings from the literature, interviews with NSW Police and Local Coordination Point (LCP)/Local Support Service (LSS) staff about their use of the DVSAT and the responses of victims of DFV to the questions. This chapter provides the findings from this assessment and makes recommendations about potential improvements to its design and use.

This chapter addresses evaluation questions 1, 3 and 4 with respect to the DVSAT.

Key findings

- The use of separate tools for police and DFV specialists in intimate DFV risk assessment is standard in some other jurisdictions, in Australia and internationally.
- Expanded definitions of DFV to include non-intimate relationships has required the development of new tools, including a valid actuarial tool for police in Victoria and the VP-SAFvR.
- The Police DVSAT in Safer Pathway seeks to identify the level of risk of harm to a victim of DFV, to prioritise the speed and level of response to higher risk matters. However:
 - it is not predictive of further aggression by the perpetrator in the current incident
 - it lacks essential elements for best practice tools
 - the questions can be misinterpreted and answered incorrectly by victims of DFV
 - not reliably administered by police
 - some victims are reluctant to answer all questions accurately in the police assessment.
- The development of a tool along the lines of the VP-SAFvR would mean that:
 - a genuinely predictive tool should lead to accurate prioritisation of high-risk cases
 - all victims of DFV in NSW, regardless of their relationship to a perpetrator, would receive each component of best practice risk assessment in DFV
 - initial police risk assessment would be less reliant on the knowledge of an individual administrator.
- The purpose of the LCP/LSS DVSAT is a comprehensive risk assessment concerned with both the level and type of threat to a victim of DFV's safety, informing both the prioritisation of serious cases and an effective service response tailored to the needs of a victim.
- The LCP/LSS DVSAT could be improved through some adjustments to formatting, weighting of items and wording of questions. However, it is a good practice tool for DFV content experts.

4.1 Existing tools and the literature on risk assessment

4.1.1 Evolution of risk assessments

Development of tools for intimate partner violence

The initial development of risk assessment tools for DFV was largely caused by legislative change in Canada and some states of the USA in the early 1990s that led to an increase in the number of male offenders coming into contact with the criminal justice systems.⁴⁷ Risk assessment tools came into common use in police settings, mainly for intimate partner violence (IPV) perpetrated by men against their current or former female partners.⁴⁸ Risk assessment tools were developed as a response to a need to direct more resources towards women deemed to be at higher risk.⁴⁹

Today, in Canada and in some states in the United States, the purpose for which police use a standardised risk assessment tool when responding to DFV – particularly IPV – is to prioritise individuals or families at high risk. In other words, the primary function is triage.⁵⁰ These tools attempt to predict the likelihood of recidivism of abusive behaviours (typically serious assault or worse) by perpetrators. They have been designed for use in IPV only, and mostly researched and tested on cases of IPV committed by males against females. These tools include:

- Ontario Domestic Assault Risk Assessment (ODARA)⁵¹
- Spousal Assault Risk Assessment (SARA)⁵²
- Brief-Spousal Assault Form for the Evaluation of Risk (B-SAFER).⁵³

Separate IPV risk assessment tools also have a history of use in settings other than policing. Correctional services in the United States are known to use the Domestic Violence Screening

⁴⁷ Northcott, M. (2012). *Intimate Partner Violence Risk Assessment Tools: A Review*. Ontario Department of Justice, Ottawa.

⁴⁸ Northcott (2012).

⁴⁹ Northcott (2012).

⁵⁰ McEwan, T.E., Shea, D.E. & Ogloff, J.R.P. (2018). The Development of the VP-SAFvR: An Actuarial Instrument for Police Triage of Australian Family Violence Reports. *Criminal Justice and Behavior*, published online October 2018.

⁵¹ Hilton, N.Z., Harris, G.T., Rice, M.E., Lang, C., Cormier, C.A., & Lines, K.J. (2004). A brief actuarial assessment for the prediction of wife assault recidivism: the Ontario domestic assault risk assessment. *Psychological Assessment*. 16(3): 267.

⁵² Kropp, P.R., & Hart, S.D. (2000). The Spousal Assault Risk Assessment (SARA) Guide: Reliability and validity in adult male offenders. *Law and Human Behavior*, 24(1): 101-118.

⁵³ Storey, J. E., Kropp, P. R., Hart, S. D., Belfrage, H., & Strand, S. (2014). Assessment and management of risk for intimate partner violence by police officers using the brief spousal assault form for the evaluation of risk. *Criminal Justice and Behavior*. 41(2): 256-271.

Inventory (DVSI)⁵⁴ to assess the needs of convicted perpetrators for probation and supervision.⁵⁵ The Danger Assessment (DA)⁵⁶ is a comprehensive risk assessment tool initially developed for use in medical settings and is now used in specialist DFV and women's services (including women's health) across the United States and Canada.⁵⁷

The development of more comprehensive tools for specialist services has also occurred in Australia. The specialist risk assessment in the Victorian Common Risk Assessment Framework (CRAF) is a compressive risk assessment designed specifically for use by specialist women's or DFV services.⁵⁸

Developments with the broadening definition of DFV

Since the 1990s, legislative changes in Australia, New Zealand, Canada, the UK and certain states in the USA have seen the definition of DFV broaden to include a larger range of relationship types, including non-intimate relationships.⁵⁹ In English speaking jurisdictions, it is estimated that between one-third and half of all DFV cases fall into the non-intimate category.⁶⁰ The implication of this development is that the wide range of validated and road-tested IPV risk assessment tools, such as the ODARA and SARA, have not been validated and may not be usable in a policy setting where DFV is defined broadly.⁶¹

Currently, there are two known risk assessment tools that have been developed for use by police in jurisdictions where broader legal definitions of DFV exist. They are:

- Domestic Violence Screening Inventory – Revised (DVSI-R):⁶² This is an actuarial tool developed by applying complex statistical modelling (hierarchical regression and receiver operating characteristic analyses) to existing data on 15,000 DFV cases in Connecticut from 2004–05,⁶³ and subsequently validated on two later samples from the same jurisdiction.

⁵⁴ Williams, K. R. (2008). Domestic violence screening instrument. *Encyclopedia of Psychology and Law*, 240-242.

⁵⁵ Northcott (2012).

⁵⁶ Campbell, J. C., Webster, D. W., & Glass, N. (2009). The Danger Assessment: Validation of a lethality risk assessment instrument for intimate partner femicide. *Journal of Interpersonal Violence*. 24(4): 653-674.

⁵⁷ Northcott (2012).

⁵⁸ The Lookout. (n.d.). Common Risk Assessment Framework (CRAF). Available at: <https://www.thelookout.org.au/family-violence-workers/risk-assessment-management/common-risk-assessment-framework-craf>

⁵⁹ McEwan, et al. (2018).

⁶⁰ McEwan, et al. (2018).

⁶¹ McEwan, et al. (2018).

⁶² Williams, K. R., & Grant, S.R. (2006). Empirically examining the risk of intimate partner violence: the revised Domestic Violence Screening Instrument (DVSI-R). *Public health reports*. 121(4), 400-8.

⁶³ Williams & Grant (2006).

- Victoria Police Screening Assessment for Family Violence Risk (VP-SAFvR): This was developed in an Australian context by replicating the statistical modelling processes used to develop the DVSI-R and applying it to a local database.

The approach taken to developing the Victorian tool reduced the cost of developing and validating a broad actuarial tool by avoiding both field-testing the DVSI-R in another jurisdiction for cross-validation and the need to adjust local data-collection protocols.⁶⁴

Like the DVSI-R, the VP-SAFvR has been shown to predict further aggression by perpetrators across a broad range of intimate and non-intimate relationship types, and across male and female perpetrators.⁶⁵ Although risk factors such as strangulation and sexual assault were not found to be predictive, a range of other risk factors associated with increased likelihood of IPV were included in the tool due to their significant predictive power across intimate and non-intimate relationships, regardless of gender (see Appendix 3).

4.1.2 Approaches to risk assessment in DFV

Across a number of institutional responses to DFV in Australia and other English-speaking jurisdictions, there have been three approaches to risk assessment⁶⁶:

- an **actuarial approach** that assesses the probability of violent behaviours occurring with a stable set of weighted risk factors statistically proven to predict violence
- an **informal professional judgement** in which the risk assessor can use their discretion over what type of information is relevant to assessing risk.
- a **structured professional judgment** approach that combines elements of the actuarial and informal professional judgment approaches.

Tools that have received the most attention in research on risk assessment are actuarial and structured professional judgement tools. While these approaches differ in important ways, a shared trait is that both contain a mix of static and dynamic risk factors.

Static risk factors are stable over time – they typically include demographic information on perpetrators and victims of DFV such as gender – whereas dynamic risk factors can change over time.

Dynamic risk factors that appear on risk assessment tools have usually shown to be associated with serious assault and death from male perpetrated IPV. Dynamic factors include controlling behaviours, jealousy, pregnancy, recent or impending separation, alcohol and

⁶⁴ McEwan et al. (2018).

⁶⁵ McEwan et al. (2018).

⁶⁶ Backhouse, C. & Toivonen, C. (2018). *National Risk Assessment Principles for Domestic and Family Violence: Companion resource*. ANROWS, Sydney.

other drug abuse, or escalation – referring to an increase in the severity and/ or frequency of any other dynamic factor.

Actuarial approaches use a checklist of factors that have shown to be predictive of further aggression or recidivism by a perpetrator of DFV.⁶⁷ Actuarial approaches typically use complex statistical processes such as hierarchical regression analysis and receiving operating characteristic analysis to generate a list of predictive risk factors. The relative weighting of an individual risk factor is determined empirically, so factors that are highly associated with further aggression or recidivism by perpetrators are usually weighted higher than other factors. The results of actuarial approaches can be easily replicated between different administrators and can be used by administrators who are not content experts.

DFV risk assessment tools that use this approach include the ODARA (Canada), the Domestic Violence Screening Inventory (DVSI; Connecticut, USA) and the revised version of the DVSI (DVSI-R; Connecticut, USA), and the VP-SAFvR (Victoria, Australia).

These tools have primarily been used in policing (ODARA, DVSI-R, VP-SAFvR) and by correctional services (DVSI).

Structured professional judgment involves the administration of an itemised checklist, but leaves room for discretion by specialists.⁶⁸ The itemised research-based checklist helps to prevent inconsistent administration. The administrator can exercise discretion by excluding factors that may, given the particulars of a situation, be irrelevant. For example, a victim of DFV may score highly on the itemised checklist, but the perpetrator is incarcerated at the time of administration.

The administrator also has the discretion to include factors in a risk assessment that may, given the particular situation, be highly relevant. For example, a victim of DFV from a culturally diverse background might be socially isolated and, therefore, quite vulnerable. The structured professional judgement approach allows the administrator to include this in their assessment.

Structured professional judgment tools are more comprehensive than actuarial tools. Many structured professional judgment tools come with added disclaimers that they are only suitable for use by content experts. Proponents of the structured professional judgment approaches argue that they are more amenable to be used in safety planning and ongoing risk management than actuarial tools.⁶⁹

⁶⁷ Northcott (2012).

⁶⁸ De Bortoli, L., Ogloff, J., Coles, J. & Dolan, M. (2017). Towards best practice: combining evidence-based research, structured assessment and professional judgement. *Child & Family Social Work*, 22(2): 660-669.

⁶⁹ Kropp, P. R. (2008). Intimate partner violence risk assessment and management. *Violence and Victims*, 23(2): 202.

Examples of structured professional judgment tools include the SARA⁷⁰ and the B-SAFER⁷¹, that are used by service providers and police in Canada, the USA and the United Kingdom, and the Danger Assessment (DA)⁷², that is used by service providers and health professionals in some states in the USA.

4.1.3 Current views on best practice

Disagreements about which approach to use

Despite a high level of research into risk assessment in DFV over the last 30 years, there is still disagreement over key definitions of risk.⁷³ Existing DFV risk assessment tools tend to address risk.

... either in terms of identifying and addressing risks to victim-survivors, or alternatively, in terms of the risk of perpetrators reoffending based on the identification of certain violent characteristics... (ANROWS NRAP Companion Resource).

This disagreement over how to understand risk itself appears to be at the heart of divergent opinions about the best approach to risk assessment in DFV. Actuarial tools tend to focus more on the behaviour of perpetrators, whereas structured professional judgment tools tend to incorporate perpetrator behaviour, the situation of the victim of DFV, and even safety planning.⁷⁴ Furthermore, proponents of the actuarial approach tend to argue that structured professional judgment tools are not predictive and allow too much discretion for the user to influence the outcome of the assessment.⁷⁵

Proponents of the structured professional judgment approach argue that actuarial approaches are too rigid and do not allow experienced practitioners the flexibility to include factors that may be uncommon, but important for assessing risk in a particular case.⁷⁶

Combining the approaches

However, the two approaches are not necessarily mutually exclusive. ANROWS' National Risk Assessment Principles⁷⁷ argue that best practice risk assessment in DFV involves a structured professional judgment approach that incorporates:

- a well-tested actuarial tool (that has predictive validity) or a tool based on evidence-based risk factors

⁷⁰ Kropp & Hart (2000).

⁷¹ Storey et al. (2014).

⁷² Campbell et al. (2009).

⁷³ Backhouse & Toivonen (2018).

⁷⁴ Northcott (2012).

⁷⁵ Northcott (2012).

⁷⁶ Kropp (2008).

⁷⁷ Backhouse & Toivonen (2018).

- victim statements and narratives that capture the victim of DFV's level of fear and self-perceptions of risk
- room for professional judgment by expert practitioners.

Available tools

Validated tools that are widely used include the ODARA in the United States and the SARA in the United Kingdom. The items in both tools are grounded in research on intimate DFV risk factors and have been tested for their predictive validity and inter-rater reliability in practical contexts, including use by police.⁷⁸

Although the SARA is more widely used, the ODARA has greater validity, with the ability to predict assault and homicide.⁷⁹ The ODARA is also a 13-item actuarial tool that could be integrated into a more complex risk assessment approach, whereas the SARA is already a comprehensive structured professional judgment tool.⁸⁰

The ODARA has also been tested for use outside of male perpetrated IPV; although more research is required for its ability to predict further aggression in diverse cases. It has had some promising preliminary results for use on IPV perpetrated by females.⁸¹ However, the ODARA is not appropriate for use in a 'broad' policy setting in which the definition of DFV includes a wide range of non-intimate relationships.

Although the broad setting has presented a significant barrier for the development and use of actuarial tools for risk assessment in DFV, the recent development of the VP-SAFvR has shown that the development of such a tool is possible.⁸²

The VP-SAFvR was developed for a broad DFV policy setting for frontline police use. The primary purpose of the tool is triage. Cases rated as high-risk are prioritised for a more comprehensive assessment and higher levels of service response. The tool has been shown to predict the likelihood of further aggression by perpetrators across a wide range of intimate and non-intimate relationship types. The VP-SAFvR is also a 12-item tool, and of these only six involve direct questions to victims of DFV; the remaining six items are collected using police record data. The tool also has two weighted items, entailing a maximum possible rating of 14. The trigger for high-risk (similar to 'at serious threat' in Safer Pathway DVSAT) is a score of four.

A strength of the VP-SAFvR is that it was developed using a local database, so it has high predictive validity in the jurisdiction in which it is used. However, this means the VP-SAFvR

⁷⁸ Lauria, I., McEwan, T.E., Luebbers, S., Simmons, M. & Ogloff, J.R. (2017). Evaluating the Ontario Domestic Assault Risk Assessment in an Australian frontline police setting. *Criminal Justice and Behavior*, 44(12): 1545-1558.

⁷⁹ McEwan et al. (2018).

⁸⁰ Northcott (2012).

⁸¹ McEwan et al. (2018).

⁸² McEwan et al. (2018).

might not be immediately useable in other jurisdictions as its implementation may involve the capture of different types of data. Furthermore, the predictive items are limited by the data-collection protocols for DFV in Victoria and the quality of the data itself. The data collection protocols in Victoria for DFV (L17 forms) do not currently collect a variable for a perpetrator's Aboriginal or Torres Strait Islander heritage status, which the developers note is a current weakness of the tool.⁸³

Poor data quality around sexuality is common in DFV in Australia,⁸⁴ and this was no different for the data used to develop the VP-SAFvR. A very low count of LGBTQI cases meant that the validity of the VP-SAFvR for this demographic has not yet been determined.⁸⁵

4.2 The DVSATs in Safer Pathway

The DVSAT, which is used in Safer Pathway, was developed through a series of cross-agency initiatives, starting with the multi-agency Cross Agency Risk Assessment Model (CARAM) project which commenced in 2006. It was designed with the intent of providing a common approach to assessing threat across agencies, and to be administered in cases where the victim of DFV is 16 years of age or older.

The DVSAT, in its current form, is a structured professional judgment tool (see section 4.1.2). The items included in the DVSAT are largely grounded on risk factors associated with serious assault or homicide in IPV risk assessment research (see Appendix 2).

Police have been implementing the DVSAT state-wide since 2015. Use of the DVSAT is mandatory among NSW Police officers who respond to DFV incidents and mandated as standard practice among LCPs and LSSs.

A 2015 NSW Bureau of Crime Statistics and Research (BOCSAR) process evaluation of Safer Pathway found the DVSAT was considered easy to use, and provided a shared understanding of threat levels and a common language for discussing victims of DFV. It also suggested consideration be given to adding more static risk factors, and that adjustments or processes be developed for reviewing victims referred to SAMs to ensure prioritisation of victims of DFV 'at serious threat'. Following the 2015 evaluation, victim review processes were introduced and the DVSAT has been further investigated in this evaluation.

⁸³ McEwan et al. (2018).

⁸⁴ Australia Bureau of Statistics. (2013). Describing behaviours and relationships. *Defining the Data Challenge for Family, Domestic and Sexual Violence*. Available at: <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4529.0main+features172013>

⁸⁵ McEwan et al. (2018).

4.3 The Police DVSAT

The Police DVSAT was intended to be used as a predictive tool for future threat of harm, particularly serious injury or death, to a victim of DFV.⁸⁶ In other words, the focus is on the level of risk of harm to an individual, so that high-risk cases can be prioritised. The DVSAT was intended to be able to identify victims of DFV who are at greater risk of harm, so that these victims can have their cases prioritised by follow-up support.

4.3.1 Validity of Police DVSAT

While the approach to risk assessment in Safer Pathway incorporates the three elements of a best practice risk assessment framework (see section 4.1.3), there are limitations in both the design and practice of these.

Limitations of the Police DVSAT include:

- It is not an actuarial tool.
- It is missing crucial components of a best-practice structured professional judgment approach for intimate and non-intimate cases.
- The wording of many questions means victims of DFV can misinterpret the question and answer incorrectly.

These issues are discussed below.

Part A is not an actuarial tool

While the items in the DVSAT (including the items in Part B regarding victim of DFV self-assessment) reflect the range of research-based risk factors, this does not mean the tool itself will be a good predictor of risk. The validity of any assessment tool can be influenced by the wording of particular items, the weighting of different items, and interpretational variation between individual administrators of the tool. The tool has not been validated actuarially or psychometrically.

This is problematic because the DVSAT, particularly the version used by police, is incorporated into the program theory as a predictive tool, with 12 positive answers currently employed as the threshold for an 'at serious threat' rating.

Although Police administrators can use their professional judgment to change the threat rating, the use of a static threshold may suggest to administrators that 12 positive responses provide an empirically-based, predictive result, which could undermine their use of

⁸⁶ NSW Police Force. (n.d.). *NSWPF state-wide implementation of the domestic violence safety assessment tool (DVSAT)*. Available at: https://www.police.nsw.gov.au/_data/assets/pdf_file/0009/349434/NSWPF_DVSAT_SUMMARY_SHEET.pdf

professional judgement. The 12-point threshold may provide an implicit recommendation for administrators to conform to that rule.

Police risk assessment in Safer Pathway is not best practice when it comes to non-intimate cases as only Part B is used, which does not include an itemised checklist of risk factors. Part A items are not weighted

No single item in Part A of the DVSAT is weighted, meaning that the 12-point trigger for a rating of 'at serious threat' is not sensitive to differences in the severity of the perpetrator's behaviours captured by each DVSAT item. Positive responses to all items contribute the same level of risk to the final risk assessment, despite some items being associated with higher risk (e.g. history of violence, coercive control, escalation). It is currently possible for an administration of the DVSAT to identify that:

- the offender has a history of violence
- the offender has recently used tactics to coercively control the victim of DFV
- the offender has threatened to kill the victim of DFV
- coercive control and threats have been increasing in frequency, and at the same time produce a risk rating of 'at threat'.

The weighting of items was also identified by police as an issue with the Police DVSAT. In cognitive interviews, police were asked which DVSAT Part A items that they believed to be weighted higher than one point, based on their opinion of each item's predictive capability of serious assault or worse (Table 2). All Police (n=8) said that Item 2, referring to physical assault by a perpetrator on a victim, should be weighted higher. Other items that scored highly were Item 3 (choking/ strangling), Item 6 (breaching ADVOs), Item 18 (access to firearms), Item 4 (assault or threatened assault with weapon) and Items 24 & 25 (sexual assault).

Table 2. Proportion of Police who think an item in Part A should be weighted higher, by DVSAT item, n=8

| Item no. | Wording | % yes |
|----------|--|-------|
| Item 2 | Has your partner ever used physical violence against you? | 100% |
| Item 3 | Has your partner ever choked, strangled or suffocated you or attempted to do any of these things? | 83% |
| Item 6 | Has your partner ever been charged with breaching an Apprehended Domestic Violence Order? | 83% |
| Item 18 | Does your partner have access to firearms or prohibited weapons? | 83% |
| Item 4 | Has your partner ever threatened or assaulted you with any weapon (including knives and/or other objects)? | 80% |

| Item no. | Wording | % yes |
|-----------------|---|-------|
| Items 24 and 25 | Sexual assault items | 80% |
| Item 1 | Has your partner ever threatened to harm or kill you? | 75% |
| Item 5 | Has your partner ever harmed or killed a family pet or threatened to do so? | 67% |
| Item 16 | Has your partner ever threatened or attempted suicide? | 67% |
| Item 17 | Is your partner currently on bail or parole, or has served a time of imprisonment or has recently been released from custody in relation to offences of violence? | 67% |
| Item 20 | Has your partner ever threatened or used physical violence toward you while you were pregnant? | 67% |
| Item 21 | Has your partner ever harmed or threatened to harm your children? | 67% |
| Item 15 | Does your partner have a problem with substance abuse such as alcohol or other drugs? | 50% |
| Item 8 | Is the violence or controlling behaviour becoming worse or more frequent? | 33% |
| Item 19 | Are you pregnant and/or do you have children who are less than 12 months apart in age? | 33% |
| Item 14 | Does your partner have mental health problems (including undiagnosed conditions) and/or depression? | 25% |
| Item 9 | Has your partner stalked, constantly harassed or texted/ emailed you? | 20% |
| Item 23 | Are there children from a previous relationship present in the household? | 20% |
| Item 10 | Does your partner control your access to money? | 17% |
| Item 22 | Is there any conflict between you and your partner regarding child contact or residency issues and/or current Family Court proceedings? | 17% |
| Item 7 | Is your partner jealous towards you or controlling of you? | 0% |
| Item 11 | Has there been a recent separation (in the last 12 months) or is one imminent? | 0% |
| Item 12 | Does your partner or the relationship have financial difficulties? | 0% |
| Item 13 | Is your partner unemployed? | 0% |

Source: Cognitive interviews.

The place of self-assessment and professional judgement

The layout of the DVSAT does not effectively distinguish the different components required in the structured professional judgment approach, especially victim of DFV self-assessment. The items concerned with victim of DFV self-assessment are listed under the tab concerning professional judgement, and it is not clear within the tool where or how a victim of DFV's self-assessment (e.g. in relation to level of fear) are expected to inform the administrator's assessment. The items are worded as questions to be asked of victims of DFV, adding to the potential for administrator confusion about the relationship between self-assessments and professional judgement.

The lack of a standardised assessment tool for victims of non-intimate DFV (who are only asked Part B items) means that one essential part of the structured professional judgment approach is missing for the initial assessment of nearly one half (41%) of the referrals into Safer Pathway.⁸⁷

The wording of Part A items

Some items in the current version of the DVSAT Part A have wording issues. For example, Item 1 – *Has your partner ever threatened to harm or kill you?* – captures two levels of harm in the same item (threats to harm and threats to kill). Half of the interviewed police believed the two levels of harm influenced how victims of DFV respond.

A lot of people will say 'no' because they focus on the 'kill' word. (NSW Police Officer, cognitive interview)

Research into risk assessment for intimate DFV supports threats to kill by perpetrators as a potential predictor of assault⁸⁸ and femicide⁸⁹. No evidence was found in literature that was examined regarding the predictive value of threats to harm, although threats with weapons are specifically identified as separate risk factor. 'Threats to harm' may be important for other aspects of service delivery, but may need to be distinguished from 'threats to kill' for a more evidence-based approach to DFV risk assessment.

When asked about DVSAT Item 24 – *Has your partner ever done things to you, of a sexual nature, that made you feel bad or physically hurt you?*, over 50% of NSW Police officers who participated in the cognitive interviews believed victims of DFV do not understand this item refers to any type of sexual violence, including denigration and coercion. Police interviewed in the focus groups and cognitive interviews also felt the complexities of the sexual assault question confused victims of DFV and are not getting captured by the DVSAT. Half of police

⁸⁷ While the standardised tool used for intimate DFV, Part A is not a valid predictive tool, it provides a common point of reference that may contribute to shared and common understandings of intimate DFV dynamics across multiple agencies.

⁸⁸ Braaf, R. & Sneddon, C. (2007). *Family Law Act Reform: The Potential for Screening and Risk Assessment for Family Violence, Issue 12*. Australian Domestic and Family Violence Clearinghouse, Sydney.

⁸⁹ Backhouse & Toivonen (2018).

who participated in the cognitive interviews agreed the different levels of harm in DVSAT Item 24 item affects how clients respond to the item.

They tend not to hear the distinctions and think just about more 'extreme' things such as rape, and then often say 'no'. (NSW Police Officer, cognitive interview)

An LCP worker also alluded the Police DVSAT does not capture this information well, found that, when victims of DFV understood the item was not only referring to sexual assault, but also a range of other behaviours, they were more likely to answer 'yes'.

We actually get a lot more 'yes' answers than we do from the police. We explain 'hurt you' as 'make you feel uncomfortable' or 'he persuaded you to do something you didn't want to do'. (LCP worker, cognitive interview)

Other items for which half of police believed multiple levels or types of harm affected how victims responded included Item 9 – *Has your partner stalked or constantly harassed or texted/emailed you?*

They tend to focus on one thing (NSW Police Officer, cognitive interview)

Also, for Item 21 – *Has your partner ever harmed or threatened to harm your children?* – which one officer links to a conflation of family violence and lawful chastisement (for disciplinary purposes).

This goes back to lawful chastisement. It may be interpreted by one parent as lawfully disciplining the child and the other thinks it is harm. (NSW Police Officer, cognitive interview)

Other items display similar wording issues, and these issues mean that the tool may not be accurately measuring the level of threat it purports to.

4.3.2 Reliability of the Police DVSAT

Focus groups and interviews confirmed police are complying with the requirement to use the DVSAT. For IPV they complete Part A with the assistance of an 'aide memoire' listing all 25 items and notebook stickers to record responses, which they then enter into the WebCOPS database at the station. For intimate and non-intimate DFV, police complete Part B after returning to their station, and also enter these details into the WebCOPS database.

However, there is significant evidence of variability in how police administer both parts A and B of the DVSAT, and of victim reluctance to answer some questions when talking to police, which undermine the reliability of the tool. These issues are discussed below, and further in Chapter 5.

Discretion used for Part A items

Some police use their discretion over which DVSAT items they will ask. In some cases, police who were interviewed said they were less inclined to ask each individual item when responding to a physical incident in which the victim was showing signs of trauma. Many police also said that, depending on the context, they would not administer the items about sexual assault. Other reasons for discretion included the presence of the victim of DFV's children nearby (after being unable to separate them from the victim of DFV).

You got to separate the kids obviously with some of the questions because, and then that is difficult if they are young kids too, they won't go into a room by themselves especially if they have just seen their mum get her head slapped up. (NSW Police Officer, police focus group)

Assessments drawn on different information for Part A

Some police are using data from WebCOPS to revise Part A, which means the assessment is made on a wider source of information. Other police, based on the belief that Part A answers should be based on the victim of DFV's perspective of the situation, will only record victim of DFV answers. This means assessments for intimate cases are being made on the basis of different information.

What the victim says is a priority, but we might moderate with what we've found out [from COPS] – which tends to be detailed in the narrative rather than by changing their answer. (NSW Police Officer, cognitive interview)

Part B: Role of victim of DFV self-assessment

Police are consistently completing Part B by making summaries of the available evidence rather than asking direct questions of the victim of DFV. This means that Part B Items 1 and 2, which relate to the victim of DFVs' current level of fear and their concern, are not reflecting victim of DFV self-assessment. It is common for police to use other evidence, such as body language, demeanour and WebCOPS history, in conjunction with the victim of DFV's statements about their fears and concerns collected at the incident.

Research on DFV risk assessment by ANROWS states that a victim of DFV's assessment of their fear is an essential risk assessment factor that should always be considered, but also never relied on as the sole factor on which final assessment should be based.⁹⁰ As Police are integrating the victim of DFV's assessment of their fear with other information in their risk assessments, it also means victim self-assessment is not being distinguished from professional judgment.

⁹⁰ Backhouse & Toivonen (2018).

Police administration of Part B: professional judgement

CRP data show Part B is widely used by police for both intimate and non-intimate DFV cases. However, there appears to be little consistency in how it is completed.

Cognitive interviews with police about Part B items found there was no standard approach to how police completed these items. Some police used information collected in Part A to answer items in Part B, and others only use Part B to capture '*any information that didn't fit in elsewhere*' (NSW Police Officer, cognitive interview).

Little evidence was found to suggest the use of Part B by police differed between intimate and non-intimate cases. During cognitive interviews, Police were explicitly asked if they used each item in Part B differently when assessing non-intimate cases; Officers rarely indicated that they did anything different for victims of non-intimate DFV.

In reliability reviews of selected matters, LCP staff noted that reliability in non-intimate cases was low when little information was provided in Part B; their re-administration could lead to a higher risk level in these cases, when more detail was included in the assessment.

Reluctance of victims of DFV to answer some questions

The reliability review of the DVSAT revealed large differences in what victims of DFV will reveal to police and the LCPs during administration of the DVSAT in intimate DFV incidents. When comparing the two assessments in selected cases (n=27), victims of DFV reported from two to five times as many risk factors to LCP workers than to Police. The risk factors commonly not reported to police included strangulation, jealous controlling behaviours, stalking, harassment, unemployment, threatening suicide, threats with weapon, financial difficulties, threats to harm children and sexual assault.

Other victims of DFV will report the behaviour to police but attempt to minimise its frequency or severity. During cognitive interviews police and LCP workers (n=20) were asked to rate how often⁹¹ victims of DFV minimise when responding to each item in Part A of the DVSAT. Across both groups, the items for which minimisation was rated most frequently (from occasionally to often) were former incidents of DFV by the perpetrator against the victim of DFV, signs of coercive control and evidence of escalation. If police accept the minimisation, they may record 'no' instead of 'yes' for those items on the DVSAT, reducing the score and reliability of risk assessment.

4.3.3 Ways the tool can be improved

The Police DVSAT, and risk assessment by Police in Safer Pathway more generally requires significant revision. The DVSAT is not valid as a predictive tool, nor is it valid as a tool that

⁹¹ On a five-point frequency scale, from Never (1), Rarely (2), Occasionally (3), Often (4), Always (5).

supports decision-making around risk. It also appears the tool has not been administered consistently across the state since its implementation in 2015, suggesting it has limited reliability. Evidence based development of the Police DVSAT contributes to action area 5 of the *NSW Domestic and Family Violence Blueprint for Reform 2016–2021*, delivering quality, evidence-based services.

One option to improve the Police DVSAT would involve a redevelopment based on the feedback provided by police from this evaluation about items that they think are more predictive and adjusting the wording of certain items where necessary. Further training for general duties police around complex DFV dynamics such as controlling behaviours and escalation may also be required. However, there is no guarantee, without actuarial validation of the tool, that these changes would lead to more accurate risk assessments by police. Furthermore, it would not address the current lack of a checklist of validated risk factors for non-intimate DFV.

The development or use of an actuarial tool for use by general duties officers who attend an incident would improve the validity and reliability of police risk assessment in Safer Pathway. The development of the VP-SAFvR in Victoria shows that an actuarial tool can be developed for use in frontline policing that would cover the broad spectrum of abusive behaviours and relationship types in an Australian context. Such a tool developed for use in NSW would mean that:

1. a genuinely predictive tool should lead to accurate prioritisation of high-risk cases
2. all victims of DFV in NSW, regardless of their relationship to a perpetrator, would receive each component of best practice risk assessment in DFV
3. initial police risk assessment would be less reliant on the knowledge of an individual administrator.

Rather than taking the VP-SAFvR from Victoria, the process used to develop the tool could be mimicked by implementing a similar project in NSW. Such a project could overcome a number of these potential issues by ensuring that data collection protocols were in place to ensure that the validity of a new actuarial tool could be tested on high-risk demographic groups. The project could also be strategically implemented in certain areas within the state to ensure that high-risk groups are more likely to be included in the data.

The development of a tool specifically for use by general duties police will mean police and LCP/LSS workers may be using different tools. There may be concern this would impact the stated goal of implementing the DVSAT in NSW to contribute to shared understanding of risk across different agencies. However, an actuarial tool developed in NSW would likely make use of data that is collected using administrations of the DVSAT, so it is likely the end result would be a reduced, simplified version of the original tool. General duties police and the LCP/LSS would still be using the same risk assessment framework.

Simplification of the Police DVSAT may be controversial as risk factors identified in empirical research may not appear on the revised risk assessment tool. It is important to note exclusion from a risk assessment tool does not mean that a factor is not important for assessing the

risk to a victim of DFV's safety. A revised police risk assessment tool will reflect the limitations police face when gathering information as first responders. Any items identified through statistical modelling reflect risk factors that police are able to collect either at the scene or through their access to historical data. An added benefit of a simplified tool is that a reduction in the number of items involving direct questioning to victims will reduce the impact of victim engagement with police on referrals into Safer Pathway (see Chapter 5).

Another implication of the development of an actuarial tool is that it may involve the use of information about the victim of DFV to predict risk e.g. the VP-SAFvR identified alcohol and other drug use by a victim of DFV as a predictive factor of further aggression by a perpetrator.⁹² This does not mean a victim of DFV is responsible for further victimisation; such an item would reflect a dynamic risk factor (a factor that can change over time) that may make a victim of DFV more vulnerable to further victimisation by a perpetrator.

The development and use of an actuarial tool for frontline policing does not mean police would be unable to use some discretion to adjust the outcome of a risk assessment. It is common practice in jurisdictions where actuarial tools are used (such as the ODARA and the DVSI-R) that frontline police can use their professional judgement and consideration of extenuating circumstances to increase, but not decrease, the risk rating produced by an actuarial risk assessment.

4.3.4 Recommendations for Police DVSAT

Recommendation

Revise the Police DVSAT to enhance its predictive ability to assess the likelihood of further aggression by a perpetrator across intimate and non-intimate cases. It is recommended the revised DVSAT includes:

- changes to the layout of the DVSAT to include parts A, B and C, where Part A involves an actuarial or itemised checklist, part B involves victim of DFV self-assessment, and Part C involves professional judgement
- guidance on the discretionary ability of police to increase, but not decrease, threat assessment, in line with other jurisdictions
- reliability testing.⁹³

4.4 The LCP/LSS DVSAT

The purpose of the LCP DVSAT is a comprehensive risk assessment. The LCP Manual emphasises threat-identification as a crucial component of risk assessment, informing both

⁹² McEwan, et al. (2018).

⁹³ We recommend that a project similar to the development of the VP-SAFvR be implemented in NSW. We do not recommend the use of the VP-SAFvR unless it can be shown in further evaluation of the VP-SAFvR that (1) it is appropriate for use in Aboriginal and LGBTQI populations, (2) has positive feedback on its usability from frontline Police and (3) would not involve a costly change in data-collection protocols in NSW.

the prioritisation of serious cases and an effective service response tailored to the needs of a victim of DFV.

Effective identification of threat allows service providers to offer clients appropriate and tailored support; [and] prioritise clients at greater risk of harm. (LCP Manual, 2015, p15)

This suggests the LCP DVSAT is concerned with both the **level** and **type** of threat to a victim of DFV's safety, as they seek to both prioritise and offer support appropriate to the victims situation, in comparison to the Police DVSAT that is more concerned with the **level** of threat to a victim of DFV's safety, in order to prioritise a response.

The LCP manual also encourages use of a semi-structured approach to administration, where appropriate.

Depending on the client's circumstances, decide whether it is more appropriate to: ask the DVSAT questions individually; or check off the questions by using a narrative approach. (LCP Manual, 2015, p18)

This is in contrast to police, who are encouraged to administer the DVSAT using a more formal approach after their usual investigative practices have been completed.

Police who attend a domestic violence incident will investigate and take action where appropriate as they would normally. However, they will also ask the victim the 25 risk identification questions on the DVSAT and record the answers in their notebook. (NSW Police Force, 2015)

The LCP DVSAT, barring some minor tweaking, is close to best practice for the setting and context in which it is used by LCP and LSS staff. LCP/LSS workers have positive views of DVSAT and have integrated it into practice in flexible ways to support their role.

4.4.1 Validity

The LCP DVSAT in its current form contains all of the components of a best-practice risk assessment framework (see 4.1.3). Although the tool has not been psychometrically validated, it is a useful tool for expert practitioners to assess the level and type of threats to a victim of DFV's safety.

The LCP DVSAT involves the administration of each of these components to all victim of DFV's that are referred into Safer Pathway. Part A functions as an itemised checklist that is used in intimate and non-intimate cases by LCP/LSS workers. Part B contains items that allow for the victim of DFV to give their perspective on their safety and items that pertain to the LCP/LSS workers professional judgment.

One weakness of the LCP DVSAT is that, consistent with findings on the Police DVSAT, the itemised checklist in Part A is not an actuarial tool and has no validated predictive properties.

Therefore, the use of a static threshold (12 points is 'at serious threat') is inappropriate as a triage mechanism for the escalation of a case to a SAM. The use of a static threshold may also give administrators the impression the tool has predictive properties, which could interfere with their decision-making around risk. However, due to limitations around data collection protocols on LCP administration of the DVSAT (the itemised responses are not captured by the CRP) and data collection on outcomes for victims of DFV, it is not possible to ascertain the need for actuarial validation or redevelopment of the LCP DVSAT at present.

Similar to the Police DVSAT, an issue with LCP DVSAT's validity is its lack of weighting for certain items that may be more predictive of serious assault or worse. LCP and LSS workers identified this as an issue with the DVSAT's validity. In cognitive interviews, LCP and LSS workers were asked if, in their opinion, each item in the LCP DVSAT should be weighted more than one point. Items that rated highly were Item 11 (strangulation), Item 12 (threats to harm or kill), Item 9 (access to weapons), Item 10 (assault or threats to assault with weapons), Item 8 (former criminal offences), Item 23 (threats or actual harm to children), and Item 17 (escalation). However, workers indicated they give greater weighting to these matters in their considerations, and this informs their recommendations to upgrade matters from 'at threat' to 'at serious threat'.

Table 3. Proportion of LCP/LSS workers who think an item in Part A should be weighted higher, by DVSAT item

| Item no. | Wording | % Yes |
|-----------------|--|-------|
| Item 11 | Has your partner ever strangled, choked or suffocated you or tried to do so? | 91% |
| Item 12 | Has your partner ever threatened to harm or kill you? | 91% |
| Item 9 | Does your partner have access to guns or other weapons? | 89% |
| Item 10 | Has your partner ever threatened or assaulted you with any weapon (knives/objects)? | 88% |
| Item 8 | Is your partner on bail or parole at the moment? Has your partner ever been to gaol? If yes, has your partner been to gaol for violent offences? | 83% |
| Item 23 | Has your partner ever threatened to harm your children or actually done so? | 83% |
| Item 17 | Is the violence or controlling behaviour getting worse or happening more often? | 82% |
| Items 18 and 19 | Sexual assault items | 78% |
| Item 5 | Does your partner have any alcohol or drug problems? | 75% |
| Item 6 | Does your partner have any mental health problems or do you have any concerns about his/her mental health? | 73% |

| Item no. | Wording | % Yes |
|----------|---|-------|
| Item 13 | Has your partner ever been physically violent toward to you? | 73% |
| Item 22 | Has your partner ever threatened to or actually physically hurt you while you were pregnant? | 67% |
| Item 15 | Has your partner stalked or harassed you or constantly texted or emailed you? | 63% |
| Item 7 | Has your partner ever threatened to or tried to kill him/herself? | 60% |
| Item 14 | Do you have any pets? Has your partner ever threatened to harm or kill your pets or actually done so? | 56% |
| Item 20 | Has your partner ever been charged with breaching an AVO? | 50% |
| Item 2 | Has your partner (or the relationship) had money problems? | 40% |
| Item 3 | Does your partner control all the money? | 40% |
| Item 16 | Is your partner jealous or controlling? | 38% |
| Item 21 | Do you have children? How old are they? (Less than 12 months apart?) Are you pregnant at the moment? | 36% |
| Item 24 | Are there children from a previous relationship living with you? | 30% |
| Item 25 | Are there any family court or child contact or residency proceedings at the moment? Has there been conflict about this? | 13% |
| Item 4 | Is your partner unemployed at the moment? | 11% |
| Item 1 | Have you and your partner separated (in last 12 months)? Are you planning to leave him/her? | 0% |

Source: Cognitive interviews.

Interviews with LCP and LSS workers suggests the LCP DVSAT largely supports the decision-making of administrators around risk. Many workers agree the items in parts A and B function as cues or reminders to:

- keep the topic of conversation on DFV so the victim of DFV understands and/or acknowledges the abusive nature of the relationship in question
- understand the victim of DFV's perspective of their own situation and prioritise what the victim of DFV wants, to improve the likelihood of getting consent for a tailored service response, and improve the response.

However, like the Police DVSAT, the layout of the LCP DVSAT does not effectively distinguish victim of DFV self-assessment from professional judgment. This could affect the tool's ability to guide decision-making around risk.

4.4.2 Reliability

Qualitative data gathered throughout the evaluation suggests administration of the DVSAT is consistent across location, and across the LCPs and LSSs.

The following discussion highlights the major commonalities of the approach used by LCP and LSS staff in their administration of the DVSAT.

Conversational approach

LCP workers usually use a flexible, conversational approach to administer the DVSAT and tick off DVSAT items as things come up.

We do it conversationally and get the questions out by having a chat. (LCP worker, focus group)

We tend to use much more of a conversation and sort of have it sitting there and go 'yep', and then you'll sort of go oh I probably don't have the answer to that', so you can sort of go 'oh look, I've got a couple more questions that I have to fill in on the form' scenario to sort of get the rest. I think that's how we sort of basically all do it. (LCP worker interview)

Towards the end of the conversation, missing items are asked directly.

Staying on topic

Part A items act as reminders/cues of DFV factors that help LCP administrators keep the conversation with victims of DFV about the abuse. It helps LCP administrators put the perpetrator's behaviour in context so the victim of DFV understands and/or acknowledges the seriousness of their situation, and stops the conversation drifting away from the abuse.

The DVSAT is good in establishing risk and stuff like that and keeping us accountable in terms of making sure that we are looking at the broader picture of domestic violence and not going on tangent which is really easy to do with clients. (LCP worker, focus group)

Autonomy

The items in Part B help LCP/LSS workers to reinforce the importance of victim of DFV self-assessment. Again, the value of the DVSAT goes beyond the sole intended purpose of reassessment to assist LCP workers with their local service coordination. Knowing what the victims of DFV think of their situation, and knowing what they want out of it, is key in establishing trust and getting consent for service coordination later on.

It's really important for us to ask her 'What would you like to happen in this situation?', 'What's been happening?', 'What's your main concern?' ... [Part A] is just really assessing

what might be an issue and a trigger and why DV is happening, but if we don't work with Part B pretty much we actually haven't addressed her needs. (LCP worker, focus group)

Local service coordination

As part of their engagement with victims of DFV, LCP/LSS workers readminister the DVSAT to reassess risk to the victim of DFV, but also to tailor a service response. This understanding of the DVSAT is not necessarily intended in Safer Pathway's program theory, but has become an important part of LCP/LSS workers' role.

I think it does help us to identify any risks that we might be looking for when we're looking at assessing a threat level too, but not just assessing a threat level but it helps us in our work to determine I guess how safe someone is and what they might be needing support with. (LCP/LSS worker, focus group)

LCP staff use discretion too

Some LCP staff said they did not always ask the sexual assault items as it can be too confronting and intrusive, especially in a first conversation. They said they might raise it in a later conversation or that it may come up in the SAM.

The last two about sexual assault are quite intense so unless we know the incident involved this, for example through the ADVO information, then try to play it by ear as to whether to ask this question... (LCP worker, focus group)

Many workers who participated indicated they will ask the item if they are re-grading the DVSAT for referrals that come in as an 'at serious threat' rating from the police, or come in with a 'yes' response to either sexual assault items.

Part A items are made relevant for victims of non-intimate DFV

LCP/LSS workers use Part A items to inform their risk reassessment of victims of non-intimate DFV.

When we're doing Part B, we're still looking at all the risk factors, even though we might not have the list of 25 questions. We're still wanting to know 'does this person have access to weapons', 'has this person harmed you before physically or psychologically or emotionally'. (LCP worker, focus group)

Workers adapt the itemised checklist to items that are relevant to the particulars of a non-intimate case.

We adapt it to what we think is relevant to them and just leave out obviously the ones that aren't. (LCP worker, focus group)

Some noted the current questions are not relevant enough for some forms of family violence, and they adapt it where necessary e.g. violence by sons towards their mothers, or siblings.

Interviews with LSS staff suggest this may be due to many of the questions in Part A of the DVSAT relating specifically to violence perpetrated by men against their current or former female partners so, when LSS staff are talking to men, they find many of the questions to be irrelevant.

But there's some in there though that are – when we say they're geared towards females, there's just other ones in there that I've noted they find too uncomfortable in answering as well like trying to find – stuff around sexual interactions, what sexual interactions and whatever else. I've literally had one of the guys that I've talked to just say to me, 'I wouldn't answer that honestly if you asked me'. There's this whole section 19 to 23, completely irrelevant. There was another there, but I can't remember what it is. (LSS worker, focus group)

This point was also made by an interview with a male victim of DFV who said:

I answered the questions fully, within reason; a lot of questions weren't of concern to my situation. (Victim of DFV interview)

4.4.3 Ways the tool can be improved

LCP and LSS workers are satisfied with the DVSAT and have consistently reported that it supports their role. Improvements around the layout of the DVSAT guide that effectively distinguishes victim of DFV self-assessment from professional judgment may help to ensure that the tool supports the decision-making of LSS and LCP administrators.

It is also worth noting the itemised checklist is not a predictive tool. However, given that LCP and LSS workers are content experts, it is unclear if the use of an actuarial tool in place of an itemised checklist, which is already integrated into their practice, would lead to better risk assessment. Better monitoring of outcomes for victims of DFV and more detailed recording of DVSAT re-administrations would allow for a more rigorous evaluation of this issue.

Recommendations

Revise the LCP/LSS DVSAT, ensuring its coherence with the police component. It is recommended the revised DVSAT include:

- Changes to the layout of the DVSAT to include parts A, B and C, where Part A involves an itemised checklist, Part B involves victim self-assessment, and Part C involves professional judgment in line with best practice protocols for DFV risk assessment
- modified wording of questions to ensure a positive response by the victim of DFV means the presence of the evidence-based risk factor that the question seeks to assess is clear in each case
- weighting of questions that the evidence base shows as most indicative of further risk of harm
- reliability testing.

Legal Aid and Victims Services develop explicit protocols and ensure that LCP/LSS staff are sufficiently trained in the administration of sexual assault items in the LCP/LSS DVSAT.

5. Domain 1: Identification and assessment

This chapter looks at the first outcome domain in the program logic, which includes the actions and processes associated with identifying victims of domestic and family violence (DFV) and assessing them using a standard, validated tool as being either 'at threat' or 'at serious threat'. The initial threat assessment and other relevant victim and incident information are sent to the Central Referral Point (CRP) so that it can be accessed by Local Coordination Points (LCPs)/Local Support Service (LSSs) for follow-up.

This chapter addresses evaluation questions 1, 2 and 3.

Key findings

- The profiles of people referred into Safer Pathway by NSW Police broadly reflect population level data:
 - more women than male victims of intimate and non-intimate DFV
 - lower levels of referral for non-intimate DFV than for intimate DFV
 - high levels of referral for Aboriginal people.
- Police and LCP/LSS workers faced some challenges identifying victims of DFV, particularly in more complex cases or where there are cross-accusations of violence.
- The priority role for police at an incident is investigating whether an offence has occurred. A lack of training in the context and purpose of the Domestic Violence Safety Assessment Tool (DVSAT) may have undermined their role as assessors of risk in DFV incidents.
- Victims of intimate DFV either answer most or all DVSAT questions or refuse to answer any. Eleven per cent of victims refused to answer all questions in the Police DVSAT.
- Nineteen per cent of victims of intimate DFV and 21% of victims of non-intimate DFV have been re-referred into Safer Pathway since 2014. Re-referral rates were higher for women, Aboriginal people and those last referred 'at serious threat', but occurred for all groups of victims of DFV.
- Overall, 48% of the non-intimate referrals were for child-parent DFV.
- For victims of DFV that engage, the administration of the DVSAT can have a profound affect. The administration of the DVSAT can cause the situation to be identified as DFV for the first time in situations that did not fit victims of DFV's own stereotypes of what comprised domestic or family violence. In other cases, victims of DFV may have recognised that there were 'elements' of domestic violence in their situation, but only when the DVSAT was administered did they register it as serious enough that they should try to change their situation.

5.1 Initial identification of domestic and family violence by Police

The decisions made around identifying and classifying incidents as DFV-related – to date almost exclusively by Police – determine which incidents come to the attention of LCPs. Qualitative data from the six site visits revealed three areas of challenge in the initial identification of DFV by police in Safer Pathway:

- understanding of intimate DFV dynamics
- identifying victims and perpetrators in complex situations
- recognising male victims.

These challenges arise for different reasons and require different responses, yet each can lead to inconsistent decisions around DFV identification.

Understanding intimate DFV dynamics

Police identification of intimate male-on-female DFV can be influenced by an individual's understanding of intimate DFV dynamics. As discussed in section 3.4.2, many police have had little training on DFV dynamics and coercive control.

One scenario discussed in site visits involved police responding to reports from neighbours of a verbal incident involving a couple. This scenario involved signs of escalation (repeated call outs) and coercive control by the male (jealousy about contact with friends, restriction of movement), as well as an accusation of theft (using stolen credit cards to purchase goods) by the male against the female. The female in this scenario also wouldn't engage with police, except to correct the narrative given by the male and disclose that he had locked her inside the residence. At almost all sites, the signs of escalation in this scenario were missed by the police respondents. Half of the sites did not identify or grasp the seriousness of the signs of coercive control from the male. Across two sites, officers perceived the male as the victim in this scenario.

Actually, she spent [the money], so it's not clear. Has she dishonestly used his card? And then he's locked her in. Doesn't justify it but it goes both ways. In this situation, what's the initial complaint? It's from him, she used the cards. (Duty Officer NSW Police)

At this same site, it was clear the other officer in the room thought the lack of engagement by the female justified the male's victim status in this scenario.

Ok, I put him down as the victim. But only because she's not open with talking and explaining herself and often that means she has something to hide. Give her a chance to talk and tell her story, and if she doesn't want to then that's on her, in my opinion. (Duty Officer NSW Police)

In this scenario, the accusation of chargeable offence (theft) seemed to be front of mind, while the signs of escalation and coercive control were not prioritised, resulting in the failure to identify the signs of a (potentially high risk) DFV situation due to a lack of understanding of intimate DFV dynamics.

Police identification of non-intimate DFV is likely to be influenced by an individual's understanding of the legal definitions of DFV in NSW, and police do appear to have reliable processes in place to assist in these decisions e.g. calling back to their stations to refer to legal definitions.

Identifying victims and perpetrators of DFV in complex situations

Identifying who is the victim and who is the perpetrator of DFV can be a challenge for first responders. Scenario testing with police and LCP staff at each of the six sites showed a limited understanding of when and how to use the tool in complex cases.

Safer Pathway does not currently allow for cases where an individual is both a victim and a perpetrator of DFV in the current incident. Police, as the main first responders of Safer Pathway, are forced to make difficult decisions. Although the NSW Police Force DFV Standard Operating Procedures provides guidance on identifying the primary victim in a DFV incident, no officer referenced these materials or processes when discussing the scenario described above.⁹⁴ There is a need to ensure police know how to make these assessments, or where to locate information to assist them to do so.

During a focus group discussion, one officer shared their approach: they would list both parties as victims and perpetrators of DFV. The DVSAT would be administered with neither party.

I don't ask them both the questions, but I will list them both as the victims and both as the offenders. (NSW Police Officer, police focus group)

As a result of this approach, the risk of neither party has been assessed.

Literature on intimate partner DFV⁹⁵ notes cases that initially present as bi-directional violence are often later found to be gendered in that they hold male to female patterns of coercive control and increased violence. Studies also note a common cause of women's violence is self-defence, and that women often suffer greater injuries than do men.

⁹⁴ NSW Police Force. (2018). *Code of Practice for the NSW Police Force Response to Domestic and Family Violence*, p. 44.

⁹⁵ DeKeseredy, W.S. & Dragiewicz, M. (2009). *Shifting Public Policy Direction: Gender-focussed Versus Bi-directional Intimate Partner Violence*. University of Ontario Institute of Technology, Oshawa.

Recognising male victims of DFV

Although the police we interviewed over the course of the evaluation were open minded about who can be victimised by DFV, some male victims have had trouble being seen as victims of DFV by police. During a focus group, LSS workers commented that police education is important in the area of men as victims of domestic violence. They observed that some police won't accept that some males are victims of DFV because they are physically strong.

| Outcome | Context | Mechanism (because) |
|---|--|--|
| Some police officers assess victims of DFV as not being 'at threat' | Inadequate DFV education for police Male victims of DFV | Assumption that victimisation is incompatible with physical size, strength |
| Some police officers assess victims of DFV as not being 'at threat' | Inadequate DFV education for police Coercive control exerted, but not physical violence | Assumption that DFV requires physical violence |

Recommendation

NSWPF ensures regular training for police includes:

- the role of safety assessment in investigation of an incident and in referral into and prioritisation of victims within Safer Pathway
- DFV dynamics and coercive control, identifying victims and perpetrators of DFV in complex situations, and DFV for male victims of DFV.

5.2 Referrals to Safer Pathway

The profile of those referred reflects population data about victims of DFV

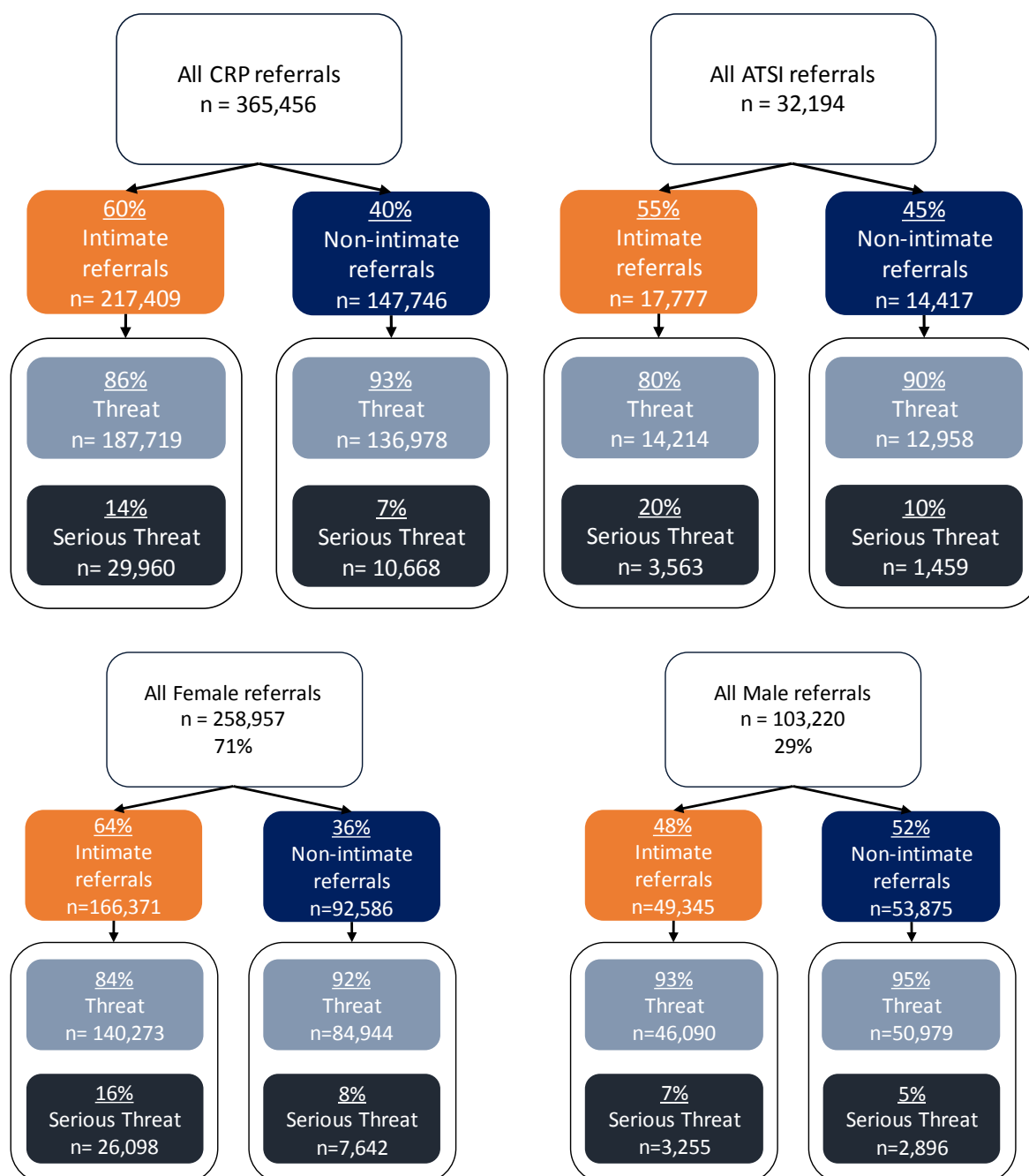
Referrals into Safer Pathway since 2014 reflect population level data about victims of DFV described in Chapter 1. Overall, victims of intimate DFV accounted for 59% of referrals since 2014 (Figure 5) and victims of non-intimate DFV accounted for 41%. Aboriginal people were referred at a higher rate, comprising 9.6% of referrals and only 3.4% of the NSW population.⁹⁶ Women were referred at higher rates than men, comprising 71% of referrals overall, 77% of intimate DFV referrals and 64% of non-intimate DFV referrals.

Victims of intimate violence were more likely to be assessed as 'at serious threat' (9%) on the initial DVSAT rating than victims of non-intimate violence (3%), but a higher proportion of

⁹⁶ Australian Bureau of Statistics. (2016). *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016*. Available at: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3238.0.55.001>

Aboriginal victims of intimate DFV were assessed 'at serious threat' (14%), as were a higher proportion of women (12% compared to 2% of men).

Figure 5. Referrals, relationship and initial DVSA threat rating



Source: CRP data 2014–18.

The reach of victims referred into Safer Pathway between April 2017 and March 2018 is detailed in Table 4 (victims of intimate DFV) and Table 5 (victims of non-intimate DFV). As for the program referral data over the period 2014–18, Aboriginal people comprised approximately 10% of all referrals.

Aboriginal people had higher rates of non-intimate DFV (45%) than all referred, as did people identified in the CRP as having a disability (48%). People identified in the CRP as LGBTQI had higher rates of referral for intimate DFV (69%) than all referred. The characteristics of victims of intimate and non-intimate DFV vary by victim group.

The demographic profiles of people referred into Safer Pathway between April 2017 and March 2018 are detailed in Table 4 and Table 5. Table 4 shows that 77% of victims of intimate DFV were women, with higher proportions of Aboriginal women (85%) and women identified as having a disability (88%). Overall, most victims of intimate DFV were between the ages of 25 and 50 (71%), although a higher proportion of Aboriginal people were aged under 25 (28% c.f. 19%), and a higher proportion of people identified with a disability were aged over 50 (18% c.f. 9%). More than half of the victims of intimate DFV lived in major cities (54%), but more Aboriginal victims of intimate DFV live in regional areas (70% c.f. 43%).

Table 4. Demographic profile of victims of intimate violence referred to Safer Pathway sites between 1 April 2017 and 31 March 2018

| | | Non- Aboriginal | Aboriginal | CALD | Disability | LGBTQI | Total |
|------------------------------|----------------|--------------------|------------|-------|------------|--------|-------|
| % intimate/ non-intimate | | 59.0% | 54.8% | 59.9% | 52.3% | 69.4% | 58.8% |
| n | | 37959 | 4810 | 5393 | 1308 | 250 | 53775 |
| % of intimate victims of DFV | | 71% | 9% | - | - | - | 100% |
| Victim gender | Female | 76.1% | 85.1% | 76.9% | 87.8% | 76.8% | 76.8% |
| | Male | 23.9% | 14.9% | 23.1% | 12.2% | 23.2% | 23.2% |
| Age at referral | Under 25 | 19.4% | 27.8% | 11.6% | 14.8% | 20.6% | 20.6% |
| | 25-50 | 71.5% | 66.7% | 77.6% | 67.5% | 70.7% | 70.7% |
| | Over 50 | 9.1% | 5.5% | 10.8% | 17.8% | 8.6% | 8.6% |
| Remoteness | Major cities | 57.4% | 24.6% | 74.1% | 48.6% | 54.4% | 54.4% |
| | Inner regional | 22.6% | 31.4% | 17.4% | 27.4% | 23.8% | 23.8% |
| | Outer regional | 17.4% | 39.2% | 7.5% | 21.5% | 19.3% | 19.3% |
| | Remote | 2.6% | 4.7% | .9% | 2.5% | 2.5% | 2.5% |

Source: CRP 2017/18 data.

NOTE: People identified as CALD, having a disability, or LGBTQI may be a subset of Aboriginal and non-Aboriginal people; 20% of records have no data on Aboriginality.

As shown in Table 5, 64% of victims of non-intimate DFV were women, with higher proportions of Aboriginal women (76%), women identified with a disability (80%) and women identified as LGBTQI (77%). Less than half of the victims of non-intimate DFV were between

the ages of 25 and 50 (49%), with almost one-third aged over 50. Higher proportions of Aboriginal victims of non-intimate DFV and people identified as LGBTQI were aged under 25 (23% for each c.f. 19%) and almost half of non-intimated victims of DFV identified with a disability were over 50 (49% c.f. 33%). More than half of the victims of non-intimate DFV lived in major cities (54%), but more Aboriginal victims of non-intimate DFV live in regional areas (70% c.f. 44%).

Overall, 48% of the non-intimate referrals were for child-parent DFV, 15% were for siblings, 14% for other relatives, 9% were for residents in the same household, with 15% 'other'. Aboriginal people had higher rates of referral for siblings (21%) and other relatives (26%). People identified with a disability had higher rates of referral for child-parent (53%) and another resident in the same household (13%). People identified as LGBTQI had higher rates of non-intimate DFV with 'other' people (26%), and with another resident in the same household (16%).

Table 5. Demographic profile of victims of non-intimate violence referred to Safer Pathway sites between 1 April 2017 and 31 March 2018

| | | Non- Aboriginal | Aboriginal | CALD | Disability | LGBTQI | Total |
|-----------------------------------|----------------------------|--------------------|------------|-------|------------|--------|-------|
| % intimate/ non-intimate | | 41.0% | 45.2% | 40.1% | 47.7% | 30.6% | 41.2% |
| n | | 26402 | 3965 | 3603 | 1193 | 110 | 37637 |
| % of non-intimate victims of DFV | | 70% | 11% | - | - | - | 100% |
| Victim gender | Female | 62.9% | 76.3% | 60.7% | 79.8% | 77.3% | 63.6% |
| | Male | 37.1% | 23.7% | 39.3% | 20.2% | 22.7% | 36.4% |
| Age at referral | Under 25 | 19.6% | 23.0% | 15.8% | 9.7% | 23.4% | 20.2% |
| | 25-50 | 48.8% | 53.6% | 49.8% | 41.5% | 62.6% | 49.3% |
| | Over 50 | 31.6% | 23.5% | 34.5% | 48.8% | 14.0% | 30.5% |
| Remoteness | Major cities | 57.1% | 25.7% | 72.3% | 51.1% | 61.8% | 53.7% |
| | Inner regional | 23.0% | 30.4% | 18.3% | 26.1% | 22.7% | 24.3% |
| | Outer regional | 17.2% | 39.5% | 8.6% | 20.6% | 12.7% | 19.3% |
| | Remote | 2.7% | 4.4% | .8% | 2.3% | 2.7% | 2.7% |
| Type of non-intimate relationship | Child-Parent | 48.8% | 40.0% | 49.7% | 52.6% | 33.6% | 47.5% |
| | Sibling | 13.9% | 20.5% | 13.4% | 8.5% | 12.7% | 14.7% |
| | Resident in same household | 10.0% | 4.1% | 11.3% | 13.3% | 15.5% | 9.3% |
| | Other | 15.0% | 9.9% | 12.5% | 13.2% | 25.5% | 14.6% |
| | Other relative | 12.3% | 25.5% | 13.1% | 12.3% | 12.7% | 13.8% |

Source: CRP 2017/18 data.

NOTE: People identified as CALD, having a disability, or LGBTQI may be a subset of Aboriginal and non-Aboriginal people; 20% of records have no data on Aboriginality.

The profiles of victims of intimate and non-intimate DFV referred to Safer Pathway provide important information for service providers delivering prevention, early intervention and support services under the Blueprint, providing both a benchmark against which service providers can assess their service accessibility for identified groups, and an indication of population sub-groups for whom services may not currently be available, to inform the development of service responses for these groups.

5.3 Police risk assessment

The quality of the initial police assessment can have a significant influence on a range of later outcomes in the referral pathway. The initial threat ratings affect the priorities of the LCP, particularly the timeliness of their attempts to contact victims of DFV following an incident. Knowing that early contact is essential for breaking the cycle of violence before the 'honeymoon phase'⁹⁷ commences, LCPs are required to attempt contact with all referrals within one business day of receipt. In busy LCPs, victims of DFV assessed as 'at serious threat' on the incoming referral are prioritised for contact. When an assessment that should have referred a victim of DFV to an LCP with a 'serious threat' rating comes in 'at threat', opportunities to engage with victims of DFV can be lost if too much time has passed before the offer of support.

LCP staff emphasised how their ability to successfully contact and build trust with victims depends in part on accurate and detailed information collected by police at the initial risk assessment stage. Incorrect details, such as mistaking the person of interest's phone number for the victim of DFV's, or the failure to identify children in a household, can have significant ramifications for program success. When information is not recorded correctly (or not recorded at all), victims of DFV, while in the process of repeating their stories, may experience re-traumatisation.

Furthermore, the recording of information in the DVSAT, particularly Part A, is important not only in providing key details that inform service responses to the initial incident, but also as historical records that may be used in the risk assessment of a future incident involving the same victim-perpetrator relationship. In addition to issues with the reliability and validity of the Police DVSAT discussed in Chapter 4, and their understanding of DFV discussed above, Police assessments are also affected by their understanding of their role, and that of the safety assessment in Safer Pathway program theory, discussed below.

Police understanding of their role: The 'investigative head'

In Safer Pathway's program theory, NSW Police are partners in a multiagency approach to risk management. There is an assumption that Police will make judgments about the likelihood of future harm for a wide variety of incidents, including those in which no incriminating evidence has been found.

There is also an assumption in the program theory that police will prioritise the risk assessment of any DFV-related incident that they respond to. However, the priority for police when they respond to an incident – DFV-related or not – is the immediate safety of those involved and investigation of offences already committed, rather than risk assessment. As one senior officer put it a focus group, police respond to DFV incidents with their

⁹⁷ The point at which the violence appears to have ended, and the perpetrator assures the victim that it will not happen again.

'investigative head'. In the cognitive interviews, police were asked to rate which items on the DVSAT they thought were important enough to be weighted to contribute more than one point towards a threat rating. Quite systematically, the DVSAT items that police rated as more important refer to chargeable offences, such as physical assault and sexual assault, as opposed to items about DFV dynamics, such as coercion, escalation and jealous behaviours. (see Chapter 4).

Across many sites, the stance of individual officers towards their risk management role in Safer Pathway varied from complete understanding and commitment to the role, an awareness of this role but resistance to the changes it requires (e.g. viewing it as a tool for psychologists, not police) and on occasion, a lack of awareness of the role and how their application of the DVSAT may affect service delivery after an incident.

Understanding how that [DFV] occurs might be different and understanding why you are getting called there 21 times and they're not disclosing to you what's occurring. (NSW Police Officer, police focus group)

Sometimes I feel like I'm collecting data for the ABS. (NSW Police Officer, police focus group)

Lack of understanding of context affects commitment

A lack of training and context given to police during implementation may have affected the commitment police have taken to their role as risk assessors and their administrations of the DVSAT. Some police reported a sense of alienation from their work, and felt as though they had not given a reasonable explanation of why they were expected to incorporate the administration of the DVSAT into their response to DFV incidents.

The biggest gripe a lot of cops had when it first came in was that we couldn't understand how the assessment was made. (NSW Police Officer, police focus group)

Some officers revealed that they were not made aware of the 12-point threshold for a serious threat rating.

The 12 points at serious risk wasn't covered at the time or went over our heads. (NSW Police Officer, police focus group)

Officers expressed a desire to know more about the processes that follow their response to an incident, particularly the outcomes of the DVSATs they administer.

It would be good to know that this is why I am asking these stupid questions – if there had to be some additional training it would be good to see why we are doing what we are doing. (NSW Police Officer, police focus group)

5.4 Victim engagement with Police

The current role of police as the primary entry point for referral into Safer Pathway is a significant barrier for some victims of DFV to seek help with their situation. Police themselves are aware of these barriers.

It's rare for us to find a genuine victim who actually wants to tell you everything that going on. (NSW Police Officer, cognitive interview)

Across all sites, police alluded to a pattern of victim engagement called 'all or nothing': victims of DFV will either talk to police openly about their situation or will not engage at all. This pattern was consistent across each site and is reflected in the CRP data that shows victims of DFV are more likely to refuse to answer all DVSAT items than answer some and refuse others, and that this pattern is consistent across victim subgroups ('No valid DVSAT responses', Table 6).

Although overall completion is high, with valid responses recorded for 12 or more DVSAT items for 87% of intimate victims, the engagement is much lower for some groups. Engagement with police by victims of DFV of Aboriginal background is lower than engagement by non-Aboriginal victims of DFV. Across each subgroup, the engagement of male victims of DFV with police is much lower than female victims of DFV. The difference in engagement between male and female victims of DFV also appears to interact with the Aboriginal subgroup in which 24% of males refuse to answer all DVSAT items compared to 16% of females (a difference of 8%), compared to non-Aboriginal people, where 11% of males refuse to answer compared to 9% of females (a difference of 2%). A similar interaction between gender and subgroup in engagement with police is noticeable for LGBTQI victims (an increase in males refusing to answer all items of 8%), although there is a lower count in this subgroup (Table 6).

Table 6. Engagement with the DVSAT across victim subgroups for victims of intimate DFV referred to Safer Pathway sites between 1 April 2017 and 31 March 2018

| | Non-Aboriginal | | Aboriginal | | CALD | | Disability | | LGBTQI | | Total |
|--|----------------|------|------------|-----|------|------|------------|-----|--------|-----|-------|
| | F | M | F | M | F | M | F | M | F | M | |
| % intimate/ non-intimate | 64% | 48% | 57% | 43% | 65% | 47% | 55% | 40% | 69% | 70% | 58% |
| n | 28884 | 9075 | 4091 | 719 | 4149 | 1244 | 1149 | 159 | 193 | 57 | 53775 |
| No valid DVSAT responses | 9% | 11% | 16% | 24% | 8% | 11% | 8% | 9% | 8% | 14% | 11% |
| Between 1 and 12 valid DVSAT responses | 2% | 2% | 3% | 4% | 2% | 2% | 2% | 2% | 3% | 4% | 2% |
| 12 or more valid DVSAT responses | 89% | 87% | 81% | 72% | 90% | 87% | 91% | 89% | 90% | 82% | 87% |

Source: CRP 2017/18 data.

NOTE: People identified as CALD, having a disability, or LGBTQI may be a subset of Aboriginal and non-Aboriginal people; 20% of records have no data on Aboriginality.

Police explanations for victims not engaging in the DVSAT were consistent across all sites. These included:

- a mistrust of authority
- an awareness of police officers' role as mandatory reporters of children at risk, and a fear that this will lead to the removal of children
- protecting their abusive partner from incrimination
- fear of retribution from partner
- some male victims of DFV not being in fear of their partner.

During site study data collection, many police described a pattern where the victim of DFV reports an incident to police, then does not engage at all with police questioning. Victims appear to call the police in to simply make the incident stop but don't want the perpetrator to be charged.

They just don't want to deal with police... a lot of the victims just won't talk to us. Happens more often than not that the victim calls the police then refuses to talk to them. They call the police to make the immediate incident cease, and if it has ceased then it's job done.
(NSW Police Officer, cognitive interview)

They'll call us and they'll want us to do something for them but then they don't want to give us too much information. (NSW Police Officer, police focus group)

However, for victims of DFV that do engage, the administration of the DVSAT can have a profound effect. The administration of the DVSAT can cause the situation to be identified as DFV for the first time in situations that did not fit victims' own stereotypes of what comprised domestic or family violence e.g. from a husband at threat due to a female partner's mental illness:

...the (police) question about 'is she violent', 'did you feel threatened' ... I didn't know how to answer them... even the suicide threats, I'd never actually considered that a form of domination or control before, so that was interesting, which is surprising because I tend to over-analyse things. I can't believe I'd never seen that before. It's so obvious... (Victim of DFV interview)

In other cases, victims of DFV may have recognised that there were 'elements' of domestic violence in their situation, but only when the DVSAT was administered did they register it as serious enough that they should try to change their situation.

Box 1: Case study—female, victim of intimate partner violence⁹⁸

Cassy is 41 years old. When she was 20, she met Joe and they had two children together. However, they had a dysfunctional relationship and would often argue. Over the years, Joe physically and sexually assaulted Cassy on several occasions. Cassy tried to leave Joe three times, but he would always threaten to harm himself if she did. After several years Cassy decided to leave Joe. She moved with the kids to a new apartment, and had an Apprehended Violence Order (AVO) taken out against him. However, Joe often breached his AVO and had physically assaulted Cassy in her new home.

Normally, Cassy wouldn't call the police because she didn't trust they could help her. However, she was worried about her children and after a particularly violent incident, she decided to call them. When the police spoke to Cassy, she was distressed and couldn't think clearly. They asked her the DVSAT questions and told her a worker from her local Women's Domestic Violence Court Advocacy Services (WDVCAS) would follow up to offer support.

Two days later, Cassy received a text from Alex, the WDVCAS worker, to find a time to talk. Cassy was interested in talking to Alex – she hadn't received any supports or services in the past and didn't know what was available. Cassy's conversation with Alex was extremely helpful. Alex understood Cassy's needs – she was genuine, listened, and offered helpful and objective advice. Cassy didn't realise how common domestic and family violence was, and that she shouldn't feel unsafe in her own home. Alex also explained to Cassy that threats of self-harm were a form of domestic violence.

Alex organised several supports for Cassy. She put her in contact with a worker at the community women's centre, helped her apply for counselling through Victims Services, and organised for someone to inspect her house to fit in new locks, a security peephole and security cameras. She offered to get Cassy financial support or food vouchers, but Cassy said she didn't need these. She also organised for Cassy to access legal aid to take Joe to court.

Cassy was really surprised by all the services available to her. Alex called Cassy a few times after the incident to check how she was going. Now, Cassy gets regular support from the women's centre, her counsellor and her lawyer. Through her conversations with women at the centre, she feels more empowered to take Joe to court. While she won't feel safe until she knows the outcome of her court

⁹⁸ Case studies are composites from multiple victim interviews; names and other details have been changed in each case study to protect the identity, privacy and safety of individuals.

case, Cassy feels reassured knowing she can always call the WDVCS – that someone will listen and care about finding her help.

The tables below set out how these demographic and interpersonal factors cause different outcomes patterns in terms of victims interacting with police.

Factors affecting engagement with Safer Pathway via Police

| Outcome | Context | Mechanism (because) |
|--|--|---|
| Receive DVSAT administered by police | Experiencing violence but not recognising it as a domestic violence situation | 'If this is an official list of actions that comprise "domestic violence", and my situation is described in them, I must be experiencing domestic violence' |
| Engage with Safer Pathway via police | Trust in police, no previous poor experiences with authority | 'Engaging could help me' |
| Lower engagement with Safer Pathway via police | Aboriginal background Mistrust of authority, previous poor experiences of authority | 'Engagement could lead to unwanted consequences' |
| Lower engagement with Safer Pathway via police | Awareness of police role as mandatory reporters of children at risk Personal or cultural history of removal of children | 'Fear of losing children if violence reported' |
| Lower engagement with Safer Pathway via police | Physical assault Reliance on partner's employment income Wanting to maintain relationship | 'Just want the violence to stop, nothing else to change' |
| Lower engagement with Safer Pathway via police | Male victim of DFV with limited fear of perpetrator | 'I can handle it' |

Victims of DFV's reluctance to seek help for DFV for many reasons means the administration of the Police DVSAT will always be challenging. However, the tool performs an important function in threat assessment, triage of victims at higher risk into a more intensive response, and victim understanding of their situation. Redesign of the tool, and increased police understanding of its role and skills in its administration recommended elsewhere in this report should increase engagement of victims of DFV.

5.5 Re-referral

It is a long-established fact that many women make multiple attempts to leave violent partners,⁹⁹ for many reasons, and that violence in intimate relationships frequently reoccurs. It is not surprising then that we found a level of re-referral into Safer Pathway; however, this has not previously been shown across all groups of victims of DFV and relationship types. Overall, 29% of victims of intimate DFV had more than one referral into Safer Pathway, as did 21% of victims of non-intimate DFV.¹⁰⁰

For victims of intimate DFV, women had higher re-referral rates than men (32% cf. 21%), Aboriginal people had double the re-referral rates of non-Aboriginal people (54% cf. 27%) and victims rated 'at serious threat' on their last re-referral had higher re-referral rates than those rated 'at threat' on their last re-referral (50% cf. 27%). At the intersection of these factors, 66% of Aboriginal women last referred 'at serious threat' for intimate DFV had multiple referrals, as shown in Table 8, compared to 19% of non-Aboriginal males last referred 'at threat' for intimate DFV, as shown in Table 7. Women identified as CALD, with a disability or as LGBTQI also had high re-referral rates when rated 'at threat' and 'at serious threat'. Patterns for men in these populations are not as reliable due to low numbers.

⁹⁹ Walker, L.E. (1979). *The Battered Woman*. Harper and Row, New York.

¹⁰⁰ Re-referral rates were calculated by aggregating referrals based on unique victim identifiers. Demographic characteristics were assigned based on if a victim had ever identified with that characteristic. Intimate/non-intimate categorisation and threat level were based on the last incident in the CRP.

Table 7. Re-referral rates for victims of intimate DFV rated 'at threat' by the Police DVSAT on their most recent referral to Safer Pathway

| | Never identified as Aboriginal | | Identified as Aboriginal at least once | | Identified as CALD at least once | | Identified as having a disability at least once | | Identified as LGBTQI at least once | | Total |
|--------------------|--------------------------------|-------|--|-----|----------------------------------|------|---|-----|------------------------------------|-----|-------|
| | F | M | F | M | F | M | F | M | F | M | |
| N | 31564 | 12376 | 2704 | 752 | 4654 | 1537 | 1009 | 163 | 196 | 58 | 47396 |
| Only one referral | 73% | 81% | 44% | 62% | 63% | 68% | 47% | 53% | 52% | 72% | 73% |
| Multiple referrals | 27% | 19% | 56% | 38% | 37% | 32% | 53% | 47% | 48% | 28% | 27% |

Source: CRP 2017/18 data.

NOTE: People identified as CALD, having a disability, or LGBTQI may be a subset of Aboriginal and non-Aboriginal people; 20% of records have no data on Aboriginality.

Table 8. Re-referral rates for victims of intimate DFV rated 'at serious threat' by the Police DVSAT on their most recent referral to Safer Pathway

| | Never identified as Aboriginal | | Identified as Aboriginal at least once | | Identified as CALD at least once | | Identified as having a disability at least once | | Identified as LGBTQI at least once | | Total |
|--------------------|--------------------------------|-----|--|-----|----------------------------------|-----|---|-----|------------------------------------|-----|-------|
| | F | M | F | M | F | M | F | M | F | M | |
| N | 2930 | 284 | 532 | 34 | 462 | 34 | 204 | 11 | 20 | 9 | 3780 |
| Only one referral | 52% | 56% | 34% | 44% | 46% | 53% | 41% | 55% | 25% | 67% | 50% |
| Multiple referrals | 48% | 44% | 66% | 56% | 54% | 47% | 59% | 45% | 75% | 33% | 50% |

Source: CRP 2017/18 data.

NOTE: People identified as CALD, having a disability, or LGBTQI may be a subset of Aboriginal and non-Aboriginal people; 20% of records have no data on Aboriginality.

Similar patterns can be seen for victims of DFV in non-intimate relationships; women had higher re-referral rates than men (24% cf. 15%), Aboriginal people had double the re-referral rates of non-Aboriginal people (39% cf. 19%), and victims rated at 'serious threat' on their last re-referral had higher re-referral rates than those rated as 'at threat' on their last re-referral (31% cf. 20%). At the intersection of these factors, 55% of Aboriginal women last referred 'at serious threat' for non-intimate DFV had multiple referrals, as shown in Table 10, compared to 14% of non-Aboriginal males last referred 'at threat' for non-intimate DFV, as shown in Table 9. Women identified as CALD and women with a disability also had high re-referral rates 'at threat' and 'at serious threat'; patterns for men in these populations and people identified as LGBTQI are not reliable due to low numbers.

Table 9. Re-referral rates for victims of non-intimate DFV rated as 'at threat' by the Police DVSAT on their most recent referral to Safer Pathway.

| | Never identified as Aboriginal | | Identified as Aboriginal at least once | | Identified as CALD at least once | | Identified as having a disability at least once | | Identified as LGBTQI at least once | | Total |
|--------------------|--------------------------------|-------|--|------|----------------------------------|------|---|-----|------------------------------------|-----|-------|
| | F | M | F | M | F | M | F | M | F | M | |
| N | 20997 | 14785 | 2555 | 1012 | 2575 | 1801 | 1016 | 245 | 111 | 34 | 39349 |
| Only one referral | 78% | 86% | 56% | 73% | 67% | 76% | 56% | 58% | 53% | 79% | 80% |
| Multiple referrals | 22% | 14% | 44% | 27% | 33% | 24% | 44% | 42% | 47% | 21% | 20% |

Source: CRP 2017/18 data.

NOTE: People identified as CALD, having a disability, or LGBTQI may be a subset of Aboriginal and non-Aboriginal people; 20% of records have no data on Aboriginality.

Table 10. Re-referral rates for victims of non-intimate DFV rated as 'at serious threat' by the Police DVSAT on their most recent referral to Safer Pathway.

| | Never identified as Aboriginal | | Identified as Aboriginal at least once | | Identified as CALD at least once | | Identified as having a disability at least once | | Identified as LGBTQI at least once | | Total |
|--------------------|--------------------------------|-----|--|-----|----------------------------------|-----|---|-----|------------------------------------|-----|-------|
| | F | M | F | M | F | M | F | M | F | M | |
| N | 820 | 435 | 119 | 38 | 138 | 58 | 70 | 27 | 3 | 4 | 1412 |
| Only one referral | 69% | 77% | 45% | 66% | 58% | 71% | 53% | 78% | 33% | 50% | 69% |
| Multiple referrals | 31% | 23% | 55% | 34% | 42% | 29% | 47% | 22% | 67% | 50% | 31% |

Source: CRP 2017/18 data.

NOTE: People identified as CALD, having a disability, or LGBTQI may be a subset of Aboriginal and non-Aboriginal people; 20% of records have no data on Aboriginality.

Program theory in Safer Pathway does not currently address re-referral, but people working within Safer Pathway understand and expect it. In interviews and focus groups, police, LCP/LSS staff and SAM members all referenced the cycle of violence as a factor in how victims engage, and the need to continue to support victims of DFV through multiple call-outs or contacts, as illustrated in this chapter and Chapters 6 and 7).

As research and service provision for men experiencing intimate partner violence, and for people experiencing DFV in non-intimate relationships increase, we will understand more about the factors that impact on DFV and re-victimisation for these groups. Meanwhile, in

looking at the effectiveness of Safer Pathway, and other victim-focussed programs, it is not appropriate to look at re-victimisation as an indication of program failure, as these programs do not impact upon perpetrator behaviour directly.

In addition, there are many factors that affect whether or not a victim of DFV experiences violence again in the future, only one of which is service engagement and quality. Rather the focus needs to be on the appropriateness and effectiveness of engagement and support, increases in safety planning and the sense of safety for victims of DFV, and the development of knowledge of and links to resources that support victims of DFV to move to a life free from DFV. Some of these measures are discussed in this report to the extent that available data allows in Chapters 5 to 8.

6. Domain 2: Contact and re-administration

This chapter looks at the second outcome domain in the program logic which is concerned with the actions and processes related to making timely local contact with victims of domestic and family violence (DFV) following Central Referral Point (CRP) referral. This contact is prioritised based on the initial threat assessment. The Local Coordination Point (LCP)/Local Support Service (LSS) worker makes a secondary threat assessment using a standard, validated tool, assessing whether they are 'at threat' or 'at serious threat'.

This chapter addresses evaluation questions 1, 2, 3, 4, 5, 6, 8 and 9.

Key findings

- The CRP functions effectively to streamline referrals from police to LCPs/LSSs.
 - It is heavily used by LCP/LSS staff and is considered easy to use.
 - Data completeness for existing variables is high overall, but there are gaps in contact and demographic fields.
- LCPs/LSSs were successful in contacting two-third of victims of DFV referred through the CRP. They were unable to contact one-tenth of victims of DFV due to no contact information, and the remaining quarter did not respond. This data reflects population-level patterns of the willingness of victims of DFV to engage with services.
- Patterns of contact and non-contact showed that women were more likely to be successfully contacted than men, and Aboriginal people were less likely to be successfully contacted than non-Aboriginal people.
- Most workers made contact within one business day of referral, and said it was easy or somewhat easy to contact victims within this timeframe. However, contacting victims of DFV within business hours was a common issue.
- Good working relationships between LCPs/LSSs and Domestic Violence Liaison Officers (DVLOs) was helpful. DVLOs played an important role in facilitating contact through updated information.
- Police informing victims of DFV to expect contact from the LCP/LSS enhanced trust and engagement.
- LCP/LSS workers were very effective in engaging victims of DFV. Victims of DFV described workers as calm, compassionate, non-judgemental and receptive.
- While some victims of DFV are initially unwilling to speak at all, willingness to engage can increase over time as their understanding of their situation and the way support is offered changes.
- Safety and safety planning were discussed with almost all victims of DFV on initial contact. Other frequent topics were victims of DFV's referral needs, child/family issues and court processes.
- LCPs/LSSs re-administered the DVSAT with 30% of intimate and 26% of victims of non-intimate DFV who have been referred into Safer Pathway.
- Women victims of DFV were more likely than men to be upgraded from 'at threat' to 'at serious threat' after LCP/LSS re-administration.

6.1 Initial contact with victims of domestic and family violence

LCPs and LSSs have been successful in contacting two thirds of the victims of DFV referred through the CRP, a high rate given with population level data about low willingness of victims of DFV to engage with services discussed in Chapter 1. This is consistent across victims of intimate and non-intimate DFV. Table 11 shows the proportion of intimate victims contacted by demographic group, plus reasons for non-contact. Table 12 shows the proportion of non-intimate victims contacted by demographic group, plus reasons for non-contact.

The pattern of contact and non-contact was broadly the same across demographic groups for both victims of intimate and non-intimate DFV. Across all groups, in line with population level data about help-seeking (Chapter 1) women were more likely to be contacted than men, despite the LCP/LSS having the correct contact information, with a marked difference found for both Aboriginal and CALD groups.

People with a disability and people who identify as LGBTIQI had the highest contact rates, with over 90% being contacted across both female and male. This is likely to be a result of the contact itself, where those who are contacted are identified as belonging to a demographic group and information is updated, while people unable to be contacted are not identified as part of these groups.

Aboriginal people had the lowest rates of contact compared to other groups. Less than half (37% intimate, 43% non-intimate) of Aboriginal men were contacted by an LCP/LSS. Low contact rates for Aboriginal people, particularly men, were due to a lack of information or incorrect information, with LCPs/LSSs not having the correct information to contact a third of victims (33% intimate, 30% non-intimate). One LCP/LSS worker commented that in their community an Aboriginal young person may be 25 years old and never had a mobile number. Others spoke of Aboriginal communities who have 'shared phones or no service or no phone. Or they don't want to give out their phone number. So, you miss a lot of those victims'.

Table 11. LCP/LSS contact rates across demographic groups for intimate Safer Pathway referrals from 1 April 2017 to 31 March 2018.

| | Non-Aboriginal | | Aboriginal | | CALD | | Disability | | LGBTQI | | Total |
|------------------------------------|----------------|-------|------------|-----|-------|-------|------------|-----|--------|-----|--------|
| | F | M | F | M | F | M | F | M | F | M | |
| % intimate / non-intimate | 64% | 48% | 58% | 43% | 66% | 47% | 55% | 40% | 69% | 70% | 59% |
| n | 28,884 | 9,075 | 4,091 | 719 | 4,149 | 1,244 | 1,149 | 159 | 193 | 57 | 53,775 |
| Contact* | 71% | 59% | 62% | 37% | 90% | 66% | 99% | 94% | 99% | 91% | 65% |
| No contact reason - no information | 8% | 12% | 16% | 33% | 3% | 6% | 1% | 1% | >0% | 2% | 10% |
| No contact reason - no response | 21% | 29% | 22% | 29% | 8% | 28% | >0% | 4% | >0% | 7% | 25% |

Source: CRP 2017 data *Notes: No contact - no information: includes incorrect referral, missing phone number, no contact details at all, phone disconnected, and wrong phone number. No contact - no response: includes identified voicemail, phone rang out, phone turned off, unidentified voicemail, and victim deceased.

Table 12. LCP/LSS contact rates across demographic groups for non-intimate Safer Pathway referrals from 1 April 2017 to 31 March 2018.

| | Non-Aboriginal | | Aboriginal | | CALD | | Disability | | LGBTQI | | Total |
|-----------------------------|----------------|-------|------------|-----|-------|-------|------------|-----|--------|------|--------|
| | F | M | F | M | F | M | F | M | F | M | |
| % intimate / non-intimate | 36% | 52% | 42% | 57% | 34.5% | 53% | 45% | 60% | 31% | 30% | 41% |
| n | 16,599 | 9,802 | 3,026 | 939 | 2,187 | 1,415 | 952 | 241 | 85 | 25 | 37,637 |
| Contact* | 72% | 63% | 60% | 44% | 88% | 70% | 99% | 95% | 100% | 100% | 66% |
| No contact - no information | 8% | 11% | 19% | 30% | 4% | 8% | >0% | 2% | 0% | 0% | 11% |
| No contact - no response | 20% | 26% | 21% | 26% | 8% | 22% | >0% | 3% | 0% | 0% | 23% |

Source: CRP 2017 data *Notes: No contact - no information: includes incorrect referral, missing phone number, no contact details at all, phone disconnected, and wrong phone number. No contact - no response: includes identified voicemail, phone rang out, phone turned off, unidentified voicemail, and victim deceased.

Ease of making contact

The ability of LCP/LSSs to contact victims was the same for victims of intimate and non-intimate DFV across all demographic groups.

Overall, LCP/LSS workers were able to contact the majority of victims of DFV within one business day of referral. Three quarters (77%) of LCP/LSS workers found it easy (most of these gave a qualified 'somewhat') to make contact with victims of DFV within this timeframe, or with at least three attempts to contact within five days.

The main reasons given for not being able to contact victims of DFV (at all or within the timeframes) were lack of accurate contact details and victims of DFV unable or unwilling to be contacted during business hours (which are the hours that LCP/LSSs work) (see below).

The value of making timely contact with a victim of DFV was illustrated by an interview with a victim of DFV who was contacted by the LCP two weeks after the incident occurred. At that time the incident had resolved, and the person did not accept the offer of further support. She commented that she may have gone into the LCP office to talk if the contact had been closer to the incident.

Difficulty contacting during business hours

One-fifth (21%) of LCP/LSS workers reported that contacting victims of DFV during ordinary business hours was a common issue, and two-thirds (68%) said it was an occasional issue. This was confirmed in interviews, with some LCP workers commenting that they only work during usual business hours, making it difficult to contact some victims at a time suitable for them.

When a victim of DFV was unable or unwilling to speak during ordinary business hours, survey responses indicate that LCP/LSS workers most often arranged a new contact time within business hours or provided a number for the client to contact. Less frequently they would arrange a contact time outside of business hours or contact the client using another method (text, email, letter).

Lack of accurate contact details

Where workers find it difficult to make initial contact it is usually because they do not have a correct contact number from the CRP. Workers perceived this to be a common issue and analysis of the CRP data indicated 11% missing or incorrect contact information (and up to 30% for Aboriginal men). Sometimes the number provided is the perpetrators, or the perpetrator is controlling the victim of DFV's phone and may answer it – a possibility workers need to be prepared for. The workforce survey suggested that making initial contact may be more difficult in regional than metropolitan areas, though numbers are small and difficult to interpret. This may correlate with the finding discussed above regarding the lower rate of

initial contact with Aboriginal victims of DFV and the high proportion of missing contact information compared with other groups.

Police are well aware of this issue and note that victims of DFV sometimes choose to give an incorrect contact number to police at the incident or do so accidentally due to the stressful circumstances. In other cases, victims of DFV change their number immediately following the incident, before the LCP/LSS tries to contact them, often on the advice of police so that the offender cannot contact them.

If a false number is provided deliberately, the victim of DFV is self-selecting out of involvement in Safer Pathway. However, given the different ways for a wrong number to enter the system it cannot be assumed that this is the choice being made.

When contact information was not in the CRP, LCP/LSS workers contacted police who were sometimes able to provide a correct number. One worker commented that it would be useful to have a field in the CRP that indicated if the victim of DFV refused to provide their phone number as this would prevent the worker contacting the DVLO, who contacts the duty officer, who checks records and relays the information back through the DVLO to the LSP/LSS worker.

Recommendation

NSWPF and Victims Services work together to support more effective engagement with victims by LCP and LSS workers by:

- investigating strategies to address high rates of non-contact with some groups
- improving the accuracy of contact data for DFV victims in the CRP, and investigating reliable pre-population/ updating of contact numbers in WebCOPS and the CRP
- improving the availability of incident and DFV victim demographic data in WebCOPS and the CRP.

6.1.1 Role of Police in facilitating contact

The Police facilitate making contact with victims of DFV through informing victims of DFV at the time of the incident that they will receive a call from a support service. They also check their records for contact details and other information about victims of DFV and incidents when contacted by LCPs/LSSs.

DVLOs often have access to more detailed and accurate information about victims of DFV and incidents. A good working relationship with DVLOs helps LCPs/LSSs to make initial contact with clients. It gives them a better understanding of cases through information sharing which helps them to build rapport with clients and decrease their fear of the system, so they feel safe to report. This can lead to more effective referrals.

LCP/LSS workers across the state were very positive about the role of DVLOs, with all workers reporting that it was important (13% gave a qualified 'somewhat') to work closely with DVLOs to get additional information to inform professional judgement or service system responses.

The relationship we have with our DVLO is paramount for the best outcome for the client. If the client can gain a trust of both us and the DVLO and can see we are all working on the same page this will give the client more confidence and more understanding of the processes of court and ADVO charges. (LCP/LSS worker interview)

[The] DVLO role seems to be under appreciated in their importance to the process: in training police, in ensuring info is recorded properly, in going to police to follow up information etc. We want the DVLO position to be more prestigious in Police. (LCP/LSS worker interview)

Several people commented on the many responsibilities of DVLOs and that they are 'run off their feet with duties and attending court', but that their capacity to review incidents that come in overnight or over the weekend and ask officers to follow up on missing information, is vital to the success of the program.

In [our area], the merging of Police into a unit with 3-4 DVLOs and a sergeant is great: it means they can share roles and go on more visits and compliance checks, while getting to court. They can better identify needs and take more action. This is really good in the area. (LCP/LSS worker interview)

Interviews with victims of DFV indicated that the initial call from LCP/LSS appeared to work best when the victim of DFV was anticipating the call e.g. when police informed them that the LCP/LSS would call or when the LCP/LSS sent a text prior to calling. This is supported by the literature, which shows that providing enough information to victims about their referral pathway and inter-agency responses helps better engage and empower them and prevents confusion about next steps.¹⁰¹

Victims were less likely to engage if they received the call during business hours to an office environment where the victim of DFV did not feel able to speak freely, or in a situation where the conversation could be overheard by children or others, including (potentially) the perpetrator.

The police told me WDVCS would be ringing me to make sure I was safe... I thought why not, they were calling me to make sure I was alright, they were willing to check on me and make sure whatever happened was dealt with. (Victim of DFV interview)

Unexpected calls raised some suspicion or resistance from some victims of DFV. Sometimes it was apparent that the police may provide the information, but the victim of DFV's agitation and shock at the time of the incident may prevent them from hearing or retaining what has been said.

¹⁰¹ Coy, M. & Kelly, L. (2011). *Islands in the stream*, p. 63; Cussen, T. & Lyneham, M. (2012). *ACT Family Violence Intervention Program review*, p. 72.

It was a surprise. The police might have mentioned that I might get a call from somebody, but at that time I was all over the place, couldn't think straight. The worker rang me a few days after I saw the police, and they were very kind. (Victim of DFV interview)

Recommendation

NSWPF continue to reinforce to police the importance of providing information about LCP/LSS contact through DVSAT and Safer Pathway training.

Box 2: Case study—male, victim of non-intimate DFV¹⁰²

Bill is 60 years old and lives in a small apartment with his 24-year-old son, Josh. As a teenager, Josh had several contacts with the justice system for larceny. Josh and Bill often argued at home. Josh would threaten to be violent towards Bill and to steal his money. Over the years, Bill struggled to find any services in his local areas for male victims of emotional abuse. He felt embarrassed about his situation and blamed himself for Josh's behaviour.

One day, during a loud argument, Bill's neighbours called the police. The police came to the house, defused the argument and completed Part B of the DVSAT in WebCOPS on returning to the police station. Two days later, Bill received a text from his Local Support Service saying that Grace would call him. Grace told Bill that police had informed her of the incident and explained the Safer Pathway process. The call from Grace helped Bill to see that his relationship with Josh was not healthy, and that support was available to help him feel safer at home. Bill was surprised by the menu of supports and services that Grace offered him. While he did not explain his story in great detail to Grace, he felt she understood his situation.

Grace called Bill three more times over the following weeks to check how he was going and if he needed any more support. She facilitated Housing support for Josh to move out. She also gave Bill the number of a counsellor and an empowerment class for men, which he is thinking about attending, and told him about the 1800RESPECT helpline. Grace's non-judgemental and open approach helped Bill feel in control of his situation. While he has not seen a counsellor yet, Bill feels much safer knowing that his Local Support Service is available to help if he ever needs.

¹⁰² Case studies are composites from multiple victim interviews. Names and other details have been changed in each case study to protect the identity, privacy and safety of individuals.

The following table sets out how the factors noted above lead to different outcome patterns in regard to LCP/LSS staff contacting victims of DFV:

| Outcome | Context | Mechanism (because) |
|---|--|---|
| LCP/LSS worker awareness of client situation and needs | Police have detailed and accurate information about victims of DFV and incidents | Good working relationship between DVLO and LCP/LSS based on valuing information sharing |
| More successful initial contacts with clients | Better LCP/LSS worker awareness of client situation and needs | Rapport with clients that helps decrease their fear of system |
| Contact attempted but victim of DFV unwilling to engage | Victim of DFV unaware that call would be made by LCP/LSS | Suspicious, fearful of unknown contact |

6.2 Engaging victims of domestic and family violence

The available evidence shows that LCPs/LSSs are engaging victims of DFV according to the guidelines. Victims of DFV reported that they found LCP/LSS workers to be calm, compassionate and non-judgemental, as well as receptive to their wishes. This helped to build trust and rapport. They also found them to be reliable in following through on what they said they would do, which increased confidence in them and the system.

| Outcome | Context | Mechanism (because) |
|--|---|--|
| Client satisfaction with services. Willingness to re-engage later if/as required | Worker calm, compassionate, non-judgemental, demonstrates belief in victim of DFV's capacity to judge own needs | Client agency to make choices |
| Increased willingness to engage with services | Take situations/offences seriously | Recognition of perpetrator behaviours as DFV |

6.2.1 Diversity of victims of DFV and situations

Anecdotal data from interviews with LCP and LSS workers provided some insights into the range of people and circumstances they encounter in their work, and some of the challenges and complexities that they face. These include different forms of male-on-male violence within families and blended families, child-on-parent violence, violence resulting from mental health or disability, and challenges and cultural differences for people from low socioeconomic backgrounds, Aboriginal, CALD and LGBTQI families and individuals.

LSS workers spoke about the diversity of DFV situations that are referred to them, including violence from sons towards their parents, violence between siblings and friction within

blended families – ‘step parents, step siblings, step sons’. They commented on bi-directional violence, and that when men acknowledge that they contributed to the situation, they are more reluctant to answer ‘yes’ to the items on the DVSAT, indicating victim of DFV status.

People with mental health issues or autism who act out violently at times present a group of people where the victims of DFV, while wanting the violence to end, remain loyal to their family member and want more than anything for them to receive medical treatment for their condition. In some cases, there have been long-term efforts to access support and/or resources for their family member (often a child). Workers report that when families have been connected to services for a long time, but have not made any progress, they will just answer ‘no’ to questions, indicating a level of resignation.

How do you differentiate DV with no mental health issues versus those suffering from disabilities and autism? (LCP/LSS interview)

Workers also observed that families with education and resources were more willing to engage with family therapy, for example, to help their 14-year-old child, because they know that the more they engage, the more services they might access. Workers also argued that these families are less concerned overall about coming under scrutiny. In contrast, families of lower socio-economic status are more likely to ‘be on the back foot’ and have greater fear of scrutiny or other negative outcomes (such as child protection) and are less likely to engage. This fear or mistrust of state agencies may be the result of previous negative experiences, particularly for victims who identify as Aboriginal or who do not have permanent residency.¹⁰³

One CALD worker commented on seeing an attitude of ‘what happens in the family stays in the family’, so that people try to work out DFV internally rather than seek (or accept) external support. For newer arrivals this could also reflect a lack of understanding and trust of local service systems, including police.

Another worker observed that sometimes LGBTQI people may not identify DFV issues because the discourse is gendered (and heteronormative). There can also be complexity around identifying as LGBTQI, especially to police as there is often a high degree of caution and mistrust. LSS workers reported that often LGBTQI status is not recorded in the CRP. This can disrupt the initial contact, as workers explain that there is a specific service for this cohort that will contact them instead.

The experiences described demonstrate an ongoing need for targeted staff training to ensure cultural competency and understanding of different community groups. Studies make strong

¹⁰³ Shorey, R.C., Tirone, V. & Stuart, G.L. (2014). Coordinated community response components for victims of intimate partner violence: A review of the literature. *Aggressive and Violent Behavior*, 19(4): 363-71.

arguments for the benefits of targeted training (including the input of service users) in addressing the needs of victims of DFV from minority groups.¹⁰⁴

Box 3: Case study—male, victim of intimate DFV

Adrian is 39 years old. Ten years ago, Adrian met Julia. The couple moved into a small house in suburbs and had two children, now five and seven years old. Soon after Adrian met Julia, she was diagnosed with bipolar disorder and began physically assaulting Adrian. Sometimes the assault would happen in front of the kids. Adrian was not sure where to go for support. He was worried about his wife's mental health and did not want to 'dob' her in to the authorities.

Over time, Julia's violence worsened and Adrian began to fear for the physical and emotional safety of himself and his children. Following a serious incident, he called the police. The police visited Adrian's home and asked him the DVSAT questions. Adrian felt relieved that the police showed concern. They were professional and forthright in their approach.

A few days later, Adrian received a call from a worker at his Local Support Service, Zoe. Zoe told Adrian that the police had reported the incident and asked how he was going. Zoe explained she could get Adrian legal advice to ensure the safety of him and his kids, and free counselling sessions. Adrian did not think he needed counselling, so was comforted when Zoe did not push him to take up the offer. He trusted Zoe – she was kind and had lots of useful information.

Zoe stayed in contact with Adrian in the weeks following the incident. Each time she called, Zoe offered Adrian the free counselling and after talking to his friends about it, Adrian decided to take up the offer.

Since the incident, Adrian and the kids continue to live with Julia. Through counselling, Adrian feels better equipped to manage and diffuse aggressive situations

The table below sets out the outcome pattern caused by these demographic factors:

| Outcome | Context | Mechanism (because) |
|--|---|---|
| Engage with LCP/LSS as gateway to access services | Mid-high socio-economic status | 'Engaging will give us access to resources that could help' |
| Lower engagement with LCP/LSS as gateway to services | Mistrust of authority, previous poor experiences of authority | Low socio-economic status |
| | Cultural norm: Family matters stay within the family | CALD background |
| | Lack of awareness of services or fear of discrimination | LGBTQI Heteronormative discourse |

¹⁰⁴ Healey, L., Howe, K., Humphreys, C., Jennings, C. & Julian, F. (2008). *Building the Evidence: A report on the status of policy and practice in responding to violence against women with disabilities in Victoria*. p. 10; State of Tasmania. (2009). p. 57; Aboriginal Family Violence Prevention and Legal Service Victoria. (2010). *Strengthening on-the-ground service provision for Aboriginal and Torres Strait Islander victims/survivors of family violence and sexual assault in Victoria*, FVPLS Victoria, p. 65; Cussen, T. & Lyneham, M. (2012). *ACT Family Violence Intervention Program review*, p. 28; Breckenridge, J., Rees, S., Valentine K, & Murray, S. (2015). *Meta-evaluation of existing inter-agency partnerships, collaboration, coordination and/or integrated interventions and service responses to violence against women: State of knowledge paper*, p. 21-26.

6.2.2 Ability to engage victims of DFV

Engagement with victims was explored in part through the workforce survey. To understand how well victims of DFV are engaged by LCP/LSSs, we looked at responses across all workers as well as any differences in engagement between LCPs (with female victims of DFV) and LSSs (with male victims of DFV). As there were substantial differences in the number of respondents from each service type (LCP: n=45; LSS: n=8), interpretations of differences must be made with caution and supported by evidence from other sources, such as interviews.

For the most part, where services are able to contact victims of DFV, victims of DFV are willing to speak with them. Only 13% of LCP/LSS workers reported that victims they contacted were commonly unwilling to speak to them at all; 57% reported victims of DFV were occasionally unwilling. LCPs with an Aboriginal specialist worker were more likely to 'occasionally' have victims of DFV who were unwilling to speak at all compared with those without (71% cf. 36%), and less likely to find this a common occurrence (3% cf. 27%). This suggests that Aboriginal specialist workers are effective in facilitating the engagement of Aboriginal victims of DFV, which is significant given that victims of DFV are less likely to engage where there is a fear or mistrust of state agencies because of a history of state violence.¹⁰⁵ LCPs/LSSs in regional areas were more likely to 'occasionally' find victims of DFV who were unwilling to speak at all compared with metro areas (76% cf. 47%), while metro areas were more likely to 'rarely or never' have this issue compared with regional areas (39% cf. 12%).

When a victim of DFV was unwilling to speak to the service at all, survey responses showed that LCP workers were most likely to provide victims of DFV with the contact details of the service and inform them that they can re-contact the service at a later time if they wish (45%), close the referral while keeping notes on the client for potential future incidents (19%); or attempt contact through another method (SMS, letter) (14%). Some respondents (10%) said that they will discuss the program generally. This was the most frequent response from LSS workers, along with closing the referral.

Recommendation

Legal Aid NSW and Victims Services review the availability of Aboriginal specialist worker positions and identify how to address availability gaps in areas with high Aboriginal populations to facilitate greater contact and engagement with Aboriginal victims of DFV.

Topics of discussion

To understand the circumstances of victims of DFV and engage them in the service, workers reported discussing a wide range of topics over the phone. The three most common topics of conversation for LCP and LSS workers were the victim of DFV's safety/safety planning (98%), their referral needs (74%) and child/family issues (64%). Other topics included court

¹⁰⁵ State of Tasmania. (2009).

processes (62% of LCP workers), the emotional state of the client and the decisions they were thinking of making, police process, housing and accommodation. LSS also commonly discussed the relationship between the victim of DFV and the POI, and information about DFV more broadly and their history with DFV. These topics are appropriate, given the aims of Safer Pathway.

6.2.3 Success factors for victim engagement

Worker knowledge and approach

LCP workers commented on the importance of being compassionate and non-judgemental and using trauma informed-practice when interacting with victims of DFV. They also commented on the importance of having good knowledge of DFV and using this to educate victims (informally) about DFV and its dynamics. They noted that this can be a long process.

Interviews with victims of DFV also emphasised the non-judgemental approach of LCP/LSS workers. This was especially important when the victim of DFV was feeling pressure from family or friends to make a particular decision. They reported feeling as though they had genuine agency in the service response they received, which was highly valued (and for some, different to previous negative experiences with the service system). All interviewees understood that they could say 'no', and that they would be believed if they said they did not need services. The workers left the impression of being genuinely interested in the victim of DFV's physical and emotional needs.

She [LCP worker] was lovely, genuine and I could tell she was trying to help me. I feel like I was heard, I feel like she listened to all my problems and my issues that I had and understood. (Female victim of DFV interview)

[Person's name] rang me – every time he rings he has such a nice manner about him, not pushy, I hate pushy people. He backed off when I said I was okay and said I can handle it, he said 'that's good, we're here for you, we're just a phone call away'. (Male victim of DFV interview)

Willingness of victims of DFV to engage

The willingness of victims of DFV to engage was a major factor in successful outcomes. This can and does change over time for many people. Staff commented that the impact on children is frequently the factor that causes victims of DFV to reach a 'tipping point', so they become willing to engage with services and face the difficulties of changing their situation. Impact on children can include changes in their behaviour, such as mimicking the behaviour or language of the perpetrator. This was supported by interviews with victims of DFV.

The last straw was the domestic violence occurred in front of the children – they're getting older and I couldn't let them live with that and think that this is okay to happen. (Victim of DFV interview)

[Decided to engage] because they're offering help, I'm a single father with three kids ... I'm not as uptight at home if I have support. (Victim of DFV interview)

Other staff referred to this as being 'ready to realise'. Sometimes people recognise that the violence will get worse if the issue is just left, so it is better to engage. Some women recognise retrospectively, for example during custody battles, with Family Law helping to make community standards clearer to them. If they are not ready, their language will indicate their ambivalence (e.g. 'I made him angry').

Some LCP staff also commented that religious beliefs can be a barrier for women recognising their situation and/or wanting to take action. Workers' approach is informed by an understanding of the cycle of violence. They offer non-judgemental support and expect many victims of DFV may not be ready to engage after the first incident. This is reflected in re-referral rates (see section 5.5).

A new perspective on the situation

For some victims of DFV, the actions of the police and the LCP/LSS in responding to their situation was a strong indicator that what had happened was not 'normal' or 'okay'. The concern shown by police sometimes helped the victim of DFV to take their own situation seriously. Sometimes the DVSAT questions bring to the surface other behaviours and reveal a pattern of behaviour that was not recognised or named before. As one person said, 'It was real, not all in my head'. This recognition leads to engagement, not always immediately, but perhaps at the next incident, or within a few months.

People often don't engage, and I give them my number to call in future if they want support – and we get people calling months later asking for support. Knowing where to go if and when they want support is the best part of this. (LCP/LSS worker)

One male victim of DFV spoke about accepting the result of the DVSAT, but at the same time recognising that his wife's mental health is the cause of her behaviour, and this is not really 'her'.

Yes, definitely [the DVSAT changed the way I looked at the situation]. It's just my wife, she suffers from bipolar, it's not my wife, her illness has changed her. I was in two minds about the way I was answering these questions because, on one hand my wife is not that person who was involved in that incident; it's a mental state when it happened which is a different mental state when she's normal. (Male victim of DFV)

Box 4: Case study – female, victim of non-intimate DFV

Sandra is a 45-year-old, single mother of two boys, aged 15 and 17. After leaving her abusive husband three years ago, Sandra now lives in with her younger son, Zach. Her eldest son, Jake, moved out of home this year to live with friends, but comes home to visit about once a week. Jake has a history of drug use. After his parents' divorce, Jake started using ice. He is sometimes violent towards Sandra, mostly when he cannot access drugs or is 'coming down'.

One night, Jake became increasingly agitated and, in an ice-induced psychosis, attempted to assault Sandra with a kitchen knife. Sandra hid and called the police immediately. When the police arrived, Sandra was extremely distressed. They asked about her relationship with Jake, if she wanted to press charges and if she felt safe for the night. Sandra explained that Jake had never been this violent before. The police recorded details of the incident and completed Part B of the DVSAT in WebCOPS on returning to the police station. They explained to Sandra that drugs were likely to have caused Jake's violent behaviour and that supports were available for both of them.

One week later, a worker from Sandra's local LCP, Adama, contacted her to see how she was going after the incident. Adama explained the supports and services with which she could be linked. She reassured Sandra that Jake's actions were not her fault. Sandra explained that she did not want to press charges and Adama did not pressure her to. Instead, she gave Sandra information about a legal centre that she could access if she ever needed to in future. She also gave Sandra the details of a local women's centre, as starting point for support. She suggested that Jake see a counsellor, and also offered to sign him up to a free local kick boxing class.

Now, Sandra regularly attends the local women's centre, and Jake has started attending counselling and kick boxing. She does not see Jake as often anymore, and she will not allow him to visit the family home until his addiction is safely managed. While this deeply upsets Sandra, her time with other victims of DFV at the centre has helped her to see that Jake is not the same person when taking drugs. While change is slow, knowing that she can contact the centre for non-judgmental advice and support has helped Sandra more confident about the future.

The table below displays the outcome pattern caused by factors related to victim of DFV readiness to engage:

| Outcome | Context | Mechanism (because) |
|-------------------------------------|---|--|
| Willingness to engage with services | Ongoing DFV | Increasing belief that violence will not stop and may worsen |
| Willingness to engage with services | DFV in front of children | Protectiveness for children Fear of children modelling on violent behaviour |
| Reluctance to engage with services | Religious beliefs relating to sanctity of relationships | 'I cannot do what my religion would not approve of' |

6.2.4 Use of interpreters

Overall, LCP/LSSs used interpreters when they were able, although this was not always possible, particularly in regional areas. It is not clear why interpreters were more difficult to access in regional areas, noting that a telephone interpreter service is used.

Information-sharing about the need for interpreters was poor. Over two-thirds (70%) of LCP/LSS workers reported they 'rarely or never' had accurate information about needing an

interpreter to speak with a victim of DFV before calling them, and only 11% reported that they 'commonly' had this information. This finding was supported by interviews where it was noted the 'language' field in the CRP was usually not completed.

LCP/LSS workers in regional areas were more likely to report rarely or never having accurate information regarding the need for an interpreter (86%) compared to those in metropolitan areas (64%).

Despite poor prior knowledge of the need for an interpreter, about half (53%) of workers reported they were commonly able to engage an appropriate interpreter within 24 hours. Workers in metropolitan areas had greater success engaging interpreters (63%) than those in regional areas (22%). The DVSAT was administered in a language other than English by one-third of LCP/LSS respondents (31%) (with or without an interpreter), all in metro areas.

6.2.5 Improving CRP data for engagement

Engagement with victims of DFV could be further supported by the CRP data if it included accurate information on Apprehended Violence Orders (AVOs), including the conditions and court dates. Demographic information (e.g. gender, Aboriginal, CALD, person with disability, LGBTQI, language spoken at home) would enable the LCP/LSS worker to offer specialist services where they are available locally, or prepare them to provide interpreter services.

Having access to the police narrative and/or the history tab on the CRP helps to provide a context to the current incident, which can help the worker to provide appropriate, trauma-informed and tailored services with the victim of DFV when they call and prevent them from needing to re-tell their story. Currently, LCPs only receive this narrative where there is an Apprehended Domestic Violence Order (ADVO) application, and sometimes when there is a charge. This means that for a large number of referrals, workers know very little about the incident that precipitated the call.

The literature highlights the importance of sufficiently comprehensive and accurate data collection, including of demographic information, to appropriately identify and address the needs of victims of DFV.¹⁰⁶ A literature review of trends in inter-agency responses to DFV highlights that inter-agency responses can be compromised when there is a lack of access to the data or records of other agencies – accurate, centralised systems facilitate better responses.¹⁰⁷

6.3 Re-administering the DVSAT

As part of their engagement with victims, LCP/LSS workers re-administer the DVSAT to identify who should be included on the SAM agenda. Overall, the CRP database has records

¹⁰⁶ State of Tasmania. (2009).

¹⁰⁷ Mulroney, J. (2003), *Trends in Inter-agency Work*, Australian Domestic and Family Violence Clearinghouse, Sydney, p. 13-14.

of an LCP DVSAT for just under one-third (30%) of victims of intimate DFV and one-quarter (26%) of victims of non-intimate DFV. This rate is lower than expected in program theory.

Engagement with victims of DFV in re-administration of the LCP/LSS DVSAT is affected by the same patterns of reluctance of victims of DFV to engage with services that have been described at all levels of Safer Pathway, and LCP/LSS workers described in interviews and focus groups the priority of building an effective relationship, assisting victims of DFV with basic safety planning advice, and providing contact information for support services over re-administering the DVSAT. Additionally, it is possible that LCP/LSS workers are re-administering the DVSAT much more frequently than CRP data indicates but are not uploading the results into the CRP.

6.3.1 Frequency of re-administration

For victims of intimate DFV referred into Safer Pathway, the frequency of LCPs/LSSs re-administering the DVSAT is shown in Table 13. In most demographic groups (non-Aboriginal, Aboriginal, CALD), men were more likely to be contacted, but not have the DVSAT re-administered. This will be in part a function of the lower rates of LCP/LSS contact of these groups, discussed above. This pattern was also observed for victims of non-intimate DFV (see Table 14).

Table 13. Re-administration of the DVSAT for victims of intimate DFV contacted by Safer Pathway LCP/LSSs between 1 April 2017 and 31 March 2018.

| | Non-Aboriginal | | Aboriginal | | CALD | | Disability | | LGBTQI | | Total |
|----------------------------------|----------------|------|------------|-----|------|------|------------|-----|--------|-------|-------|
| | F | M | F | M | F | M | F | M | F | M | |
| % intimate / non-intimate | 64% | 48% | 58% | 43% | 66% | 47% | 55% | 40% | 69% | 69.5% | 58% |
| N | 28884 | 9075 | 4091 | 719 | 4149 | 1244 | 1149 | 159 | 193 | 57 | 34195 |
| Record of LCP DVSAT | 38% | 18% | 38% | 15% | 60% | 26% | 74% | 77% | 67% | 81% | 30% |
| No record of LCP DVSAT | 62% | 82% | 62% | 85% | 40% | 74% | 26% | 23% | 33% | 19.3% | 70% |

Source: CRP 2017/18 data.

NOTE: People identified as CALD, having a disability, or LGBTQI may be a subset of Aboriginal and non-Aboriginal people; 20% of records have no data on Aboriginality.

Table 14. LCP re-administration of the DVSAT for non-intimate victims contacted by Safer Pathway LCP/LSSs between 1 April 2017 and 31 March 2018.

| | Non-Aboriginal | | Aboriginal | | CALD | | Disability | | LGBTQI | | Total |
|----------------------------------|----------------|-------|------------|-------|------|------|------------|-------|--------|-------|-------|
| | F | M | F | M | F | M | F | M | F | M | |
| % intimate / non-intimate | 36% | 52% | 43% | 57% | 35% | 53% | 45% | 60% | 31% | 30% | 42% |
| N | 16599 | 9802 | 3026 | 939 | 2187 | 1415 | 952 | 241 | 85 | 25 | 24376 |
| Record of LCP DVSAT | 33% | 18% | 31% | 18% | 54% | 22% | 66% | 66% | 64% | 60% | 26% |
| No record of LCP DVSAT | 67% | 82.2% | 69% | 82.4% | 46% | 78% | 34% | 34.0% | 36% | 40.0% | 74% |

Source: CRP 2017/18 data.

NOTE: People identified as CALD, having a disability, or LGBTQI may be a subset of Aboriginal and non-Aboriginal people; 20% of records have no data on Aboriginality.

Recommendations

Legal Aid NSW and Victims Services explore options to increase LCP/LSS DVSAT re-administration rates for vulnerable groups.

6.3.2 Outcomes of re-administration

Re-rating threat to victims of DFV

Women victims of intimate DFV were more likely than men to be upgraded from 'at threat' to 'at serious threat' after LCP/LSS administration of the DVSAT, with this gender difference remaining steady across non-Aboriginal, Aboriginal, CALD and disability groups (see Table 15). This pattern was also observed for victims of non-intimate DFV (Table 16). However, the proportion of non-intimate victims of DFV upgraded to 'at serious threat' was lower across all demographic groups. The re-grading by LCP/LSSs is based on updated DVSAT scores and professional judgement (see Chapter 4).

Interviews with LSS staff suggested that DVSAT's 'at serious threat' are often downgraded to 'at threat'. However, this is not reflected in the data below, which shows that overall, 5% of matters were downgraded. Both LCP and LSS staff noted that if they downgraded someone from 'at serious threat', they still included them on the SAM agenda for noting.

Table 15. Outcome of LCP DVSA re-administration for victims of intimate DFV.

| | Non-Aboriginal | | Aboriginal | | CALD | | Disability | | LGBTQI | | Total |
|--|----------------|-------|------------|-------|-------|-------|------------|-------|--------|-------|-------|
| | F | M | F | M | F | M | F | M | F | M | |
| % referrals with LCP DVSA | 37.6% | 17.5% | 38.1% | 15.4% | 60.2% | 26.0% | 74.2% | 77.4% | 67.4% | 80.7% | 30.5% |
| N | 10853 | 1591 | 1557 | 111 | 2499 | 324 | 853 | 123 | 130 | 46 | 16423 |
| Stayed at 'at threat' | 66.8% | 87.9% | 53.6% | 73.0% | 75.2% | 92.9% | 58.5% | 82.9% | 76.2% | 73.9% | 66.5% |
| Stayed at 'at serious threat' | 16.2% | 6.2% | 24.3% | 11.7% | 10.4% | 4.0% | 19.8% | 6.5% | 10.8% | 10.9% | 17.0% |
| 'At threat' re-graded to 'at serious threat' | 12.5% | 2.5% | 13.2% | 4.5% | 12.1% | 2.2% | 17.2% | 7.3% | 10.8% | 10.9% | 11.1% |
| 'At serious threat' re-graded to 'at threat' | 4.5% | 3.4% | 9.0% | 10.8% | 2.4% | .9% | 4.5% | 3.3% | 2.3% | 4.3% | 5.3% |

Source: CRP 2017/18 data.

NOTE: People identified as CALD, having a disability, or LGBTQI may be a subset of Aboriginal and non-Aboriginal people; 20% of records have no data on Aboriginality.

Table 16. Outcome of LCP DVSA re-administration for victims of non-intimate DFV.

| | Non-Aboriginal | | Aboriginal | | CALD | | Disability | | LGBTQI | | Total |
|--|----------------|-------|------------|-------|-------|-------|------------|-------|--------|-------|-------|
| | F | M | F | M | F | M | F | M | F | M | |
| % referrals with LCP DVSA | 33.3% | 17.8% | 30.7% | 17.6% | 53.8% | 22.3% | 66.2% | 66.0% | 63.5% | 60.0% | 25.9% |
| N | 5532 | 1748 | 928 | 165 | 1176 | 316 | 630 | 159 | 54 | 15 | 9743 |
| Stayed at 'at threat' | 87.5% | 86.4% | 85.5% | 77.6% | 90.1% | 87.7% | 86.7% | 80.5% | 92.6% | 86.7% | 86.2% |
| Stayed at 'at serious threat' | 6.1% | 7.5% | 7.0% | 10.3% | 4.3% | 7.0% | 6.0% | 11.9% | 3.7% | 13.3% | 6.9% |
| 'At threat' re-graded to 'at serious threat' | 3.3% | 1.1% | 3.2% | .6% | 3.1% | 0.0% | 4.9% | .6% | 1.9% | 0.0% | 2.9% |
| 'At serious threat' re-graded to 'at threat' | 3.0% | 5.0% | 4.3% | 11.5% | 2.6% | 5.4% | 2.4% | 6.9% | 1.9% | 0.0% | 4.0% |

Source: CRP 2017/18 data.

NOTE: People identified as CALD, having a disability, or LGBTQI may be a subset of Aboriginal and non-Aboriginal people; 20% of records have no data on Aboriginality.

Supporting SAM prioritisation

Almost all (96%) SAM members who responded to the workforce survey were positive about the processes for identifying victims of DFV for the SAM agenda leading to effective prioritisation of the most serious cases, with 59% saying the processes work 'very well'.

7. Domain 3: Referral and case coordination

This chapter looks at the third outcome domain in the program logic which is concerned with referrals and case coordination by Local Coordination Points (LCPs)/Local Support Services (LSSs) for victims of domestic and family violence (DFV) at all threat levels.

This chapter addresses evaluation questions 1, 2, 3, 4, 5, 6, 7 and 8.

Key findings

- Of those contacted, about half of victims of intimate and non-intimate DFV received referrals – either a supported referral or information-only. This data reflects population-level trends in reluctance to receive help from DFV services.
 - Women were more likely to receive referrals or information than men, across all groups (64% of non-Aboriginal women and 61% of Aboriginal women)
 - One-fifth of Aboriginal men and one-quarter of non-Aboriginal male victims of DFV who were contacted received a referral or information
 - Victims of DFV in regional areas were more likely to receive referrals than metro areas.
- Two-thirds of referrals for victims of intimate DFV were supported referrals, whereas half of referrals for victims of non-intimate DFV were for information only.
- LCPs made more warm referrals than LSSs, who reported a lack of local services to refer male victims of DFV to and relied more on national support and advice lines.
- LCPs with Aboriginal specialist workers were also more likely to make supported referrals than those without.
- Most referrals by LCPs connected victims of DFV to a new service, suggesting a new or broader approach to their situation.
- LCPs/LSSs can experience difficulty in identifying services to refer victims of DFV to, particularly Aboriginal people and males.
- Referral type (i.e. supported versus information only) provided by LCPs appropriately matched victims of DFV's threat ratings—those 'at serious threat' were more likely to receive supported referrals than those rated 'at threat'.
- LCPs in small towns and remote areas made supported referrals at a higher rate than the LCPs in cities or large towns.
- Partner agencies and victims of DFV were very positive about the Safer Pathway case coordination. Common gaps were case management service (especially in small towns/regional areas), mental health services (especially for LSSs) and housing or crisis accommodation.
- There are high rates of workers continuing to provide or coordinate support for a victim of DFV after closing their case on the CRP, though this happened more at LCPs.
- LCPs/LSSs and partner agencies described a wide range of appropriate safety outcomes for victims from referrals and case coordination.

7.1 Referrals

LCP staff report their main goal as trying to achieve safety for the victim of DFV and their family. This includes many practical considerations e.g. accommodation, food, enlisting support of trusted neighbours, installing cameras, having a reliable phone, changing locks as well as emotional, psychological, medical or financial support. Based on their initial contact with victims of DFV and their understanding of needs, LCP and LSS workers make either a warm (supported) referral to a local service or provide an information-only referral. Of those contacted, about half (53% of victims of intimate DFV and 44% of victims of non-intimate DFV) received referrals – either a supported or information-only. Workers commented that they do not have brokerage funding to provide practical assistance.

For victims of both intimate and non-intimate DFV, women were more likely to be provided referrals than men (across all demographic groups). Between one-fifth and one-quarter of male victims who were contacted received a referral or information, with Aboriginal men slightly less likely to receive a referral than other male victims (see Table 17).

Victims in regional locations were more likely to receive referrals than victims in metropolitan areas – 61% of victims of intimate DFV in small towns and remote areas received referrals, compared to 50% of victims of intimate DFV in major cities and large towns; and 53% of victims of non-intimate violence in small towns and remote areas received referrals compared to 40% of victims of non-intimate violence in major cities and large towns.

Table 17. Information and referrals provided for victims of intimate and non-intimate DFV

| | | Non-Aboriginal | | Aboriginal | | CALD | | Disability | | LGBTQI | | Total |
|--------------|----------------------------------|----------------|-------|------------|-----|-------|-------|------------|-----|--------|-----|--------|
| | | F | M | F | M | F | M | F | M | F | M | |
| Intimate | N | 20,044 | 5,314 | 2,439 | 265 | 3,558 | 806 | 1,120 | 147 | 187 | 52 | 34,195 |
| | Information or referral provided | 64% | 25% | 61% | 21% | 73% | 32% | 80% | 65% | 71% | 64% | 53% |
| | Other contacted | 36% | 75% | 39% | 79% | 27% | 67.6% | 20% | 35% | 29% | 36% | 47% |
| Non-intimate | N | 11,689 | 6,129 | 1,758 | 406 | 1,845 | 973 | 929 | 227 | 82 | 25 | 24,376 |
| | Information or referral provided | 59% | 21% | 56% | 21% | 67% | 24% | 77% | 44% | 82% | 40% | 44% |
| | Other contacted | 42% | 79% | 44% | 80% | 33% | 76% | 23% | 56% | 18% | 60% | 56% |

Source: CRP 2017/18 data.

NOTE: People identified as CALD, having a disability, or LGBTQI may be a subset of Aboriginal and non-Aboriginal people; 20% of records have no data on Aboriginality.

7.1.1 The referral process

Drawing on samples of outgoing referral data from six LCP sites¹⁰⁸, we can better understand where LCPs are making referrals to, the types of referrals they are providing, referral take up rates, and LCP worker and victim of DFV experiences of the referral process. As all sites were LCPs, we are unable to examine the LSS referral process at this level. However, the workforce survey and interviews provided insights into LSS workers' experiences of the process.

Analysis of a sample of LCP referral records shows LCPs most commonly provided referrals directly to victims of DFV – 91% of intimate DFV referrals and 82% of non-intimate DFV referrals. Victims of DFV's children were the second most common subject to receive a referral (7% for both intimate and non-intimate DFV referrals). For non-intimate DFV, adult-child perpetrators were an equally common subject of referrals (7%), highlighting the importance of services appropriate for both victims of DFV and perpetrators.

¹⁰⁸ Three in cities/large towns and three in small towns/remote areas.

7.1.2 Referral types

The LCP Manual preferences making warm (supported) referrals over information-only support. A sample of LCP referral data from 2017 shows that victims of intimate DFV were more likely to receive a supported referral (65%) than information-only (35%). Conversely, just over half of victims of non-intimate DFV receive an information-only referral (54%) rather than a supported referral (46%) (see Table 18). This may reflect a disparity in the services that are suitable for intimate and non-intimate domestic violence, and the availability of services in some areas. It may also reflect a difference in the willingness of the victim of DFV to receive further support at that time.

The provision of supported referrals depends on the availability of services as well as the willingness of the victim of DFV to receive support. There may be a service gap in some locations. Also, some high demand services are difficult to access in a timely way as the existing services are often at capacity e.g. caseworker services and mental health services.

In other situations, families may already be receiving external support for mental health or disability issues, and so do not need a referral for these. For example, interviews commented on situations of non-intimate violence that involved mental health issues or autism of a child, where families were already seeking whatever treatment or support was available.

Table 18. Type of outgoing referral given by the client relationship to POI

| Info/ Referral* | Intimate | | Non-Intimate | |
|--------------------|----------|------|--------------|------|
| | Count | % | Count | % |
| Supported referral | 275 | 65% | 94 | 46% |
| Information-only | 146 | 35% | 111 | 54% |
| Total | 421 | 100% | 205 | 100% |
| Missing | 44 | | 23 | |

Source: LCP referral data *Note: Sample data is for last incoming referral in 2017.

When providing referrals (both supported and information-only), LCP workers indicated a reason for that referral. For all victims, 'support' was the most common reason, followed by 'information/advice'. However, 'information/ advice' was more common for victims of non-intimate DFV, which may reflect a lack of services appropriate for this group, or different needs. Victims of intimate DFV were more likely to be referred to case-management services, although 12% of victims of non-intimate DFV were also referred for case management (see Table 19).

Table 19. Reasons for outgoing referrals by relationship type

| Referral Reason | Intimate | | Non-Intimate | |
|------------------------------|----------|------|--------------|------|
| | Count | % | Count | % |
| For support | 200 | 48% | 98 | 48% |
| For information/ advice | 114 | 27% | 77 | 38% |
| For case management | 81 | 19% | 25 | 12% |
| To implement a safety action | 26 | 6% | 3 | 2% |
| Total | 421 | 100% | 203 | 100% |
| Missing | 44 | | 25 | |

Source: LCP referral data.

The workforce survey suggests the frequency of supported referrals differed between LCPs and LSSs (see Table 20). While most (81%) of LCP workers reported ‘commonly’ making supported referrals for victims of DFV, LSS workers reported ‘occasionally’ making supported referrals (note that the number of LSS respondents was low [n=8] and so may not be representative). The reasons are unknown, but could reflect different needs, LSS resourcing levels, a lack of local services available for male victims of DF, and their reliance on national support or advice helplines. LSS workers commented in interviews that ‘there’s no court advocacy for men, no housing for male victims specifically, and if they have children it’s even harder because SHLV¹⁰⁹ are just for women.’ However, it could also reflect some reluctance by men to accept referrals, as suggested in one interview:

Sometimes it’s just a phone call; they don’t want anything. Because we’re over the phone as well, I think men are less inclined to talk to their families and support networks, and are more willing to talk to a stranger over the phone who’s not from their town. We’ve had so many who have just let all of their stuff out over the phone. (LSS worker interview)

LCPs with an Aboriginal specialist worker were more likely to make warm referrals to services than those without (90% ‘commonly’ made warm referrals compared to 43%), which could indicate culturally appropriate service delivery by these LCPs. Warm referrals were also more common from LCPs with 10 or more staff, suggesting that staff capacity may also influence the provision of supported referrals.

¹⁰⁹ Staying Home Leaving Violence program.

Table 20. Frequency of warm referrals by LCP or LSS

| | LCP | | LSS |
|-----------------|-------|------|-------|
| | Count | % | Count |
| Commonly | 35 | 81% | 1 |
| Occasionally | 8 | 19% | 7 |
| Rarely or never | 0 | 0% | 0 |
| Total | 43 | 100% | 8 |

Source: Workforce survey.

The sample of LCP referral data showed that most (82%) referrals made by LCPs connected victims of DFV to a 'new' service (the remainder connected them to a service where they were an 'existing' client or had been a 'previous' client). The connection to new sources of support is a valuable service, suggesting a new or broader approach to their situation.

Similarly, DFV victims who were upgraded from 'at threat' to 'at serious threat' by the LCP Domestic Violence Safety Assessment Tool (DVSAT) had the highest rate of referrals to 'new' services (93%). This suggests the trusting relationship developed with the LCP (indicated by the greater amount of information provided in the LCP DVSAT) is leading to an opening up of new avenues of support for people who may have become receptive to making changes.

How DVSAT ratings impacted referral type

Overall, LCPs appear to be prioritising referrals appropriately according to the victim of DFV's threat rating. Victims of DFV who were rated by LCPs as 'at serious threat' (83%) were more likely to receive a supported referral than those rated as 'at threat' (57%).

How location impacted referral type

LCPs in small towns and remote areas made supported referrals at a higher rate than the LCPs in cities or large towns. This may reflect that workers in these locations have stronger links with available services. Conversely, LCPs in cities or large towns made information-only referrals at a higher rate than small towns or remote areas. This was supported by the workforce survey, which indicated that workers in small towns or remote areas made warm referrals 'commonly' at a higher rate than workers in cities or large towns (82% compared to 65%).

However, cities or large towns were significantly more likely to provide referrals 'for case management' than small towns or remote areas (24.3% of referrals compared to 13.5%). This was supported by data from the workforce survey and interviews, where case management was the most commonly raised service gap by LCP workers in small towns or remote areas.

7.1.3 Ease of identifying services to refer victims to

Responses to the workforce survey indicated that the majority of LCP and LSS workers found it very easy or somewhat easy to identify local services to refer victims of DFV to (see Table 21).

However, a higher proportion of LSS workers than LCP workers reported finding it not very easy to identify services, but numbers are low and may not be representative. They were also less likely to make warm referrals than LCP workers. This finding may reflect the fact that LSSs are not based in the local area and so may not be aware of local services. It could also point to there being fewer services available for male victims of DFV and/or a reluctance on the part of men to be referred for support.

Table 21. How easy LCP and LSS workers found it to identify local services to refer victims to

| | LCP | | LSS |
|-----------------|-------|------|-------|
| | Count | % | Count |
| Very easy | 11 | 24% | 1 |
| Somewhat easy | 31 | 69% | 5 |
| Not very easy | 3 | 7% | 2 |
| Not at all easy | 0 | 0% | 0 |
| Total | 45 | 100% | 8 |

Source: Workforce survey. % not provided for LSS due to small numbers.

Both LCP and LSS workers found it harder to identify Aboriginal-specific services compared to non-Aboriginal specific services to refer Aboriginal victims of DFV to. However, LSS workers were twice as likely to report that it was 'not very easy' to identify these services compared to LCP workers (63% compared to 30%). Having an Aboriginal specialist worker correlates with how easily LCP workers were able to identify local Aboriginal specific services. The majority of LCPs with an Aboriginal specialist worker found it 'very easy' (23%) or somewhat easy (57%) to identify an appropriate local service to refer Aboriginal people to.

Frequency of attending local DFV inter-agency meetings also influenced how easily LCP workers were able to identify services to refer victims of DFV to. Of those who reported that it was very easy to identify services to refer victims of DFV to, 67% frequently attended the local DFV inter-agency meeting. However, over half (57%) of LCP workers did not regularly attend inter-agency meetings. Workers in small towns or remote areas were more likely to regularly attend than workers in cities or large towns (53% compared to 29%).

Recommendation

Women NSW and Safer Pathway partner agencies identify any service gaps in availability of short and longer-term supports for victims, in particular services for Aboriginal victims, male victims and victims of non-intimate DFV.

7.1.4 Referral outcomes

Referral take-up

From the data available, we know that just over half (56%) of referrals made by LCPs were taken-up by victims of DFV. Eight per cent of referrals were not taken up, and the take-up outcome of the remaining 35% of referrals is unknown. Unsurprisingly, the majority of unknown take-ups were for information-only referrals, as this was harder to track than supported referrals. Notably, victims of intimate DFV were more likely to take up referrals than victims of non-intimate DFV (60% compared to 42%), which reflects the higher proportion of supported referrals for this group.

Interviews indicated that often, victims of DFV decided to take up the supports offered because they were at a point where they felt they needed to or were ready to engage with any available supports. Several victims of DFV were surprised by the range of supports available to them.

...at that point I wanted to try anything, whatever that may be, whoever was willing to help and take it on. (Victim of DFV interview)

I was kind of surprised, but it was nice to know that someone's out there trying to help you and get you into the right referral and get you some help and stuff, because I had no idea like there were such services available... (Victim of DFV interview)

Reasons for choosing not to take up supports included not being in the right 'head space' and having 'too much going on', already receiving supports from friends, family, a counsellor or a doctor, or not feeling they needed the support.

Safety outcomes

As there is no data assessing the outcomes of victims of DFV, our understanding of the safety outcomes comes from the partner and workforce surveys and from interviews. LCP/LSS workers provide a short-term intervention only, so cannot comment on long-term safety outcomes.

Most partner agencies that responded to the survey (79%) reported that proactive contact with victims of DFV and the coordinated service response by LCPs/LSSs are significant factors leading to better safety outcomes.

Safety outcomes observed by partner agencies included support with safety planning and fast access to security upgrades such as changing locks, installing cameras, peep holes and SOS alarms. Electronic monitoring devices may also be used to increase safety.

Improving access to safe housing was a key intervention for many. This included assistance for victims of DFV to access temporary/emergency housing, providing financial assistance, support through Housing NSW and Start Safely, supporting housing transfers and fast-tracking housing for vulnerable victims of DFV through good networking.

Other forms of support included obtaining Apprehended Violence Order (AVO) protection, locating the offender, increased monitoring and compliance by community corrections and increased breaching by NSW Police. Assistance with navigating the legal system helps to ensure that victims of DFV get AVOs that go some way towards protecting their safety. Providing advocacy for victims of DFV can help give them access to further support and assists them to follow through on putting safety plans into place.

Child safety outcomes include school safety planning for children and upgrading risk of significant harm (ROSH) responses.

With stable and safe accommodation established, along with food security, clients were also able to benefit from improved access to health care, including counselling and improved ability to engage in work or education.

Most victims of DFV who were interviewed said they felt safer as a result of the support they received from their LCP/LSS worker. They commented that simply knowing there was someone listening and looking out for them and that services were available if they needed was comforting.

Safer Pathway have made me feel safer – even though they didn't actually do anything, I felt better talking to them; particularly in getting me the support I needed, extremely caring. (Victim of DFV interview)

...I knew if I needed any help or if they couldn't help me they could give me referrals/services. You don't feel so isolated and alone when you have people like that. (Victim of DFV interview)

Other things that made some victims of DFV feel safer were being connected to a psychologist (n=3) or a local women's/family centre (n=2).

The table below sets out outcome patterns related to victims' increased sense of safety and how it is achieved:

| Outcome | Context | Mechanism (because) |
|--|--|--|
| Increased sense of safety | Ongoing contact with LCP worker Awareness that services and referrals are available | Decreased sense of isolation. Knowing 'support available if required' increases confidence. |
| Increased sense of (and potentially actual) safety Increased likelihood of accessing services | Provision of information and advice at the point of crisis – when victims of DFV least likely/able to search for support | Timely access to services Decreased stress |
| Increased sense of (and actual) safety | Referral from LCP/LSS to other services Clients 'at serious threat' Provision of physical safety upgrades to home | DFV victims are less vulnerable |

7.2 Case coordination

Overall, LCP/LSS workers, partner agencies, and victims of DFV were very positive about the Safer Pathway case coordination.

Almost all workers reported that the local responses coordinated through their LCP/LSS were operating 'very well' (46%) or 'somewhat well' (50%) to make victims of DFV safer. LCP workers were slightly more positive than LSS workers that responses were coordinated 'very well' (48% compared to 38%). Ratings were similar across service locations.

Most partner agencies also reported that the coordinated and proactive contact by LCPs/LSSs with victims of DFV led to better safety outcomes either to a 'great extent' (79%) or 'some extent' (14%). Proactive contact was reported to improve safety outcomes through providing victims of DFV with information and services that they would otherwise not be able to access. Most agencies reported being 'satisfied' or 'mostly satisfied' with coordination functions related to sharing client information, receiving referrals from LCPs/ LSSs, making referrals to LCPs/ LSSs, and providing services to victims of DFV that are case-coordinated by an LCP/LSS. Agencies were also positive about the impact.

Several victims of DFV also spoke positively about the ability of Safer Pathway to coordinate supports for them.

I needed the extra support because being in that state you're not in the mood to go searching and trying to find out numbers for help. It's nice to have someone to call you and let you know there's these services. (Victim of DFV interview)

I needed the help and I'd been calling people for help and I got knocked back (as most services were for women only) and I was quite desperate. (Male victim of DFV interview)

It was amazing – it made a really hard time, a horrible situation [easier], it took stress off me, I had enough stress at the time and I didn't have to worry about what I had to do next, who I had to contact, I couldn't fault them. (Victim of DFV interview)

7.2.1 Success factors for case coordination

Victim of DFV characteristics

Some LCP/LSSs commented in interviews that there can be better results from younger victims of DFV for whom the DFV incident is a new development in their relationship. They have no ties, such as a house, children or perhaps even mutual friends who would represent a significant loss to leave. They are willing to engage with agencies/service providers to leave the situation they are in, and hopefully more equipped to avoid it in the future.

Partner agencies suggested case coordination can produce effective short-term safety outcomes for victims of DFV with a range of characteristics. They indicated case coordination efforts were more likely to be effective in delivering:

- **short-term safety outcomes** for victims of DFV:
 - who were ready to engage with services, or were otherwise required to engage due to the involvement of children or young people
 - in remote areas where services are limited, ensuring that services work together and avoid duplication
- **long-term safety outcomes** for victims of DFV:
 - who initially engaged for short-term services and came back later for further support (where services were not time limited)
 - with a strong support network, including having family and personal support, stable and safe housing, and financial support.

Partner agencies also suggested case coordination efforts were less effective at delivering greater safety outcomes for victims of DFV:

- with complex circumstances, including addiction and mental health related issues, homelessness, and generational exposure to domestic violence
- in denial about their experience of domestic violence or who were undecided about leaving
- who were not cooperating with the police
- where children were not involved so there was no statutory mandate for engagement.

Around two thirds (63%) of LCP/LSS workers also indicated that case coordination was 'a little' or 'much' more appropriate for victims of intimate DFV than non-intimate DFV. Comments suggest that, while both types of DFV were handled with the same level of seriousness, there were more resources available for referrals for victims of intimate violence to case coordination. The complex nature of non-intimate abuse within families was also raised as a factor why some responses (e.g. AVOs) may be easier to coordinate for victims of intimate DFV.

Workers' knowledge and approach

The findings on the attitude and approach of LCP workers towards victims of DFV at the contact and engagement stage are equally relevant at this stage of their work, i.e. the importance of being compassionate and non-judgemental, and using trauma informed-practice when interacting with victims.

Similarly, partner agencies highlighted workers' thorough working knowledge of local services and high-level of expertise in the DFV field as key factors in helping to bring a coordinated service response to victims of DFV. They referred to the flexible, swift services responses that LCPs/LSSs were able to provide, as well as the shared knowledge base of the history of victims of DFV that allowed workers to be well-prepared and able to share information to resolve complex issues effectively.

Victims of DFV also emphasised that workers were non-judgemental, empathetic and engaged with them on an emotional level.

...it was good to talk to a non-judgmental voice at the end of the telephone. (Victim of DFV interview)

...seems more interested in victim as a person than just ticking boxes to get them linked to service. (Victim of DFV interview)

They validated my experience... that I was legitimately going through something and it was not all in my head... Just being able to ask them anything, and to be honest... No matter what, their professionalism was consistent... they gave me that opportunity to feel heard and understand which I hadn't had; that's why they were so imperative, why they were so necessary. (Victim of DFV interview)

Cooperation with partner agencies

The majority of partner agencies received referrals from more than one LCP/LSS, and 65% of agencies reported having contact with an LCP/LSS at least once a week.

All partner agencies reported that LCP/LSSs helped bring a coordinated service response to DFV clients in their service location to 'a great extent' (80%) or 'some extent' (20%). Almost all

reported that LCP/LSSs worked cooperatively with their organisation either to 'a great extent' (60%) or to 'some extent' (33%).

7.2.2 Challenges for case coordination

Hard to reach groups

LCP/LSS staff indicated it was more difficult to support certain harder to reach groups. These included CALD communities with a cultural attitude of female subordination within marriage – one stakeholder expressed it as husbands having a sense of ownership of their wives. Within these groups, the extended families and community do not (in general) support the woman leaving her husband. According to one stakeholder, there can also be a message to women that behaviour labelled here as sexual assault is 'part of marriage' or at least a private matter, with a high degree of shame attached to disclosure.

Victims of DFV with significant co-factors, such as drug or alcohol abuse were also reported as harder to engage, as they often have chaotic lives, with DFV one part of this picture. Another scenario is couples who have committed relationships, but have episodic incidents of DFV related to alcohol consumption.

Service gaps

Workers identified a range of gaps in service delivery that prevented them from making referrals and delivering a coordinated service response. Gaps differed by service type, victim of DFV characteristics, and location. The data suggests that there is a lack of:

- case management services, particularly in regional areas (see section 8.1.2)
- mental health services (identified by a higher proportion of LSS respondents, but numbers are low and not easily interpreted)
- housing services, including crisis accommodation with a lack of criteria. LCP workers commented that specific refuges for women escaping DFV have been defunded, refuges that exist are often filled by homeless people, and male victims of DFV are not always accepted. The literature also highlights that resourcing safe and secure housing is a common issue that impacts the safety of victims of DFV.¹¹⁰

Interviews confirmed the service gaps identified through surveys, also illustrated how service staff try to meet the needs of clients by going beyond their role descriptions.

We don't have enough support services. We need case management and we just don't really have it here. We've got to try and find the line because we don't have the time to do it but you don't want to go just 'yeah, see you later; we've done our (name of form)'. We've all had to learn to have those boundaries and obviously sometimes we have done things

¹¹⁰ Healey et al. (2008).

that are outside our role because we go 'well, you can't just leave them there, we have to do something'. (LCP interview)

Both refuges have changed hands during this process... we had small NGOs, now a much bigger organisation [which] has its difficulties. As opposed to you being able to ring so and so and say 'hey, I've got this can you help me out'... [as part of a] big organisation you have to go through some 1300 number that doesn't answer for three days. Very different than me being able to pick up the phone and go 'hey'. (LCP interview)

You do engage with some men who can't be case coordinated. They need someone there for case management. And you're not always going to find someone to case manage them. Housing NSW is like that; they don't case manage their clients. So, we have to go through the process with them, you have to do an application, you have to be on their list, tick the box to say you're a DV victim, then you have to apply for rent start. When they have no one looking after them, they fall back on us. But if they're going to engage with us, then it's worth it. (LCP interview)

The most common reasons for service gaps were that the available service is at capacity or not available in the location.

It is noted a lower proportion of supported referrals are made for victims of non-intimate DFV and for male victims of DFV (see section 7.1.2). It is not clear whether this is due to lack of service availability or lack of engagement for other reasons.

Case coordination after case closure

The LCP Policy Manual provides guidelines on case coordination and case closure. It does not mention LCPs providing case coordination after cases have been closed on the CRP.

However, a majority of LCP/LSS workers reported they continued to provide or coordinate support for a victim of DFV after closing their case on the CRP system either 'occasionally' (58%) or 'commonly' (25%). This happened more frequently at LCPs than LSSs – 30% of LCP workers reported 'commonly' providing support after case closure, compared to zero LSS workers, and half of LSS workers reported 'rarely or never' providing support after case closure, compared to just 11% of LCP workers.

LCPs/LSSs were also more likely to provide support after case closure:

- in cities or large towns than in small towns or remote areas
- if they had an Aboriginal specialist worker.

Partner agencies also commented that the lack of a process for LCPs to follow-up victims of DFV before or after Safety Action Meetings (SAMs), and the lack of service coordination after SAMs end were issues for providing coordinated responses. Increasing funding for LCP/LSS workers to allow for follow up with victims of DFV was suggested as a change that would bring a better coordinated service response for victims of DFV.

Interviews with victims of DFV supported this data – many mentioned they continued to stay in contact with their LCP/LSS worker and that they felt comfortable calling them if something went wrong.

The table below sets out short- and long-term outcome patterns related to case coordination.

| Outcome | Context | Mechanism (because) |
|---|---|---|
| Range of services provided, short-term safety outcomes | Remote areas, few services, culture of collaboration | DFV incident triggers 'normal practice' of collaboration |
| Engage with services, short term safety outcomes Long-term safety outcomes | Intimate partner DFV Greater range of services available than for other forms of DFV | Access to appropriate services |
| | Young clients with few ties | 'Nothing to lose by getting out' |
| | Clients mandated to engage with services | Compliance |
| | Client readiness to make significant changes | Clients re-engage 'later' |
| Long-term safety outcomes | Clients with higher social and economic capital | 'I have what I need to make changes' |
| Lesser impact on safety | Clients with complex needs (AOD, mental health) | Services unavailable when/where needed; may specifically exclude clients with complex needs |
| Lesser impact on safety | Inter-generational DFV | Effective service response unavailable |
| Lesser impact on safety | In denial about DFV | 'I don't need support'/don't engage with services |

7.3 LCP/LSS worker perspectives on sustained threat reduction and reduced re-referral

The importance of case management services and the fact these are often unavailable has been raised earlier in the report. LCP workers and partner agencies identified the lack of a case management process as an area where changes could help bring a better response for victims of DFV. In the absence of this process, partner agencies reported LCPs were often providing some case management even though it is not their role.

Some LCP staff suggested including short-term case management as part of their role, with a brokerage allowance for immediate practical support.

Some made other suggestions for improvement, including additional funding to allow follow-up with clients, and more coordination before and after SAMs, a sentiment echoed by a respondent to the partner survey:

There needs to be better referral pathways identified for the LCP. There appears to be quite a bit of case management done by the LCP which isn't their role. The LCP should be facilitating the service system to refer DFV clients not holding the risk themselves. There also needs to be a review of the Safer Pathway Program on how to engage with difficult to engage clients who won't accept referrals/services. Particularly those where there is no legal mandate - no children/FACS involvement. There needs to be the development of a post-SAM joint case management process where one agency is expected to lead the process and other appropriate agencies are expected to provide comprehensive services. A joint case management clinical governance structure be developed with standards tools (joint case plans etc which are measurable and outcome based). This will increase the safety outcomes of DFV clients and their children. (Partner survey)

Other suggestions included reintroducing the automatic grading of matters 'at serious threat' where victims of DFV had been referred multiple times, and the inclusion of the police narrative from WebCOPS in each referral, particularly for those rated 'at serious threat'.

8. Domain 4: Integrated support in response to serious threat

This chapter looks at the fourth outcome domain in the program logic which is concerned with coordinated support provided through the SAMs to victims at 'serious threat'.

This chapter addresses evaluation questions 1, 2, 3, 4, 5, 6, 7 and 8.

Key findings

- Cases on SAMs were appropriate for the forum – victims of DFV who are 'at threat' are rarely listed on a SAM, usually where the cases have been downgraded.
- The low rate of LSS DVSAT reassessment for men (18%) means few men, and very few Aboriginal men, are being referred to the SAMs.
- CRP data quality issues make it difficult to describe with certainty the profiles of those listed and discussed at the SAM. Available data suggests approximately just over half of the cases assessed 'at serious threat' by LCPs/LSSs were listed and discussed on the SAM, with similar proportions for intimate/non-intimate matters, and Aboriginal and non-Aboriginal victims of DFV, but half that proportion for male victims of DFV.
- Members were very positive about how SAMs coordinated inter-agency actions worked to reduce serious threats to victims of DFV. Members from the longest-running SAMs were more positive than those at newer SAMs.
- Information sharing was seen as key to the effectiveness of SAMs, supporting informed discussions and decision-making.
- SAM members and external partner agencies described a changing culture that sees DFV as the responsibility of all agencies.
- SAMs are serving a valued and useful function within Safer Pathway in coordinating resources across agencies in complex cases.
- The majority of SAM members thought SAMs were appropriate for intimate and non-intimate cases of DFV. The higher number of services available for victims of intimate partner violence was commonly raised by those who reported that the SAM was more appropriate for these victims of DFV.
- SAM members' suggestions for system improvements to sustain threat reduction and reduce re-referral included better access to case management services, better follow-up of victims with DFV, more information at the SAM on re-referred victims of DFV, and better information on the completion of agreed safety actions by SAM members.

8.1 Victims referred to SAMs

As discussed in Chapter 6, two-thirds of victims can be contacted by the LCPs/LSSs, and 30% of intimate DFV cases and 26% of non-intimate cases contacted have the DVSAT re-administered by the LCPs/LSSs. These are victims that are then eligible to be referred to the SAM if, after the second assessment, they are 'at serious threat'. The low rate of reassessment for men (18%) means it is not known how many are 'at serious threat', and few men, and very few Aboriginal men are being referred to the SAMs.

Overall referrals of victims to the SAM were generally appropriate, i.e. are victims of DFV, male or female, identified as 'at serious threat'.¹¹¹ This was supported by SAM members in the workforce survey – 41% reported they 'rarely or never' observed victims of DFV on the SAM agenda where the safety threat was not serious and 51% said that they 'occasionally' saw these cases.

CRP data quality issues make it difficult to describe with certainty the profiles of those listed and discussed at the SAM. A sub-set of CRP data was analysed for a six-month period between upgrades to the CRP, when Victims Services indicated the best quality data was available (1 April to 30 September 2017). However, significant data gaps in SAM reporting in the CRP mean this data can only be considered indicative.

For victims of intimate DFV, this CRP data suggests just over half (56%) of the cases assessed 'at serious threat' by LCPs/LSSs were listed and discussed at the SAM. The proportions are similar for Aboriginal and non-Aboriginal victims of DFV, but much lower for male victims of DFV, at just under one quarter (23%). In raw numbers, two of the seven Aboriginal men who were victims of intimate DFV and were rated 'at serious threat' were listed and discussed at the SAM, and 15 of the 67 non-Aboriginal men. Figures for victims of non-intimate DFV showed a similar pattern, but with only 50% of cases assessed 'at serious threat' by LCPs/LSSs listed and discussed at the SAM. As all cases rated 'at serious threat' should be going to a SAM, these figures highlight a serious problem with data collection, and possibly a problem with service provision but this cannot be confirmed due to the poor data quality.

The CRP data suggests that victims rated 'at threat' were very rarely listed on a SAM, with only 3% of intimate cases and 1% of non-intimate cases rated 'at threat' by LCPs/LSSs listed at a SAM. More than 80% of these were cases downgraded from 'at serious threat' to 'at threat' and hence listed on the agenda for review by member agencies, in case any wished to discuss them.

Recommendations

Victims Services ensure that planned or future developments of the CRP:

- provide more information to SAM members about DFV victims who are re-referred to Safer Pathway
- include systematic data capture about LCP/LSS DVSAT re-administration, including reasons for non-re-administration, and outcomes for victims

¹¹¹ NSW Government. (2016). *Safety Action Meeting Manual*. Legal Aid NSW, Sydney.

- include a mechanism for identifying and reporting on the completion of actions in safety action plans
- enable accurate monitoring of the number, proportion and profile of victims whose matters are referred to SAMs and provide training and direction to LCP and LSS staff to ensure SAM referral data is entered into the CRP.

8.2 Victim outcomes from SAMs

As there is no data assessing outcomes of victims of DFV from SAMs, our understanding of the SAM outcomes comes from the SAM members' experiences from the workforce survey and from interviews.

The extent to which victims of DFV were informed about the SAM is not clear. Two interviews indicated v knew their case had been discussed at the SAM. The literature indicated that providing information to victims about their referral pathway and inter-agency responses is important for engaging and empowering victims of DFV, and reducing confusion about case coordination.¹¹²

8.2.1 Reducing current threat

SAM members were very positive about how well SAMs coordinated inter-agency actions worked to reduce serious threats to victims of DFV. Almost all respondents (98%) of the workforce survey reported that the SAM worked very well (65%) or somewhat well (33%) at reducing serious threats to victims of DFV.

Looking at responses across the different organisations and SAMs, there appears to be an increase in perceived effectiveness with greater maturity of the SAM. Respondents from the longest running SAMs were the most positive and those from the newest SAMs were least positive about the impact coordinated inter-agency responses had on the safety of victims of DFV. There was no difference by SAM location (see discussion in Chapter 3).

8.2.2 Safety outcomes

SAM members reported high levels of agreement about appropriate safety actions, with 91% of respondents reporting there was 'commonly' a shared view among SAM members about the most appropriate safety actions for victims of DFV.

SAM members reported a wide variety of safety outcomes that their agencies were typically responsible for implementing.

- LCPs and LSSs commonly referred victims of DFV to other services and implemented safety planning, with LCPs more likely to implement safety actions around court support than LSSs.

¹¹² Coy & Kelly (2011), p. 63; Cussen & Lyneham (2012), p. 72.

- Police reported commonly finding out more information about the incident and implementing safety actions related to Apprehended Violence Order (AVO)/ Apprehended Domestic Violence Order (ADVO) compliance checks. Health reported sharing information and referring victims of DFV to other services as typical safety actions.
- Safety actions regarding housing and accommodation, and child safety were frequently reported by SAM members from FACS.
- The most common safety action for SAM members from Education was notifying personnel in schools about school aged children raised at SAMs.
- Corrective Services reported being involved in a wide range of safety outcomes, including sharing information, supervising perpetrators, and providing security assessments and upgrades.
- DFV specialist NGOs commonly implemented safety actions regarding housing/ accommodation, safety planning, and case management, whereas NGOs without a DFV specialist reported implementing safety actions regarding accommodation/ housing and sharing information.

Survey results showed that partner agencies were also broadly positive about SAMs and the safety outcomes they can lead to for victims of DFV assessed 'at serious threat'.

8.3 Success factors for SAMs

Information sharing and collaboration

Information sharing is a key aspect of SAMs, allowed under Part 13A of the *Crimes (Domestic and Personal Violence) Act 2007*. The open sharing of relevant information and the actions made at meetings and reported on at the following meeting go a long way to building trusted relationships between the SAM members.

These relationships are an important factor in the successful functioning of the program. People share information outside the meetings as well and will contact each other between meetings if urgent situations arise. In this way, traditional silos are broken down and genuine collaborative partnerships created for addressing DFV. Some members commented that discussions before and after SAM are just as valuable as the meeting itself.

This component of Safer Pathway is grounded in the literature, which suggests a commitment to information sharing allows agencies to have the information they need to reduce duplication, adequately address risk, and identify systemic gaps in service provision that can help achieve longer-term outcomes of increasing victims of DFV's safety.¹¹³ Having mechanisms for agencies to listen to and share their voice, without being dominated or co-

¹¹³ Domestic Abuse Intervention Programs. (2017). *The Duluth Model*.

opted by a single agency, is central to inter-agency collaboration, enabling the identification of gaps in knowledge and practice.¹¹⁴

SAM members were very positive about the impact this had on ensuring the relevant information is available to inform discussions about safety planning. Almost three-quarters (74%) of members reported in the workforce survey that information sharing worked 'very well', and this was confirmed in interviews.

...it's really helpful when, sometimes children aren't on the agenda because sometimes it might not be known, but Health can often find the children's details on their system and then bring that information to the table. Because of that professional rapport that can be established during meetings, collaboration can happen offline. There's some excellent work that goes on offline between professionals. (SAM focus group)

SAM maturity also seems to impact on members perceptions of the effectiveness of information sharing provisions. SAM members who attended the oldest SAMs were the most positive about the impact of information sharing in ensuring the appropriate information was available for safety planning.

SAM members attending the newest SAMs were least likely to report that information sharing worked well in informing safety planning discussions. SAM members in small towns or remote areas were slightly less positive about the impact of information sharing on informing safety planning discussions than SAM members in cities or large towns (67% reporting this worked well compared to 76%).

Collaboration

Large partner agencies – Health, Education, FACS including Housing and Child Protection – reported in interviews that SAMs enable a strong inter-agency collaboration that is able to provide quicker and better networked response to DFV reports of high risk, e.g. schools being informed of students being affected by DFV, which can enable better understanding and diagnosis of learning and behaviour difficulties, and better care. Also, Housing may be able to provide more nuanced responses, including not evicting victims of DFV and children due to arrears or perpetrator behaviour.

Services have confidence when talking with victims of DFV that they know what is going on and are on the same page with police and other agencies. They reported that victims of DFV need cooperative organisations to look after them when they are in highly vulnerable/at risk situations.

The SAMs provide a more holistic range of information about the circumstances of victims of DFV, and position police within a broader response range. This avoids duplication and helps

¹¹⁴ Commonwealth Government. (2010). *AVERT Paper: Multi-disciplinary Collaboration and Integrated Responses to Family Violence*, Australian Institute of Social Relations, Attorney-General's Department, Canberra. Page 9.

with overall effectiveness. There is a changing culture that sees DFV as not just an issue for certain agencies.

Partner agencies also noted the standardised process, fast response times, and knowledgeable people attending who were committed to actions were factors that contributed for better safety outcomes for victims of DFV escalated to SAMs.

LCP's and SAMs support proactive, swift, coordinated and well resourced (due to everyone bringing what they can to the table, thereby reducing the burden on any one particular org). This truly is collaboration and coordination. Most importantly it's breaking down long standing silos – NGO and government departments are sharing info/responsibility. 'Women's' and 'men's' services are doing the same, police are fully engaged with the DV sector in addressing DV etc. (Partner survey)

The table below sets out an outcome pattern related to SAM collaboration.

| Outcome | Context | Mechanism (because) |
|---|--|--|
| Quicker, more networked responses Less service duplication | Trusting relationships between services People share information outside of meetings as well as at meetings | Breakdown of silos and genuinely collaborative problem solving |

Victim characteristics

The workforce survey revealed mixed responses regarding who SAM responses are most appropriate for and why. More than half of SAM members (55%) reported there was no difference in the appropriateness of responses through the SAM for victims of intimate or non-intimate partner violence. However, as with the LCP/LSS response, just under half of respondents reported that SAM responses were either a little (23%) or much more (21%) appropriate for victims of intimate violence. Respondents, who reported there was no difference in how appropriate responses through the SAM were for victims of intimate and non-intimate violence, overwhelmingly reported this was because the same resources and appropriate actions were put into place regardless of relationship. The higher number of services available for victims of intimate partner violence was commonly raised by those who reported the SAM was a little or much more appropriate for these victims of DFV.

8.4 SAM member perspectives on sustained threat reduction and reduced re-referral

Only one-third of SAM members who responded to the workforce survey reported LCPs, SAM members and others could do things differently to sustain threat reductions and reduce

re-referral rates for victims of DFV. NSW Police were the least likely to think that changes could reduce re-referral rates, with 89% of respondents reporting that nothing could be done differently to reduce these. Half of the SAM members from Health (54%) and LSSs (50%) reported that changes could help sustain threat reductions and reduce re-referral rates. The greater confidence and effectiveness that comes with SAM maturity was also reflected, with respondents from newer SAMs being more likely to report things could be done differently at SAMs to produce better outcomes.

In common with LCPs/LSSs (Chapter 7) SAM members' most frequent suggestion was that better access to case management services for clients, particularly in rural/remote areas, would sustain threat reduction and reduce re-referral. Better follow-up with victims of DFV was also suggested, including services informing the SAMs when clients stop engaging with case management. SAM members also wanted better information on when victims of DFV were re-referred to the LCP/LSS or the SAM, and more historical information for those re-referred victims of DFV.

SAM members also reported that a better system for seeing if actions were completed would help support their work. There was also a desire for better processes to be put in place regarding the use of information shared in SAMs to assist victims of DFV, and to prevent oversharing of client information. This is reflected in the literature, which shows a commitment and openness to continual self-auditing of collective agency actions – with a formal structure to monitor the coordination, performance monitoring of actions taken and accountability to stakeholders – is important to successful integrated responses.¹¹⁵ Having a senior representative from agencies to ensure agreements are followed can also support effective inter-agency responses.

Recommendation

Safer Pathway partner agencies ensure that all existing and incoming SAM members are supported to attend SAM training as soon as possible in order that they understand SAM purpose, process and appropriate use of the information provisions.

¹¹⁵ Commonwealth Government. (2010); Breckenridge et al. (2015); McCoy, E., Butler, N. & Quigg, Z. (2016), *Evaluation of the Liverpool Multi-Agency Risk Assessment Conference (MARAC)*, Centre for Public Health, World Health Organization Collaborating Centre for Violence Prevention, Liverpool John Moores University, Liverpool.

9. Conclusion

Safer Pathway has been implemented largely as intended and is generally meeting its intended objectives of ensuring a consistent, effective and timely response to victims across NSW. All five components of the initiative have been implemented and work together.

As a result of Safer Pathway, threat assessment is consistently undertaken by police for every DFV victim (DVSAT), the DVSAT is completed by specialist domestic violence support services that receive police referrals (LCPs/LSSs), DFV victims at serious threat are prioritised throughout Safer Pathway service response (including at SAMs), and the DVSAT is available for use by all service providers. A single streamlined referral pathway between NSWPF and LCPs/LSSs has replaced the previous service fragmentation and duplication that arose from different referral arrangements in each PAC.

The information sharing provisions (Part 13A of the *Crimes (Domestic and Family Violence) Act 2007*) mean all DFV victims are now automatically referred to LCPs/LSSs for support, and service providers can now share information in order to lessen or prevent a serious threat to a person's life, health or safety due to domestic violence (without consent in certain circumstances).

There is now a standard level of service for DFV victims across NSW, with all female DFV victims referred to a LCP, and all male DFV victims referred to an LSS. DFV victims at high risk now receive a consistent, coordinated response across NSW and across service providers.

Opportunities for improvement exist, including improvements to the threat assessment process, Safer Pathway's reach with vulnerable groups, and monitoring and evaluation.

Providing support to victims of DFV is often difficult. Victims of DFV take many actions to make themselves, children and other family members safe, but most victims of DFV do not report their experiences to police or seek professional or other support services, due to a range of internal, inter-personal, cultural and external factors. This is reflected in patterns of victim engagement at all stages of Safer Pathway, and in police, LCP/LSS and SAM interactions with victims. These service providers seek to help victims live in safety, while recognising the complexities of DFV, and of victims' responses to and choices around it. These factors mean that Safer Pathway will not be able to end the experience of DFV for many victims in one referral into the program.

Responses to DFV in Australia, as internationally, developed in response to the most prevalent form of DFV – intimate partner violence perpetrated by men on women of the mainstream community. Because of this, training best supports an understanding of this pattern of violence, tools such as the DVSAT best identify risks for this pattern of DFV, and service responses best meet the needs of women escaping violent male partners.

This conclusion summarises the overall pattern of service provision for victims of intimate and non-intimate DFV, then briefly describes how these patterns differ for Aboriginal people, men, people identified as LGBTQI or CALD, people identified as having a disability, and for metropolitan and rural areas.

Overall pattern of Safer Pathway

Overall, almost two-thirds of referrals into Safer Pathway were for intimate partner violence. Police completed a DVSAT for almost 90% of these referrals, rating just under 8% at 'serious threat'. Less than 5% of referrals for non-intimate DFV were rated at 'serious threat'.

LCPs/LSSs were able to contact two-thirds of victims from these referrals, for victims of both intimate and non-intimate DFV, with no contact details for 10%, and 25% not responding to contact. LCPs/ LSSs provided information or referrals for other services to approximately half of those they were able to contact, though the rate was higher for victims of intimate DFV – approximately one-third of all referrals into Safer Pathway for victims of intimate DFV, and one quarter for victims of non-intimate DFV.

There are records of LCPs/LSSs DVSATs for almost one-third of all referrals for intimate DFV, and just over a quarter of referrals for non-intimate DFV. The majority of referrals stayed at 'threat' (67% of intimate and 86% of non-intimate DFV referrals reassessed) or at 'serious threat' (17% of intimate and 7% of non-intimate DFV referrals reassessed). Just over 10% of referrals for intimate DFV were up-graded to 'serious threat', with 3% of non-intimate referrals up-graded.

Data quality is not strong, but results suggest half of the referrals into Safer Pathway that were ultimately rated at 'serious threat' were listed and discussed on the SAM, along with a very small proportion of those graded at 'threat'. Most referrals down-graded to 'threat' were listed but not discussed at the SAM.

Aboriginal people in Safer Pathway

Aboriginal people comprised approximately 10% of all referrals to Safer Pathway. Of those referred, Aboriginal people (along with people with disability) had higher rates of intimate and non-intimate DFV than all referred, and Aboriginal women had much higher rates of intimate DFV than Aboriginal men. Overall, however, Safer Pathway was less effective in engaging and supporting Aboriginal victims than non-Aboriginal victims.

Aboriginal victims had noticeably lower engagement with police than non-Aboriginal victims. Aboriginal males had the lowest levels of engagement, with 24% refusing to answer all DVSAT items asked by police, compared to 11% of non-Aboriginal males. Aboriginal people also had lower rates of contact from LCP/LSSs compared to other groups. Again, Aboriginal men had the lowest rates, with less than half contacted. Aboriginal victims, particularly

women, were also the least likely group to receive referrals from an LCP/LSS; and both LCP and LSS workers found it harder to identify Aboriginal-specific services to refer to.

These low levels of engagement are reflected in Safer Pathway's re-referral rates—Aboriginal people had double the referral rate of non-Aboriginal people. The finding confirms the commentary found in DFV research which recognises the challenges of engaging victims where there is fear or distrust of state agencies because of a history of state violence.

Having an Aboriginal specialist worker appeared to support better engagement and outcomes for Aboriginal victims. Having these workers meant victims were more likely to be willing to speak to the LCP and that workers were more able to identify local Aboriginal specific services to refer to.

Male victims in Safer Pathway

While male victims comprised almost one-third (29%) of all victims referred to Safer Pathway, the program was less effective in engaging and supporting them than female victims.

Across all groups, the engagement of male victims with police was much lower than female victims. Interviews suggested that police identification of intimate male-on-female DFV can be influenced by an individual's understanding of intimate DFV dynamics and that some male victims have had trouble being seen as victims by police. Some males may also choose not to engage with police due to limited fear of the perpetrator or an 'I can handle it' attitude.

Across all groups, men were less likely to be contacted by LCP/LSSs than women. Of those contacted, men from most demographic groups (non-Aboriginal, Aboriginal, CALD) were less likely to have the DVSAT re-administered or to be upgraded from 'at threat' to 'at serious threat' after re-administration. Men, particularly Aboriginal men, were also less likely to receive referrals from LCP/LSSs. LSS workers were also less likely than LCP workers to make supported, rather than information only, referrals. The reasons are unknown, but could reflect different needs, LSS resourcing levels, a lack of local services available for male victims and their reliance on national support or advice helplines. Data quality is not strong, but results suggest one quarter of male victims assessed at 'serious threat' were discussed at a SAM.

People identified as LGBTQI in Safer Pathway

The findings suggest Safer Pathway has been effective in supporting victims who identify as LGBTQI. This group (along with people with disability) had the highest contact rates from LCP/LSSs, with over 90 per cent being contacted. Victims of non-intimate violence who identify as LGBTQI were also the most likely group to receive referrals from LCP/LSSs. However, it's important to note these findings are likely the result of the process for updating demographic information following a successful contact, and that women who identify as LGBTQI also had high re-referral rates to Safer Pathway.

People identified as CALD in Safer Pathway

The findings suggest Safer Pathway faced some challenges engaging people from CALD backgrounds. LCP/LSS staff indicated it was more difficult to support CALD communities with a cultural attitude of female subordination within marriage. Overall, women from CALD backgrounds were more likely to be victims of intimate DFV than men from CALD backgrounds, but were also more likely to be contacted by an LCP/LSS than men. Women from CALD backgrounds also had high referral rates to Safer Pathway.

People identified with disability in Safer Pathway

People with disability, together with Aboriginal people, had higher rates of intimate and non-intimate DFV than all referred, and women with disability had much higher rates of intimate DFV than men with disability.

The findings suggest Safer Pathway has been effective in supporting victims with disability. This group, together with people who identify as LGBTQI, had the highest contact rates from LCP/LSSs, with over 90 per cent being contacted. Victims of intimate violence with disability were the most likely to receive referrals from LCP/LSSs. However, it's important to note these findings are likely the result of the process for updating demographic information following a successful contact, and that women with disability also had high re-referral rates to Safer Pathway.

Safer Pathway in metropolitan and rural areas

Major cities had a higher rate of intimate DFV (54%), and regional areas had a higher rate of intimate DFV for Aboriginal people (70% compared to 43%) and non-intimate DFV (70% c.f. 44%). Overall, Safer Pathway was less effective in engaging regional victims, but was better at supporting victims where LCPs had a high level of local knowledge about services.

Regional victims were harder to engage than those in metropolitan areas. With victims in regions 'occasionally' likely to not speak at all (76% cf. 47%) compared with metropolitan areas, while metropolitan areas were more likely to 'rarely or never' have this issue compared with regional areas (39% cf. 12%). In regional areas victims were less likely to have access to interpreters when undergoing the DVSAT. Regional LCP and LSS staff also reported a limited ability to share information regarding best practice/processes with others, due to geographic location.

The findings suggest strong links with available services and local knowledge made it easier for LCP workers to refer victims. Regional victims were more likely to receive referrals than those in metropolitan areas. LCPs in regional areas made supported referrals at a higher rate than in cities or large towns, perhaps reflecting that workers in these locations have stronger links with available services. Frequency of attending interagency meetings also increased how easily LCP workers were able to identify services to refer victims to. LSS workers found it

harder to identify services for victims (however, numbers are low and not easy to interpret) and were less likely to make warm referrals than LCP workers. This suggests there may be a lack of services available locally for male victims, or that LSSs not based in the area they are servicing are not aware of local services.

LCP workers in metropolitan areas were significantly more likely to provide referrals 'for case management' than those in regional areas. Regional LCP workers recognised this as a service gap in regional areas that may be leading to reduced outcomes for victims.

Conclusion

The overall pattern described above shows a systematic, state-wide response to DFV in NSW, with the development of a shared understanding of DFV behavior and risks, and the language to describe it, by police, government agencies and NGOs within the sector. This in turn is having an educative impact on people experiencing the DFV cycle of violence. Consistent threat assessment and support are leading to threat reduction for many victims of DFV.

However, challenges remain in reaching groups with a reluctance to engage in services, particularly where police are involved. Additionally, the relatively new inclusion of non-intimate DFV into the policy area means an understanding of and service delivery to victims of non-intimate DFV require further development.

Appendix 1. Reference List

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Appendix 2. Intimate DFV risk factors and their relationship with DVSAT Part A

| Intimate DFV risk factor | Relevant DVSAT Part A items | Evidence base |
|--|---|--|
| History of DFV by perpetrator against victim(s) of DFV | <i>'Has your partner ever used physical violence against you?'</i> <i>'Has your partner ever threatened or used physical violence toward you while you were pregnant?'</i> <i>'Has your partner ever harmed or threatened to harm your children?'</i> | ANROWS, Extensive evidence based from research in Australia ¹¹⁶ and overseas ^{117 118} . Primary risk factor for femicide and most common precursor to all intimate partner homicide (regardless of gender). |
| Separation (actual or pending) | <i>'Has there been a recent separation (in the last 12 months) or is one imminent?'</i> | ANROWS, evidence from Australia ¹¹⁹ and abroad ¹²⁰ , relationship with intimate partner homicide. |
| Intimate partner sexual violence | <i>'Has your partner ever done things to you, of a sexual nature, that made you feel bad or physically hurt you?'</i> <i>'Has your partner ever been arrested for sexual assault?'</i> | ANROWS, evidence from Australia ¹²¹ and abroad ¹²² . Relationship with femicide. |
| Non-lethal strangulation | <i>'Has your partner ever choked, strangled or suffocated you or attempted to do any of these things?'</i> [*] | ANROWS, extensive evidence base in Australia ¹²³ and overseas ¹²⁴ . |

¹¹⁶ Davies, M. & Mouzos, J. (2007). *Homicide in Australia: 2005/06 National Homicide Monitoring Program Annual Report*. Australian Institute of Criminology, Canberra.

¹¹⁷ Roehl, J., O'Sullivan, C., Webster, D. & Campbell, J. (2005). *Intimate Partner Violence Risk Assessment Validation Study: Final Report*, US Department of Justice, Washington.

¹¹⁸ Campbell et al. (2003). Risk Factors for Femicide in Abusive Relationships: Results from a Multisite Case Control Study. *American Journal of Public Health*, 93 (7).

¹¹⁹ Davies & Mouzos (2007).

¹²⁰ Roehl et al. (2005).

¹²¹ Braaf & Sneddon (2007).

¹²² Campbell et al. (2003).

¹²³ Braaf & Sneddon (2007).

¹²⁴ Block, R.C. (2003). How Can Practitioners Help an Abused Woman Lower Her Risk of Death?. *National Institute of Justice Journal*. No 250.

| Intimate DFV risk factor | Relevant DVSAT Part A items | Evidence base |
|--|---|--|
| Stalking | <i>'Has your partner stalked, constantly harassed or texted/ emailed you?'</i> | ANROWS, evidence from overseas. ¹²⁵ Relationship to actual and attempted femicide. |
| Threats to kill | <i>'Has your partner ever threatened to harm or kill you?'</i> [*] | ANROWS, evidence from Australia for threats to kill only. ¹²⁶ |
| Access to or prior use of weapons (any tool that can injure or destroy property); includes threats made with weapons | <i>'Has your partner ever threatened or assaulted you with any weapon (including knives and/or other objects)?'</i> [*] <i>'Does your partner have access to firearms or prohibited weapons?'</i> | ANROWS, evidence from Australia ¹²⁷ and abroad ¹²⁸ . |
| Escalation | <i>'Is the violence or controlling behaviour becoming worse or more frequent?'</i> [*] | ANROWS, evidence from abroad ¹²⁹ . |
| Coercive control | <i>'Is your partner jealous towards you or controlling of you?'</i> <i>'Does your partner control your access to money?'</i> | ANROWS, Australian evidence suggests this is the strongest risk factor for contemporary male-on-female intimate DFV. ¹³⁰ International evidence suggests that this factor is an important indicator in femicide risk where no previous physical violence has occurred. ¹³¹ |
| Pregnancy and new birth | <i>'Are you pregnant and/or do you have children who are less than 12 months apart in age?'</i> | ANROWS, evidence from abroad. ¹³² |

¹²⁵ Block (2003).

¹²⁶ Braaf & Sneddon (2007).

¹²⁷ Mouzos, J. 2003. *Family Homicide in Australia – Trends and Issues in crime and criminal justice*. No. 255, Australian Institute of Criminology, Canberra.

¹²⁸ Roehl et al. (2005).

¹²⁹ Campbell et al. (2003).

¹³⁰ Mouzos, J. & Makkai, T. (2004). *Women's Experience of Male Violence: Findings from the Australian Component of the International Violence Against Women Survey (IVAWS)*. Australian Institute of Criminology, Canberra.

¹³¹ Block (2003).

¹³² Campbell et al. (2003).

| Intimate DFV risk factor | Relevant DVSAT Part A items | Evidence base |
|--|--|---|
| History of violence | <i>'Is your partner currently on bail or parole, or has served a time of imprisonment or has recently been released from custody in relation to offences of violence?'</i> <i>'Has your partner ever harmed or killed a family pet or threatened to do so?'</i> | BOCSAR – bail or parole item. Evidence for harm to pets in Australian research ¹³³ and supported by ANROWS |
| ADVO breaches | <i>'Has your partner ever been charged with breaching an apprehended domestic violence order?'</i> | BOCSAR 2018, and prior research into DFV recidivism. ¹³⁴ |
| Alcohol or other drugs (AOD) | <i>'Does your partner have a problem with substance abuse such as alcohol or other drugs?'</i> | BOCSAR, ANROWS, evidence from Australia ¹³⁵ and abroad ¹³⁶ . |
| Suicidal tendencies, threats of suicide, attempts of suicide | <i>'Has your partner ever threatened or attempted suicide?'</i> | ANROWS. Evidence from Australia ¹³⁷ and internationally ¹³⁸ . |
| Mental health | <i>'Does your partner have mental health problems (including undiagnosed conditions) and/or depression?'</i> | BOCSAR, for female perpetrators against intimate partners. Evidence from Australia ¹³⁹ and abroad ¹⁴⁰ . |
| Financial situation | <i>'Does your partner or the relationship have financial difficulties?'</i> | BOCSAR, evidence from Australia ¹⁴¹ and abroad ¹⁴² . |

¹³³ Braaf & Sneddon (2007).

¹³⁴ Fitzgerald, R. & Graham, T. (2016). Assessing the risk of domestic violence recidivism. *Crime and Justice Bulletin*. No. 189. NSW Bureau of Crime Statistics and Research, Sydney.

¹³⁵ Mouzos & Makkai (2004).

¹³⁶ Roehl, et al. (2005).

¹³⁷ Braaf & Sneddon (2007).

¹³⁸ Koziol-McLain, J., Webster, D., McFarlane, J., Block, C., Ulrich, Y., Glass, N. & Campbell, C. (2006). Risk Factors for Femicide-Suicide in Abusive Relationships: Result from a Multisite Case Control Study. *Violence and Victims*. 2(1).

¹³⁹ Braaf & Sneddon (2007).

¹⁴⁰ Roehl et al. (2005).

¹⁴¹ People, J. (2005). Trends and Patterns in Domestic Violence Assault. *Crime and Justice Bulletin*. no.89. NSW Bureau of Crime Statistics and Research, Sydney.

¹⁴² Roehl et al. (2005).

| Intimate DFV risk factor | Relevant DVSAT Part A items | Evidence base |
|-------------------------------------|--|--------------------------------------|
| Unemployment | <i>'Is your partner unemployed?'</i> | BOCSAR |
| Children from previous relationship | <i>'Are there children from a previous relationship present in the household?'</i> | Evidence from abroad. ¹⁴³ |
| Court proceedings | <i>'Is there any conflict between you and your partner regarding child contact or residency issues and/or current Family Court proceedings?'</i> | ANROWS. |

¹⁴³ Roehl et al. (2005).

Appendix 3. VP-SAFvR

Table 22. VP-SAFvR items

| VP-SAFvR risk factor | Explanation |
|--|--|
| Any prior DFV in same dyad | Former aggression by perpetrator against the same victim Risk factor commonly found in literature |
| Respondent has prior charge for breaching intervention (restraining) order | Former breach of ADVO (against any victim) Risk factor on DVSAT |
| Respondent has prior charge for breaching correctional order | Probationary violation, etc. |
| Respondent has prior charge for violent offence | Former violence (general) |
| Respondent has a previous family violence incident | Former intimate DFV or non-intimate DFV (any victim) |
| Victim of DFV has mental health concerns | Victim vulnerability due to mental health |
| Any alcohol or drug use by the victim of DFV | Victim vulnerability due to AOD abuse |
| Financial difficulties | Risk factor commonly found in literature Risk factor on DVSAT |
| Pregnancy or recent birth | Risk factor commonly found in literature Risk factor on DVSAT |
| Recent separation | Risk factor commonly found in literature Risk factor on DVSAT |
| Children present at incident | Children at the incident increases risk – different to how children are integrated into the DVSAT |
| Family violence duration more than 1 month | Item was created using a ROC curve to find the optimum duration for predicting future family violence based on an ordinal categorical duration variable recorded by police on the L17 - may require further explanation from authors |
| Controlling behaviours by perpetrator | Coercive control - risk factor commonly found in literature Risk factor on DVSAT |

Appendix 4. Methods

The evaluation used a mixed-methods approach, drawing on and synthesising qualitative and quantitative data sources. The evaluation was conducted in two stages. Stage 1 provided the theoretical basis and understanding of the primary quantitative data source for the development of tools and approaches utilised in stage 2. The methods in each stage are described in brief below, with achieved sample sizes and estimated response rates where relevant.

Stage 1

Review of policy and program documents

Purpose: To ensure the evaluation is informed with an accurate understanding of the Safer Pathway components and any developments in the model, and is appropriately contextualised in the NSW DFV service system and reform environment.

Scope: Program and policy documents that were publicly available and/or provided to the evaluation team. Key NSW Government documents include the:

- *NSW Domestic and Family Violence Blueprint for Reform, 2016-2021*
- *It Stops Here Framework for Reform, 2014*
- *It Stops Here: Safer Pathway Overview, 2014*
- *Domestic Violence Information Sharing Protocol, 2014*
- *Safety Action Meeting Manual (SAM Manual), updated August 2017*
- *Domestic Violence Safety Assessment Tool Guide (DVSAT Guide), June 2015*
- *Domestic Violence and Child Protection Guidelines (DV&CP Guidelines), 2014*
- *Domestic Violence Justice Strategy, 2013-2017*

Approach: Reviewing documents to identify, clarify and confirm components of Safer Pathway and the policy context, and summarising findings to describe the background/context.

Literature scan of integrated DFV responses

Purpose: To identify 'what works' in integrated DFV agency and service responses in general (i.e. what is known about good practices) and build an understanding of the ways in which responses work in different contexts to inform the realist Safer Pathway program theory.

Scope: The literature scan included English language sources about inter-agency responses to DFV identified from a meta-evaluation of international and Australian inter-agency responses, an online search and sources sent to the evaluation team by experts. Sources include academic articles, evaluations of similar initiatives from the USA, UK and Australia, and literature reviews on inter-agency collaboration.

Approach: A modified rapid realist review drawing on Rameses principles to identify context-mechanism-outcomes (CMO) configurations. This approach started with the desired outcomes and policy interventions involved in Safer Pathway to develop a theoretical understanding of the contexts and mechanisms through which these interventions work. The findings were summarised in CMO tables to inform the program theory workshop and the development of the data collection tools. The findings also informed this report.

Literature scan of DFV data collection and information systems

Purpose: To identify research and industry/ sector standards around quality DFV related data collections and information management systems to inform an assessment of the CRP and scope for its improvement.

Scope: English language peer-reviewed literature from academic journal databases focusing on information system technology and factors predicting their successful design, diffusion and use in social work and human services workplace contexts, as well as common shortcomings. This was supplemented by grey literature on data collection protocols and evaluations of information systems used in Australia and internationally.

Approach: We identified key search terms ('decision-making support systems', 'information management systems' and 'knowledge management systems') and inclusion and exclusion criteria. Two searches were done, which are outlined below:

- first, a search to establish the type of information systems used in the human services sector, whether there are any systems or features of systems common to the DFV context, and what consequences tend to result when new information systems are introduced into social work and human services sectors
- second, a search to establish evaluative standards of information systems against which framework could be constructed for the assessment of the CRP.

The findings informed the CRP report.

Literature scan of the DVSAT evidence base

Purpose: To describe the development of the DVSAT and build an understanding of the evidence base informing the tool and how this relates to research on similar tools.

Scope: Historical documents about the development of the DVSAT provided by police, Legal Aid and Women NSW, including key documentation and the evaluation of its predecessor, the CARAM-DFV tool. English language peer-reviewed literature from academic journal databases focusing on current findings on DFV risk measurement, supplemented with recent grey literature and evaluations of other risk assessment tools in Australia and internationally.

Approach: We identified key search terms for risk, threat and safety assessment tools in a DFV context, with inclusion and exclusion criteria. The analysis highlights the risk assessment

factors, common components of effective risk assessment tools and other findings that are applicable in the context of the Safer Pathway DVSAT. The findings informed the review of the DVSATs in this report.

Scoping consultations with key stakeholders

Purpose: To ensure that the evaluation is appropriately contextualised in view of the current status of Safer Pathway rollout and the NSW DFV service system and reform environment; to understand in detail key elements of the Safer Pathway approach, CRP system and DVSAT in practice to inform methods planning; and to identify potential realist program theories.

Scope: Key policy informants, sector and community stakeholders, specifically:

- Evaluation Working Group members representing Women NSW, Victims Services, NSW Police and Legal Aid NSW (Women's Domestic Violence Court Advocacy Program)
- BOCSAR representatives who are undertaking a separate research project to assess the predicative validity of the DVSAT for re-victimisation
- The academic (Associate Professor, Social Work and Policy Studies, USYD) who played a key role in the development of the DVSAT tool
- Aboriginal elders from Baabayn Aboriginal Women's Corporation, and the Warringa Baiya Aboriginal Women's Legal Centre.

Approach: We used a combination of individual phone and small group meetings. Notes or minutes were taken to record information needed for evaluation planning purposes. There were no transcriptions.

Scoping Survey

Purpose: To inform the review of the CRP data system, for quality assurance and to ensure the data analysis plans were informed by an understanding of the nature and quality of available information.

Scope: Informants from government and non-government agencies who use the CRP to make, receive and manage referrals into Safer Pathway are eligible, specifically, i.e. crime managers and DVLOs from NSW Police Force, and LCP staff at WDVCSs and LSSs.

Approach – survey type: We used an online survey (built in Survey Gizmo) accessed through one URL, i.e. a 'generic' link. This meant respondents could not be identified by their email address.

The survey contained a mix of closed and short-answer questions and incorporated a skip-logic, i.e. respondents answered relevant questions targeted according to their responses to initial questions about their role/involvement with the CRP. No respondent answered all of the questions.

Approach – inviting informants: Legal Aid and Victims Services provided ARTD with email addresses for 278 LCP staff, and emailed these people to inform them about the upcoming survey. ARTD sent the survey invitation, the survey link and two reminders directly to these potential informants. NSWPF emailed advance notice, the survey link and two reminders to 60 crime managers, and copied the DVLOs in their stations.

Analysis: Most quantitative questions were specific to respondents' organisation type and role, and were analysed in those categories. Three overall satisfaction questions addressed to all respondents were also analysed by metropolitan/rural location, frequency of use, length of experience with the system and client gender.

Qualitative data was analysed by organisation type and role, and identified which parts of the system function well, for which tasks, where improvements could be made, and what those improvements could be. The results have been provided to the EWG as part of the CRP quality review report.

Response rate: Responses were received from 151/278 (54%) LCP/LSS; 50/120 (42%) police. Respondents were from a broad range of services and PACs across NSW, and well spread across newer and older Safer Pathway sites.

Quality review of CRP data and process

Purpose: To review the quality and completeness of the CRP data collection, and understand user experiences with the system, to confirm the evaluation questions that are answerable on the basis of these data (for analysis in stage 2), and to identify improvements that could be made.

Scope: We used a data snapshot from January to December 2017. De-identified data was provided in four extracts from Victims Services: DVSAT WebCOPS (128,938 records), DVSAT External (39 records) and Referrals (128,910 records). These were combined on Client Reference Number (CRN) and referral date, resulting in 128,869 combined records. A further extract of perpetrators CNI's was provided and these were joined on the CRN and referral date victims of DFV, adding the perpetrators CNI where a match could be made. The data is held securely on ARTD in house server, with limited access to relevant staff only. Analysis staff signed the Victims Services CRP Confidentiality and Security Agreement prior to commencing analysis.

Analysis: The data was matched and analysed in an ACCESS database. The review summarised the user-reported data quality field, looked at each variable for completeness (not missing), and described the range of user responses for key variables. The analysis is integrated with scoping survey findings, a literature review and interviews with key stakeholders to identify gaps and possible improvements that will be further investigated during the evaluation, leading to recommendations.

Stage 2

Key informant and stakeholder consultations with expert practitioners

Purpose: To ensure the evaluation is appropriately contextualised in view of the emerging status and developments in Safer Pathway, and the NSW DFV service system and reform environment.

Scope: Key policy informants, sector and community stakeholders, specifically:

- Evaluation Working Group and Advisory Group members
- Sector peaks (e.g. WDVCS NSW and DVNSW)
- Expert DVSAT practitioners
- Aboriginal community organisations.

Approach: Informants were consulted throughout the evaluation to update our understanding of the emerging policy and delivery environment, and our understanding of findings in view of this.

Analysis of CRP data

Purpose: To contribute to the understanding of how Safer Pathway and the DVSAT work for different client groups in different situations. To describe patterns and trends in client/ case type (gender, relationship, risk assessment and reassessment) and case load over time. To examine the impact of changes in the DVSAT risk rating rules, and the use of professional judgment.

Scope: De-identified unit record data comprised of all records from September 2014–March 2018, where the DVSAT COPS or external DVSAT records could be matched with referrals records. (There were 365,456 up to 31 March 2018.)

Analysis: The data was matched and preliminary analysis conducted in an ACCESS database. Preliminary analysis was descriptive, producing tables, crosstabs and charts describing frequencies and proportions. Further analysis was carried out in SPSS where patterns or trends suggested major differences by client type, case type or location in the application of rules or processes.

Workforce survey

Purpose: To understand the consistency and variety of LCP and SAM functioning across the state. To understand members' views of what elements of SP and the DVSAT, and its administration work for which victims of DFV, in which contexts and why. The questions were finalised following completion of fieldwork, to address any gaps then identified.

Scope: All regular government and NGO SAM members, which includes SAM coordinators, in SP sites with established SAMs across NSW.

Approach: The survey was administered on line using Survey Gizmo, and distributed directly to all regular SAM members using emails provided to ARTD by SAM Coordinators, along with the LCP site name.

Response rate: n= 273 respondents/520 distributed links (53%) (estimated based on 30 WDVCS with four staff, nine LSS with seven staff, 43 SAM coordinators with eight SAM members per SAM¹⁴⁴). Respondents were from a broad range of services and PACs across NSW, and well spread across newer and older Safer Pathway sites.

Analysis: The analysis examined the data by key variables drawn from program theory, such as the maturity of the site, and the agency of respondent.

Site studies

Purpose: To understand the contexts that support/constrain the mechanisms that affect how and how well Safer Pathway operates to provide an effective referral and case coordination pathway and to support outcomes for victims of DFV, including diverse groups of victims of DFV. The site studies were also used to test the validity and reliability of the DVSAT.

Site selection: Purposive and theory-driven site selection based on our understanding of the contexts that enable or constrain the mechanisms that we hypothesised are linked to outcomes. Site selection was designed to test realist hypotheses that have been developed based on the scoping evidence (interviews, literature and CRP data review).

Table 23. Theory based sampling for site visits

| Element of theory | Indicator from data sources |
|---|--|
| <u>Strong and stable leadership</u> from a lead agency can contribute to more effective inter-agency responses | Maturity and structural relationships between LCPs/LSSs, SAMs and PACs, as described in program documentation and scoping interviews; date SAM commenced as described in program documentation |
| <u>Data quality and completeness about victims of DFV</u> , especially particular groups, can limit the appropriateness of the service response | Data quality and completeness in different LCPs, identified from CRP review |
| <u>Shared understanding of DFV risks and dynamics</u> between police and LCP staff will lead to consistent threat assessment across agencies | Proportion of cases re-graded by LCP staff in different LCPs, identified from CRP review |

¹⁴⁴ Estimates based on workforce survey data.

| | |
|---|---|
| <u>Case load can impact on SAM operations</u> - When there is a high volume of cases that come to multi-agency meetings, it is possible for cases to not get enough attention or for staff to have to spend more time at meetings | Average caseload in different LCPs, identified from CRP review |
| <u>Victim engagement and help-seeking behaviour facilitates safety</u> , but can be difficult owing to fear and distrust of agencies and stigma, especially in Aboriginal and new immigrant communities, and among male and LGBTQI victims of DFV | Demographic profiles of victims of DFV, in different LCPs, identified from CRP review Geographical area of LCP |

Approach: Two-day visit per site, plus some follow up activity (phone interviews and partner survey). The detail of activities undertaken in each site visit is described below.

Review of LCP referral data

Purpose: To describe referral and case coordination received by victims of DFV who interact with Safer Pathway, both those 'at threat' and 'at serious threat', and build an understanding of differences and factors associated with these differences in referral and case coordination across LCPs.

Scope: Approximately 50 referral records held by WDVCS at each of the six site study locations were randomly sampled. Data on the reason for the referral, the agency referred to and the uptake of the referral were entered into a spreadsheet. These were matched with information from the CRP data base, such as:

- demographics of the victim of DFV (gender, age, CALD, Aboriginality, LGBTQI identification, disability if recorded in CRP)
- type of incident (i.e. intimate or non-intimate)
- secondary DVSAT grading.

Analysis: The data was matched and analysed conducted in SPSS.

Victim of DFV interviews

Purpose: To understand experiences of victims of DFV of their interactions with Safer Pathway, and how and why this makes a difference to service engagement, threat reduction and safety outcomes, including for different groups of victims of DFV.

Scope: Telephone interviews with female and male victims of DFV over the age of 18 in site study locations who had interacted with Safer Pathway, i.e. received initial and secondary threat assessment and:

- victims of DFV assessed as 'at threat' who received case coordination

- victims of DFV assessed as 'at serious threat' who were referred to SAM for case coordination and safety planning
- victims of DFV of intimate and non-intimate partner violence.

Screening

The sample *excluded* victims of DFV who were screened-out by an LCP/LSS worker given considerations about how being contacted for an interview may impact on their wellbeing.

This screening probably biased the sample towards victims of DFV with more positive Safer Pathway engagements, but safety of victims of DFV is a priority and in our experience is still common to hear a range of diverse views even within a screened cohort of this kind.

Achieved sample: n=22 victims of DFV at six sites.

Analysis: Interview transcripts were analysed against the program theory, particularly with regard to engagement with victims of DFV.

Focus groups with LCP workers

Purpose: To understand how and why local support coordination for female victims of DFV is working well, or not so well. Also, to understand how and why information sharing, inter-agency collaboration (through SAM and through existing referral networks), and other interpersonal and institutional factors make a difference to outcomes for victims of DFV. To understand the role of the secondary DVSAT assessment in how and why local case prioritisation and coordination works well or not so well.

Scope: SAM Coordinators and other key LCP workers at the WDVCAS in each selected site.

Achieved sample: n= 20 workers at six sites.

Approach: Focus group, face-to-face or over the phone where these could not be scheduled during the site visit. A semi-structured guide was used.

Analysis: Audio recordings and notes were analysed against the program theory, particularly with regard to engagement with victims of DFV and case coordination.

Focus groups with LSS workers

Purpose: To understand how and why local support coordination for male victims of DFV is working well or not so well. Also, to understand how and why information sharing, inter-agency collaboration (through SAM and through existing referral networks), and other interpersonal and institutional factors make a difference to victim outcomes. To understand the role of the secondary DVSAT assessment in how and why local case prioritisation and coordination works well or not so well.

Scope: Key LSS workers in each selected site.

Achieved sample: n= 14 workers at six sites.

Approach: Focus group, face-to-face or over the phone where these could not be scheduled during the site visit. A semi-structured guide was used.

Analysis: Audio recordings and notes were analysed against the program theory, particularly with regard to engagement of DFV and case coordination.

Interviews with SAM Chairs

Purpose: To understand how and why inter-agency collaboration, information-sharing and decision-making is occurring through the SAMs to address immediate threats to victims of DFV and facilitate referrals and case coordination, and to understand how the DVSAT informs safety planning at the SAM. To understand the role of local training of police in responding to DFV and using the DVSAT, and to explore scope to improve these processes.

Scope: The senior police officer who regularly chairs the SAM (usually the crime manager)

Achieved sample: n= six chairs at six sites.

Approach: A semi-structured interview lasting 45 minutes – 1 hr, conducted face-to-face or over the phone.

Analysis: Audio recordings and notes were analysed against the program theory, particularly with regard to inter-agency coordination, safety planning and threat reduction.

Focus group with SAM members

Purpose: To understand how and why inter-agency collaboration, information-sharing and decision-making is occurring through the SAMs to address immediate threats to victims of DFV and facilitate referrals and case coordination, and to understand how and why the DVSAT informs safety planning at the SAM. To understand how and why taking safety actions (through the Safety Action Plan) impacts on threat levels, and to explore scope to improve these processes.

Scope: Representatives of agencies that are standing members of the SAM, and other NGOs that attended regularly (where this occurs). At a minimum, this includes:

- NSW Health (including drug and alcohol and mental health reps)
- Family and Community Services
- Department of Education
- Corrective Services NSW.

Approach: Focus group, face-to-face or over the phone where these could not be scheduled during the site visit. A semi-structured guide was used.

Achieved sample: n= 56 workers at six sites

Analysis: Audio recordings and notes were analysed against the program theory, particularly with regard to inter-agency coordination, safety planning and threat reduction.

Reliability review of sample of DVSAT records

Purpose: To test the reliability of the DVSAT for assessing threat by following up cases to determine whether the grading derived from the initial and secondary assessments were accurate in predicting threat of DFV, the relationship between the two assessments, and the usefulness of the two-stage process, and, if possible, to identify factors accounting for the accuracy or lack of accuracy.

Approach: Cases were purposively sampled in coordination with the LCP/LSS who were asked to provide cases where the risk was accurately assessed by the tool, and cases where it was not, for victims of DFV 'at threat' and those 'at serious threat', and by relationship type (intimate/non-intimate).

The accuracy of the assessment was understood qualitatively, i.e. whether the DVSAT provided an assessment that matched what the LCP or LSS staff and SAM members came to know about the situation of the victim of DFV, and what happened subsequently.

Achieved sample: n= 27 records, 21 LCP/LSS workers at five sites

Analysis: Audio recordings and notes were analysed against the program theory, particularly with regard to risk assessment, safety planning and threat reduction.

Focus groups with Police DVSAT administrators

Purpose: To understand the police experience of administering the DVSAT, factors that support and constrain its administration and the use of professional judgement, how administering the DVSAT works in with other responsibilities at and following an incident, and the nature and level of training and support in using the DVSAT that they receive.

Scope: The group included a mix of general duties officers, probationary constables and supervisors at one of the PAC/PDs in each study site.

Achieved sample: n= 33 Police at six sites

Approach: Focus groups were arranged to coincide with shift change-over when more police were available. A semi-structured guide was used.

Analysis: Audio recordings and notes were analysed against the program theory, particularly with regard to engagement with victims of DFV, and process fidelity.

Cognitive interviews and scenario testing with Police and LCP-DVSAT administrators

Purpose: To understand how consistently the tool is applied and how the items are understood/interpreted, and test the reliability of the tool in different scenarios

Scope: Police and LCP/LSS DVSAT administrators in site study locations.

Achieved sample: n= eight police and 12 LCP/LSS workers at six sites

Approach – cognitive interviews: The interview was conducted face-to-face where possible, otherwise over the phone. Respondents were asked approximately 15 questions about each of the items in the DVSAT to explore how questions are asked, how questions are understood and answered by victims of DFV, and how answers are recorded.

Analysis – cognitive interviews: Responses were entered into a response template in Survey Gizmo for ease of recording. Synthesis focused on identifying if any items are less reliable than others, and why.

Approach – scenarios testing: We developed three scenarios for police and one for LCP/LSS workers. The scenarios had a particular focus on situations in which the correct course of action is not clear from a procedural perspective, and/or the victim is not engaging in help-seeking. Scenarios covered decisions about whether and with whom to administer the DVSAT, how to record responses in particular situations, and the use of professional judgement.

Analysis – scenarios testing: Synthesis focused on identifying if any situations are responded to with greater variety, and why.

Partner agency Survey

Purpose: To understand the referral practices used by service providers and their roles and relationships in the local service network, local contexts in which Safer Pathway is operating, and when, why and for whom Safer Pathway works well or does not work well.

Scope: Government agencies and non-government organisations that regularly work with (through formal or informal partnerships) the LCP to receive referrals and/or contribute to case coordination.

Achieved sample: n= 17/46 (37%) respondents from six sites.

Approach: LCPs and LSSs were requested to provide contact details of agencies to which they regularly referred clients. We emailed an online survey to the key contact in each identified agency/ organisation.

Analysis: Descriptive analysis was conducted in EXCEL, producing tables, crosstabs and charts describing frequencies and proportions.

