



# PROTECT

- Identifying and Protecting High Risk Victims  
of Gender Based Violence - an Overview

ENGLISH

# EDITORIAL INFORMATION





PROTECT

PROTECT - Identifying and Protecting High Risk Victims of Gender Based Violence - an Overview  
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# INTRODUCTION

**PROTECT**: Good Practice in Preventing Serious Violence, Attempted Homicides, Including Crimes in the Name of Honour, and in Protecting High Risk Victims of Gender Based Violence

## I.

### INTRODUCTION

The European Network **WAVE - Women Against Violence Europe** - took part in the call for Action Grants by the **DAPHNE** programme and was granted the financial means to conduct the one-year project **PROTECT** in 2010.

**WAVE** is a network of European women's non-governmental organisations and works in the field of ending violence against women and children. The network was founded in 1994 and is coordinated by the **AÖF** (Austrian Women's Shelter Network), an umbrella organisation of the Austrian autonomous refuge workers. The **WAVE** network consists of more than 94 Focal Points located in the 27 countries of the European Community, the applicant countries Croatia, Turkey and Republic of Macedonia as well as in 42 other European countries, including the Balkan countries.

**WAVE** aims at reducing violence against women and children by improving the protection of and services for women and children victims of violence. **WAVE** has a long-term experience in developing and carrying out trainings for different professionals, in developing quality standards for the protection and support of victims and in the improvement of multi-agency cooperation.

The **WAVE** database contains more than 4 000 addresses of women's organisations and is highly frequented. Furthermore **WAVE** focuses on the dissemination of good practice models and on lobbying for gender equality and the prevention of violence against women at the European, national, regional and local levels.

### A. PROJECT DESCRIPTION

The project **PROTECT** aims at contributing to the prevention and reduction of the most serious forms of gender-based violence against girls, young women and their children, such as grievous bodily harm, homicide and attempted homicide, including so-called honour crimes and killings.

Gender-based intimate partner violence against women and girls can take very severe forms such as grievous bodily harm, deprivation of liberty by locking victims up, often over days or even years, attempted murder or murder. These crimes seem to be motivated by different factors and concepts – extreme jealousy, possessiveness, accusation of 'dishonouring' the family and other reasons – however, all of these crimes seem to have the similar goal of exercising power over women and girls and controlling their lives. Any move that is seen as a challenge to such concepts of power and control, e.g., if a woman or girl tries to leave her violent partner or father, can endanger her life, health and liberty.

Ultimately, the beneficiaries of this project are women, young women, and girls, who are at high risk of severe violations of their fundamental human rights: the right to life, health and liberty. Research shows that violence can be reduced by systematically identifying and comprehensively protecting victims at high risk. Such coordinated interventions are still missing in most EU countries and regions; therefore the project aims at improving the protection of high risk victims.

The project's target groups are professionals from core agencies responsible for the protection and support of victims and the prevention of violence, organisations and institutions working in the area of violence prevention, policy makers and – last but not least – victims of gender-based violence.

The project includes several strings of action: research on statistics on homicides/femicides and attempted homicides/femicides, including so-called killings in the name of honour, a summary of intimate partner violence and intimate partner femicide risk assessment studies (literature review), research on standards of protection and support available to high risk victims, three expert group meetings, and the **PROTECT** Online Resource Centre which is launched on the **WAVE** website.

The main results of the project **PROTECT** are summarised in this **PROTECT** final research report which is available in eight languages (Bulgarian, Czech, English, French, German, Italian, Slovakian and Spanish) in digital form for free download at the **PROTECT** Online Resource Centre on **WAVE**'s website. Regarding the three core activities of the project **PROTECT**, the report is structured in three main chapters: II. A Summary of intimate partner violence and intimate partner femicide risk assessment studies, II. B. Report on research results related to mapping of eight countries concerning the protection and safety of high risk victims of gender based intimate partner violence, including a description of the functioning of the MARACs in England and Wales, and II. C. Availability of reliable, systematically collected and analysed data on gender-based intimate partner homicide / femicide in Europe. The last section of the **PROTECT** final research report provides conclusions based on the outcomes of the project.

We would like to thank all twelve **PROTECT** partners – Andres Abad (General Directorate for Gender Based Violence Prevention and Youth Reform, formerly IMRM, Spain), Valentina Andrasek (Autonomous Women's House Zagreb, Croatia), Diana Barran (CAADA - Co-ordinated Action Against Domestic Abuse, UK), Tomás Criado Martín (Dirección General de la Mujer de la Comunidad de Madrid, Spain), Walter Dillinger (Federal Police Department of Vienna, Austria), Katarína Farkašová (Alliance of Women in Slovakia, Slovakia), Dušana Karlovská (FENESTRA Women's Interest Association, Slovakia), Alben Koycheva (Bulgarian Gender Research Foundation, Bulgaria), Kornelia Krieger (Women Counselling Centre Frauenberatungsstelle Osnabrück, Germany), Petra Švecová (ROSA – Centre for battered women, Czech Republic), Angela Romanin (Casa delle Donne per non subire violenza, Italy), Klara Weiss (Domestic Abuse Intervention Centre Vienna, Austria) – and advisory board members Sonia Chirinos Riviera (Special Court for Gender Violence, Madrid, Spain), Daniela Gloor (Social Insight, Schinznach-Dorf, Switzerland), Carol Hagemann-White (University of Osnabrück, Germany), Birgitt Haller (Institute of Conflict Research, Vienna, Austria), Marianne Hester (University of Bristol, UK), Amanda Robinson (University of Cardiff, UK) and Renée Römkens (University of Tilburg, Netherlands) for their valuable input and excellent cooperation.

## **B. GLOSSARY - PROTECT DEFINITIONS & ABBREVIATIONS**

### **VIOLENCE AGAINST WOMEN, DOMESTIC VIOLENCE, INTIMATE PARTNER VIOLENCE:**

Intimate partner violence against women/domestic violence against women

= gender-based violence by a partner or ex-partner

Family violence

= gender-based violence against a woman or girl by a family member

### **HOMICIDE:**

Intimate partner homicide = the killing of

- current spouses (including common-law spouses), current non-marital partners
- dating partners, including first date (heterosexual or same sex)
- boyfriends/girlfriends (heterosexual or same sex)
- former marital partners, divorced spouses, former common-law spouses, separated spouses, former non-marital partners
- former dates (heterosexual or same sex)
- former boyfriends/girlfriends (heterosexual or same sex)

# INTRODUCTION

## **FEMICIDE:**

Gender-based intimate partner homicide of women = femicide

## **SO CALLED HONOUR CRIMES:**

In PROTECT we use the term 'so-called honour crimes' to demonstrate that the issue here is violence, not honour.

## **IMPACT ON CHILDREN:**

- Gender-based partner violence against women is a form of violence against the child/children of the women; it includes direct violence against the children to the extent of homicide, as well as children having to live with violence and witness violence
- This violence against the children is a form of gender-based partner violence against the women
- Child abuse in the family = any form of physical, psychological, sexual violence or neglect by the parents or other child carer or family member

## **RISK IDENTIFICATION AND RISK ASSESSMENT:**

### **Risk Identification**

Procedures in an agency to systematically identify women at high risk of gender-based violence

### **Risk Assessment**

The ongoing processes to identify risk factors and protective factors in cases of violence against individual women

## **SAFETY MANAGEMENT, RISK MANAGEMENT:**

**Safety Management** – survivor oriented, includes

- individual and ongoing safety planning
- Safety measure in the agency for clients and staff
- Safety as a management task within the agency
- and multi-agency safety management models (i.e. MARACs)

**Risk Management** – perpetrator related

- the processes to prevent violence by trying to influence risk factors and protective factors
- within every agency, multi-agency (i.e. MAPPAs)

## **HIGH RISK VICTIMS:**

**High risk victims are women and their children at risk of experiencing**

- homicide or attempted homicide
- violence by use of weapons or dangerous objects
- violence causing severe injuries that require emergency medical treatment
- violence causing repeat injuries death threats, severe and ongoing coercion and control, stalking
- deprivation of liberty over a longer time, slavery, torture

## **Following abbreviations are used in the report:**

AVC Anti Violence Center

DA Danger Assessment

DAIP Domestic Abuse Intervention Project Duluth MN USA

DV Domestic Violence

IDVA Independent Domestic Violence Advisor

IPV Intimate Partner Violence

MARAC Multi Agency Risk Assessment Conference

NGO Non-governmental Organization

NRW Northrhine-Westfalia

RAI Risk Assessment Instrument

SARA Spousal Abuse Risk Assessment

SPSHRV Standards of Protection and Support available to High Risk Victims

VAW Violence Against Women

## C. PARTNER & EXPERT GROUP MEETINGS

In order to learn about specific risk assessment models which are applied in different EU countries – such as the model of a comprehensive law on gender violence in Spain, the UK model of independent domestic violence advisors and MARACs, and the Austrian model of victim support and protection – three Partner and Expert Group Meetings were held in Vienna (22–24 March), Madrid (26–28 May) and Bristol (27–29 October). In the course of these meetings an exchange of information regarding strengths and possible weaknesses of each system as well as the issue of data sharing in multi-agency work took place among the **PROTECT** partners and advisory board members. The dialogue was extended by inviting international and national experts and policy makers responsible for the protection of victims of violence, and their practical experience had been included in the discourse. Through this international dialogue, awareness on the importance of a specific and systematic protection of women and children at high risk of intimate partner violence had been raised.

For this reason the three-day Partner and Expert Group Meetings were based on the concept to organise a public day in which policy makers, senior police staff, representatives of the justice system, of women's services, of the health care service, of the municipalities as well as the **PROTECT** partners and advisory board members participated. Through each Partner and Expert Group Meeting about 30 – 45 professionals at management level were reached, who have acted as multipliers by passing on information and relevant material to staff responsible for the protection and support of victims. In the remaining one and a half day, the **PROTECT** Partner and Expert Group Meeting was only accessible to **PROTECT** partners and advisory board members in order to reflect on the results of the public day and to discuss further project steps.

The Partner and Expert Group Meetings offered a fruitful platform to discuss definitions, explanations, possible causes and risk factors in the area of severe gender-based intimate partner violence. Representatives of organisations and institutions working in the area of violence prevention, professionals from core agencies responsible for the protection and support of victims and the prevention of violence, deputies of relevant government departments and experts from the **PROTECT** team exchanged knowledge and practical experience in identifying and managing risk and developed suggestions on how to effectively prevent serious crimes and protect high risk victims.

At each Partner and Expert Group Meeting a number of well-selected publications and information material relevant for the protection of high risk victims was provided through an information desk. Thus models and tools of risk assessment and safety planning were introduced to help agencies to improve their policies regarding the safety of victims.

The **PROTECT** Partner and Expert Group Meetings turned out to be a valuable method to generate information by bringing together the expertise and perspectives of different agencies, to raise awareness and to discuss concepts on how to improve the protection and support of high risk victims of gender-based intimate partner violence.

The contributions at these **PROTECT** meetings are included in the **PROTECT** final research report and additionally summarised in detailed reports about the **PROTECT** Partner and Expert Group Meetings, which are available at the WAVE Website.

## D. PROTECT ONLINE RESOURCE CENTRE

Within the framework of the project **PROTECT** an Online Resource Centre was established on the website of the European Network **WAVE**. Besides providing general information about the project **PROTECT** and about the project activities, the Online Resource Centre offers a platform to share information between the participating project partners as well as with the general public.

# RESEARCH REPORTS

The **PROTECT** Online Resource Centre contains relevant project results such as programmes and detailed reports of the three Partner & Expert Group Meetings held in Vienna, Madrid and Bristol as well as the final **PROTECT** research report which is available on the website in eight languages; English, German, Spanish, Czech, Slovakian, Italian, French, and Bulgarian. Furthermore, the Online Resource Centre facilitates access to additional material. A number of well-selected publications related to the protection of high risk victims of gender-based intimate partner violence and on the issue of femicide data in Europe are available for practitioners, researchers and policy makers.

The **PROTECT** Online Resource Centre makes information about risk assessment and safety planning instruments widely available and distributes the project outcomes among project partners, policy makers and professionals who have participated in one of the three **PROTECT** Partner & Expert Group Meetings in Austria, Spain and the UK, and to the entire **WAVE Network**, which comprises more than 4 000 women's NGOs – such as women's help lines, women's shelters and women's counselling centres – in 47 different European countries. The **WAVE** website is visited between 50 000 and 90 000 times per month, so a wide dissemination of the project results material is ensured.

## II.

### A. SUMMARY OF INTIMATE PARTNER VIOLENCE AND INTIMATE PARTNER FEMICIDE RISK ASSESSMENT STUDIES

Violence against women in intimate relationships is a very frequent event that takes on different forms (physical and psychological, sexual, or psychological only) and different levels of severity (blows, bruises, severe injuries, or homicide) and also has different prognoses in different countries (Echeburúa et al., 2009). In Canada, spousal assaults now account for the vast majority (>80%) of simple assaults reported to police, which in turn are the majority (>80%) of all violent crimes reported to police (Kropp & Hart, 2000). In Spain, intimate partner violence affects at least 3.6% to 9.6% of women older than 18 years, and 60 to 70 women are killed every year by their partners (Echeburúa et al., 2009). In the United States, at least 30% of women who are killed are murdered by an intimate partner or expartner according to the Supplemental Homicide Records (SHR), and when hand counts corrected the misclassifications in the SHR, the percentage increased to 40%–50% (Roehl et al., 2005). In Sweden, approximately 22 000 cases of assault against women are reported to the police every year (Sweden has approx. 9 million inhabitants). Close to 80% of all violence against women in Sweden is carried out by a perpetrator known to the victim (Belfrage, 2008).

Cases of severe intimate partner violence and femicide have usually a history of previous abuse, so these severe acts are the last links in the chain of violent behaviour. Intimate partner violence is typically a repetitive crime with same victim and perpetrator as before and has a tendency to escalate over the course of the relationship. It is known that the risk of severe violence and murder may increase if the victim attempts to end the relationship or separates from the abuser (Roehl et al., 2005). Moreover, many victims and perpetrators have had previous contacts with police, emergency departments and other institutions dealing with domestic violence. This means that the potential victim and perpetrator are known to the system, which makes a big difference from the cases of general violence or threats and gives a unique opportunity to protect the victim.

Sharps et al. (2001) found that 74% of 239 murdered women and 88% of victims of attempted femicide had been seen in emergency departments for some ailment during the year before the incident. From all these facts we can assume the predictability of this crime, and in this sense it is important to have instruments that allow one to assess the impending danger to the victim. All of the systems that interact with battered women (health care, criminal justice, social service) need to keep

in mind the 'duty to protect' as well as duties to warn (Campbell, 1994, Roehl et al., 2005). All actors in these systems have responsibility to decide what actions will be taken against the perpetrator and also what measures will help to protect the victim. Risk assessment can help in this decision-making process.

The process of risk assessment can also help to increase the victim's awareness of the risk they run and come to a more realistic appraisal of the danger in their situation (Roehl et al., 2005), because in spite of evidence that abused women's perception of high risk is often accurate, Campbell's 11-city femicide study found that only about half of the women who were victims of actual or attempted partner homicide assessed their risk accurately (Campbell et al., 2003).

## **1. CURRENT STATE OF PREDICTING DANGEROUSNESS IN INTIMATE PARTNER VIOLENCE – METHODS AND RESEARCH**

Violence risk assessment is a process of identifying risk and protective factors for violence. Violence risk is multi-faceted and one must also consider the nature, seriousness, frequency or duration and imminence of any future violence (Hart, 2008).

Compared to the field of risk assessment for sexual, violent and general criminal recidivism, there has been relatively little empirical work on risk assessment for intimate partner violence (Hanson et al., 2007, Roehl et al., 2005). Dutton and Kropp's (2000) review described the 'science and practice of spousal assault risk assessment (as) still in its infancy' (p.178).

In the intimate partner violence field, checklists developed to aid practitioners' expert judgment are widely used. Checklists, clinical interviews, practitioners' intuition and formal assessment instruments identifying forms of present violence are used to help in safety planning with victims. As Hanson et al. (2007) summarised in their meta-analysis study, the most common approaches to spousal assault risk assessments are partner (victim) ratings, spousal assault risk scales (both actuarial tools and structured professional judgment) and risk scales designed for general or violent recidivism.

More recently several instruments have been developed to determine the cases more likely to escalate to severe or lethal violence. As Roehl et al. (2005) mentioned, it is important to tailor the response to the level of dangerousness, in order to make the response appropriate. For several of these instruments, predictive validity support has recently been published.

### **1.1. DIFFERENCES BETWEEN RISK ASSESSMENT INSTRUMENTS**

#### **A) Risk assessment of intimate partner re-assault vs. Risk assessment of intimate partner homicide**

Although there is an overlap between the risk factors for re-assault and homicide, there seems to be a difference of degree and some different patterns (e.g. substance abuse or child abuse victimisation are rather risk factors for re-assault, while perpetrator suicidality or gun ownership are more of a risk factor in homicide or homicide-suicide) (Roehl et al., 2005). Intimate partner violence (IPV) re-assault is easier to predict accurately because IPV re-assault has a higher occurrence (approximately 25% to 30% of IPV cases) than does intimate partner homicide (approximately 0,04 % of IPV cases) (Campbell et al., 2009; Dutton, 2008). Some of the instruments were designed explicitly to predict a risk of homicide or lethal violence in intimate partner violence situations (e.g., Danger Assessment, MOSAIC-20). Others were created to predict re-assault (e.g., SARA, ODARA, DVI, K-SID). There are also some instruments trying to predict both (Navy Risk Assessment or most recently SIVIPAS) (Roehl et al., 2005, Hilton et al., 2008, Echeburúa et al., 2009).

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## **B) Clinical assessment tools vs. Actuarial assessment tools**

According to Hart (2008) there are at least two types of actuarial decision making. One is the actuarial use of psychological tests; the second type of procedure is the use of actuarial risk assessment instruments, which are not designed to measure anything (as psychological tests) but to predict the future. Roehl et al. (2005) defined the actuarial method as an instrument that 'provides weightings and empirically based scores that rate predictor variables selected from measured associations with criterion variables in representative samples' (p. 6).

Hanson et al. (2007) give an explanation of the difference between actuarial scales and clinical / structured professional judgment. In actuarial scales evaluators mechanically combine the ratings on a structured list of risk factors into a total score (e.g. ODARA, K-SID). In structured professional judgment, evaluators similarly rate a structured list of risk factors, but the overall evaluation of risk is left to the professional judgment (e.g. SARA).

Decision making in structured professional judgment is assisted by guidelines, which attempt to define the risk being considered, recommend what information should be considered and how it should be gathered, and identify a set of core risk factors. Unstructured professional judgment is a process that could be characterised as 'intuitive' or 'experiential.' Historically, it is the most commonly used procedure for assessing violence risk, is very person-centred and focused on unique aspects of the case, but there is little evidence that intuitive decisions are consistent across professionals. Another type of professional judgment procedure can be referred as anamnestic risk assessment that has limited degree of structure (Hart, 2008).

## **C) Differences in regard to the primary source of information**

There are also differences in regard to the primary source of information. It can be perpetrator (e.g. DVI), victim (e.g. DA) or other sources, such as criminal records etc. Furthermore, there are differences in regard to the subject which will benefit from the information (victim, victim assistance programs, probation, justice system, etc.).

As mentioned by Roehl et al. (2005) there are unique ethical and empirical issues in assessing risk of intimate partner violence. Concerning intimate partner homicide, the low rate of these incidents makes it especially problematic to predict in terms of statistics. A unique aspect of prediction in IPV is that a particular individual victim is the object of concern, rather than the population at large addressed in predictions of sexual assault and mental patient violence. Knowing the identity of the potential victim makes it possible, and therefore incumbent on service providers, to consider her safety as paramount. Furthermore, the known potential target will have her own perception of the dangerousness of the perpetrator, a prediction that may be more accurate than any instrument or clinician.

## **1.2. VICTIMS' PREDICTIONS**

Roehl et al. (2005) mentioned that recent studies found women's perception of risk important in determining risk of re-assault by an intimate partner. Weisz et al. (2000) found that women's perception of danger was the single best predictor of re-assault, a stronger predictor than any of the 10 items from the Danger Assessment available in criminal justice records. Similarly, Goodman et al. (2001) in a sample of 92 women found that women's prediction of re-assault was the strongest single predictor of re-assault. In an analysis of their data on 499 men in batterer intervention programmes and their partners, Heckert & Gondolf (2004) found women's perception of risk to be a significant predictor of re-victimisation by an intimate partner, stronger than the SARA (Spousal Assault Risk Assessment) and K-SID (Kingston Screening Inventory for Domestic Violence), but not as strong as a simulated version of the Danger Assessment. The best model of prediction was the DA along with women's perception of risk. However, in the 11-city femicide study (Campbell, 2003), only 47% of the actual femicide victims and 54% of the victims of attempted femicide accurately assessed that their perpetrator was capable of killing them (Roehl et al., 2005).

## 2. RISK FACTORS

Many studies attempted to identify factors associated with spousal violence. Some studies registered risk factors that discriminated between violent and non-violent partners; others describe factors associated with risk of re-assault and/or severity or potential lethality of re-assault. As Kropp (2008) mentioned, there is considerable agreement amongst these studies regarding the important factors to consider when assessing risk for spousal assault. These risk factors can be categorised in numerous ways. We can distinguish risk factors on the perpetrator's side, (e.g., general antisocial behaviour, negative attitude towards women, mental health and personality disorder, substance use problems etc.), risk factors on the side of the victim, such as level of personal support, access to support services, child-related concerns, employment and financial situation etc. There are also risk factors related to a history of intimate partner violence and, stability of relationship (separation).

Grann & Wedin (2002) in their study identified risk factors for recidivism among spousal assault and spousal homicide offenders. They retrospectively obtained SARA ratings from files of 88 offenders convicted of spousal assault or homicide. The SARA scores were correlated with other RAI to establish indices of future violence risk (number of previous convictions, PCL-R, H-10, VRAG) and showed a Pearson  $r$  correlation of about 0.30 to 0.60, similar to the findings reported by Kropp & Hart (2000).

A few SARA items were associated with increased risk of recidivism in a statistically significant measure, namely the items past violation of conditional release or community supervision, personality disorder with anger, impulsivity, behavioural instability (psychopathy), and extreme minimisation or denial of spousal assault history. Past physical assault or violation of no-contact orders as well as minimisation or denial of spousal assault history, were all risk factors for recidivism consistent with the previous findings by Kropp & Hart (2000). The authors found that it was the Part 2 of the SARA (that is, the items specifically addressing partner violence risk) that provided the most value as to informed risk assessment.

Campbell et al. (2003) conducted an 11-city study with the aim to identify and establish risk factors for femicide in abusive relationships. The sample consists of 220 cases of femicide, 143 attempted femicide cases (added later) and 343 abused controls. From femicide cases records had been chosen which were eligible for the study. At least 2 potential proxy informants, individuals knowledgeable about the victim's relationship with the perpetrator, were identified from the records. Proxies were contacted and those who agreed and fulfilled the requirements of the study were interviewed. Attempted femicide cases were retrieved from police assault files, shelters and trauma hospitals database.

In compliance with the aim of the study, results showed that there are identifiable risk factors for intimate partner femicide. Pre-incident risk factors associated in multivariate analyses with increased risk of intimate partner femicide included perpetrator's access to a gun and previous threat with a weapon, perpetrator's stepchild in the home, and estrangement, especially from a controlling partner. Never having lived together and prior domestic violence arrest were associated with lowered risks. Significant incident factors included the victim having left for another partner and the perpetrator's use of a gun. Other significant bivariate-level risks included stalking, forced sex, and abuse during pregnancy.

Approximately half of the victims (54% of actual femicides and 45% of attempts) did not accurately perceive their risk – that the perpetrator was capable of killing her or would kill her.

According to the study 32% of femicide cases were followed by suicide of the perpetrator. Risk factors for femicide-suicide seem to be partner suicide threats and history of poor mental health; incidence was higher in married couples and in higher educated levels (unemployment was still a risk factor).

# RESEARCH REPORTS

Across the studies of risk factors for intimate partner homicide, prior intimate partner violence is clearly the most common risk factor (67% – 80% of IPH cases) (Campbell et al., 2009). A study of risk factors for violent death of women in the home (Bailey et al., 1997) found that mental illness, drug use, prior criminal involvement and the presence of firearms in the home were associated with increased risk of homicide.

The study of homicide risk factors among pregnant women (Decker et al., 2004) showed drug abuse by the male partner (60%) and violent jealousy of the partner (58%) to be the most frequent homicide risk factors. Snider et al. (2009) identified 5 questions (risk factors) of the Danger Assessment that are most predictive of severe abuse and potentially lethal assaults: increased frequency or severity of the physical violence, use of a weapon or threatening with a weapon, women's belief that the partner is capable of killing her, beating during pregnancy and violent or constant jealousy of the partner.

Jealousy and controlling behaviour was perceived as a significant risk factor also by Robinson (2006). The author found that jealous or controlling perpetrators were also more likely to have a criminal record, to have injured the victim, to have aggravating problems, to have threatened to kill the victim, to have choked or strangled the victim and to have threatened to commit suicide.

Separation is commonly understood as a significant risk factor for severe harm or homicide. Assessing the risk level of separation is connected to child contact, which can provide the opportunity for violence to continue or escalate. Research from the United Kingdom shows that after separation, more than 75% of women from the sample suffered further abuse and harassment from their ex-partners and that child contact was a point of particular vulnerability for both women and children (Humphreys et al., 2003).

Within the Metropolitan Police Domestic Violence Risk Identification, Assessment and Management model SPECCS (Humphreys, 2005) six prominent risk factors were identified: separation (child contact), pregnancy, escalation, culture, stalking and sexual assault. Further six factors are also included as prompts for front line police officers to consider (abuse of children, abuse of pets, access to weapons, either victim or perpetrator being suicidal, drug and alcohol problems, jealous and controlling behaviour, threats to kill and mental health problems). The SPECCS risk assessment is a three-stage model. The first stage involves the front line police officers undertaking an initial response and investigation of the incident, the second stage involves an assessment of the risk based on the six plus six factors outlined above. The third stage consists of a more comprehensive assessment and taking further actions on the case.

Echeburúa et al. (2009) assessed risk markers in intimate partner femicide and severe violence cases with the goal to develop a new scale to predict intimate partner violence and severe violence. The instrument was elaborated from the components that seemed to be more closely related to severe partner violence, based on the authors' clinical experience, review of previous studies and suggestions made by officers of the police force. A 20-item scale (awarded 0 or 1 point) was derived from a larger 58-item scale, based on the calculation of the capacity of each item to differentiate between severe and non-severe aggressors. Concerning reliability, the internal consistency index, obtained by Cronbach's alpha in the total sample of participants (severe and non-severe aggressors, N = 1 081), was 0.71. As for validity, the scale differentiates adequately between severe and non-severe perpetrators, and it does so both in the global score and in each of the proposed items. Moreover, there are five items that are particularly significant, as the two groups present a difference of more than 19.5 points in them (d index): Items 8 (weapons), 9 (intentional injuries), 11 (jealousy), 17 (justification of violence), and 18 (danger of death).

After testing all the possible cutoff scores, a calculation of three levels of severe violence risk was established: low (0-4), moderate (5-9), and high (10-20).

The authors pointed out that both aggressors and victims in the severe violence group have a higher rate of immigration and included this status as a risk factor in the instrument

### 3. OVERVIEW OF INTIMATE PARTNER VIOLENCE AND HOMICIDE RISK ASSESSMENT INSTRUMENTS

In the studies that we used for this summary we found the following risk assessment methods (Tab.1). As a basis we used the table from the study of Roehl et al. (2005) and added other methods.

METHOD	DESCRIPTION	ADMINISTRATION	PRIMARY INTENDED USES
<b>Danger Assessment (DA)</b> (Campbell, 1986, 1995, 2003)	Review of past year with a calendar to document severity and frequency of battering and 20 yes/no questions about risk factors. Scoring: 3–40 & four risk categories (variable, increased, severe & extreme danger).	Interview with the victim, usually by victim advocate. Filling out the calendar, also with a victim advocate.	Assessing the risk of extreme dangerousness and lethal violence for victim education, awareness, safety planning and service provision.
<b>Brief Risk Assessment for the Emergency Department</b> (Snider, Webster, O'Sullivan & Campbell, 2009)	Shortened version of DA that consists of 5 questions. A positive answer to any three questions has sensitivity for high risk of severe assault of 83%.	Interview with the victim by Emergency Department health care provider.	Instrument developed for Emergency Departments to identify victims at highest risk for suffering severe injury or potentially lethal assault.
<b>DV-MOSAIC</b> (Gavin de Becker & Associates, 2001)	Computer-assisted method that includes 46 multiple response items about risk and protective factors. Scoring: Program computes risk score of 1–10 and a missing data (IQ) score.	Criminal justice professional enters responses after victim, perhaps offender and other interviews; reviews of criminal records and police reports.	Assessing immediate, short-term threat of severe or lethal domestic violence situations for victim awareness, safety planning, further investigation, and criminal justice responses.
<b>Spousal Assault Risk Assessment (SARA)</b> (Kropp, Hart, Webster & Eaves, 1994, 1995, 1998)	20 questions divided in 4 groups, with 4 different scoring approaches including a 0–2 assessment of as well as absolute presence of each of the 20 risk factors + space for the evaluator to add 'other consideration' which can be also counted.	Evaluator should use as many sources of information as possible, including victim and perpetrator interviews, additional criminal justice records and available standardised instruments.	Designed to assess risk of reoffending in the criminal justice system, it is recommended for use as a part of an indepth assessment for judicial and probationary decisions.

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METHOD	DESCRIPTION	ADMINISTRATION	PRIMARY INTENDED USES
<p><b>Brief Spousal Assault Form for the Evaluation of Risk (B-SAFER)</b> (Kropp, 2008, Belfrage, 2008)</p>	<p>Shortened version of SARA comprising 10 risk factors divided into two sections. The first section, Spousal Assault, contains 5 factors related to the perpetrator's history of spousal violence, the second section, Psychological Adjustment, contains 5 factors related to the perpetrator's history of psychological and social functioning. The summary risk rating has to be done 3-dimensionally (low, moderate or high risk).</p>	<p>After considering the 10 risk factors, the evaluator should provide a judgment of risk level and recommendation for managing that risk. There is a 'Definition of Risk Factors' as well as semi-structured interview for victims and Recommended Risk Management Strategies section.</p>	<p>Shortened, simplified and revised version of SARA designed for use by police, therefore omits the assessment of the mental health of the perpetrator. 3-dimensional risk rating allows not only assessment risk for recidivism, but also for severity of a possible relapse. Winkel (2008) suggests that in a victim support context, B-SAFER may also serve as a tool to raise revictimisation awareness and facilitate preventive behaviour.</p>
<p><b>Domestic Violence Inventory – Risk and Needs Assessment (DVI)</b> (www.riskandneeds.com)</p>	<p>Questionnaire takes 30–35 minutes to complete. There are seven scales including one for truthfulness, alcohol and drug abuse scales, violence potential and treatment needs. The scores are divided into categories of low, medium, problem and severe risk.</p>	<p>Questionnaire is structured to be completed by the perpetrator.</p>	<p>Designed not only to assess risk of re-assault but also to assess treatment needs.</p>
<p><b>Kingston Screening Instrument for Domestic Violence (K-SID)</b> (Gelles, 1998)</p>	<p>10 questions about risk factors, each with 2 to 3 response categories, and an offender's poverty status scale. Scoring: Risk scores of 0 to 10 and four risk categories (low, moderate, high, or very high).</p>	<p>Offender and victim interviews and review of police reports by probation or other court officer.</p>	<p>Assessing the risk of recidivism/re-assault for offender charging and supervision decisions, set conditions for release, probation, and protective orders.</p>

METHOD	DESCRIPTION	ADMINISTRATION	PRIMARY INTENDED USES
<p><b>Domestic Violence Screening Instrument (DVSI)</b> (Williams &amp; Houghton, 2004)</p>	<p>12 questions to be given 0–3 points, primarily related to offender’s criminal history, employment, &amp; several other risk factors. Scoring: Risk score 0–30, and two risk categories (not high risk &amp; high risk).</p>	<p>Probation or other court officer completes instrument based on offender’s criminal record and interview.</p>	<p>Assessing the risk of recidivism/re-assault for supervision, probation/parole, and other offender related decisions.</p>
<p><b>Ontario Domestic Assault Risk Assessment (ODARA)</b> Hilton, Harris, Rice, Houghton, Eke (2008)</p>	<p>Contains 13 empirically selected items, some apparently specific to domestic relationships and several aimed to the risk of antisocial behaviour in general.</p>	<p>Predicts recidivism using only variables readily obtained by frontline police officers.</p>	<p>Actuarial risk assessment for wife assault recidivism. Originally intended for use by police officers, therefore only information ‘routinely available in the field’ was considered for inclusion.</p>
<p><b>Domestic Violence Risk Appraisal Guide (DVRAG)</b> Hilton, Harris, Rice, Houghton, Eke (2008)</p>	<p>The 14-item DVRAG comprises the original ODARA items, combined with the Hare Psychopathy Checklist (PCL-R), which best improved prediction of recidivism, occurrence, frequency, severity, injury and charges.</p>	<p>For example, a police officer can score the ODARA in time for a bail decision and a forensic clinician or probation officer can subsequently score the DVRAG to provide an improved assessment to aid sentencing, supervision, and treatment decisions.</p>	<p>Predicts wife assault recidivism and its severity. Together, the ODARA and DVRAG represent not a proliferation of instruments but a coherent system of risk assessment.</p>
<p><b>Severe Intimate Partner Violence Risk Prediction Scale (SIVIPAS)</b> (Echeburúa, Fernández-Montalvo, de Corral, López-Goni, 2009)</p>	<p>Questionnaire consists of 20 questions, divided into 5 groups (personal data*, couple relationships status, type of violence, male batterer’s profile, victim’s vulnerability). Scoring: Questions are given 0 or 1 point. There are 3 risk categories for severe violence – low, moderate and high.</p>	<p>–</p>	<p>Predict intimate partner homicide and severe violence.</p>

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METHOD	DESCRIPTION	ADMINISTRATION	PRIMARY INTENDED USES
<b>Victim assessment of risk</b> (Goodman, Dutton 2000; Heckert & Gondolf, 2004; Weisz, Tolman, Saunders 2000)	2 questions about victim's perception of the likelihood that she will be physically assaulted or seriously hurt by abuser in the next year. Scoring: victim rates likelihood on a scale of 1–10	–	–
<b>Aid to Safety Assessment Planning (ASAP)</b> (Millar, 2009)	The ASAP manual incorporates items from SARA and B-SAFER and includes 11 Abuser Factors identifying the abuser's actions that increase a woman's risk of being abused or decrease the level of safety. It also includes 12 Safety Support Factors that outline what the victim needs to ensure the best possible safety plan.	Interview with the victim, usually by victim service workers.	The objective of this manual is to reduce the risk of violence by providing a comprehensive and coordinated safety management strategy, designed for use by victim service workers in cooperation with other relevant justice agencies to support women in making safety assessment decisions.

\*Perpetrator or victim immigrant status is seen as a risk factor.

Obviously, the list of risk assessment instruments presented in the table above is not comprehensive. There is a wide range of different checklists, protocols, projects and other risk assessment instruments, e.g. Navy Risk and Safety Assessment, Domestic Violence Risk Assessment Form, Lethality Checklist and Physical Abuse Scale, Risk Assessment and Lethality Assessment, Domestic Violence Supplementary Report Form (DVSRF), Family Violence Investigation Report (FVIR), Family Violence Risk Factor Checklist etc.

## 4. PREDICTIVE ACCURACY OF DIFFERENT RISK ASSESSMENT INSTRUMENTS

Several studies had been conducted with the aim to evaluate the predictive accuracy of different risk assessment instruments. The **Intimate Partner Violence Risk Assessment Validation Study** (Roehl et al., 2005) used multisite field test to assess the predictive accuracy of 4 instruments (DA, DV-MOSAIC, DVSI, K-SID). The authors also aimed to evaluate the impact of risk assessment on the victim's self-perceived risk and self-protective behaviour. The study showed that all of the instruments had evidence of concurrent validity in terms of significant correlation with frequency and severity of physical abuse at baseline as measured by the CTS2, with DA having the strongest correlation (0.459) and the K-SID the weakest (0.134).

By most analytic strategies, the Danger Assessment had the strongest psychometric properties, including the predictive statistics; DVSI and DV-MOSAIC had significant associations with future re-assault. The K-SID was least strong, however, it did best at predicting re-arrest using the criminal justice data. Some of the differences in the results could be attributed to the different purposes for which these methods were developed. By most analytic strategies, women's perception of risk did better than the other assessment methods or almost as well as the DA, the most predictive of those tested. But even the women's prediction left much of the re-assault unanticipated.

On the subject of sensitivity and specificity, all instruments were high on sensitivity (0.80–0.90 for the DA and DV-MOSAIC with cut-offs at the second lowest levels of risk), in other words they correctly classified most of the women that were indeed re-assaulted as being at somewhat elevated risk. The great majority of women with the lower risk scores or ratings were not subsequently re-assaulted (over 80% on the DA and DV-MOSAIC; 67–72% on the DVSI and K-SID). This high sensitivity of instruments is good for victims' safety, but there is a still 16–33% false negative depending on the method used (women who were predicted to be at low risk still experienced violence, even severe violence).

In the **Study of Validity of Risk Assessments for Intimate Partner Violence** (Hanson et al., 2007) authors compared 18 studies (10 from United States, 6 from Canada and 2 from Sweden), which examined the ability of risk assessment to predict spousal violence or any violence (including spousal) recidivism. This study is a meta-analysis review of the predictive accuracy of different approaches that are used to assess risk of recidivism for male spousal assault offenders. Most offenders in studies were recruited from community settings. The most common source of recidivism information was local criminal justice system records and/or national records. Six studies used partner reports. From the methodological aspect, each study was coded using a standard list of variables and explicit coding rules. As an index of predictive accuracy, the standardised mean difference, *d*, was selected, which measures the average difference between the recidivists and the non-recidivists, and compares this difference to how much recidivists differ from each other and how much non-recidivists differ from each other.

For the prediction of spousal assault recidivism, the four approaches (spousal assault scales, other risk scales, structured professional judgment, and victim judgment) were similar. Although the differences between the categories were not significant (the confidence intervals overlapped), the risk scales designed to predict other types of recidivism (e.g., criminal, violent) were somewhat more accurate ( $d = 0.54$ , 95% C.I. of 0.42 to 0.66) than the risk scales designed to predict spousal assault recidivism ( $d = 0.40$ , 95% C.I. of 0.32 to 0.48). Additionally, structured professional judgment ( $d = 0.36$ , 95% C.I. of 0.19 to 0.54) and victim judgment ( $d = 0.36$ , 95% C.I. of 0.26 to 0.45) showed the same accuracy, which was somewhat but not significantly lower than the risk scales designed to predict either spousal assault or other types of recidivism. The most accurate tools were those in which the items were selected empirically (i.e., based on observed predictors in group data). Concerning results of SARA, it is worth noting that there was significant variability among the two studies that used SARA to structure professional judgment. Kropp and Hart (2000) found high predictive accuracy ( $d = 0.76$ ) when the SARA judgments were coded from files by researchers, whereas the predictive accuracy was low ( $d = 0.21$ ) when the SARA was coded by Swedish police officers in the course of their duties (Kropp, 2003)

#### 4.1. RESEARCH ON SARA

Kropp & Hart (2000) evaluated the reliability and validity of judgments concerning risk for violence made using the SARA. They analysed SARA ratings in 2 groups of probationers and inmates divided into 6 samples (total number of 2681 offenders). SARA ratings were based on an interview with the offender and a review of all relevant file information or on the basis of files only. Evaluators coded the presence of the 20 risk factors on a 3-point scale and also indicated whether they considered the risk factor to be a 'critical item' (e.g., an item strongly related to violence risk in the particular case).

The SARA total scores were compared to three other measures of general violence risk (Hare Psychopathy Checklist: Screening version (PCL-R), General Statistical Information on Recidivism and VRAG). In a subset of 102 offenders, the difference between SARA total and Part 1 and Part 2 mean scores for recidivists and non-recidivists were examined.

Structural analyses of the risk factors indicated moderate levels of internal consistency and item homogeneity. Interrater reliability was high for judgments concerning the presence of individual risk factors and for overall perceived risk. SARA ratings

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significantly discriminated between offenders with and without a history of spousal violence in one sample, and between recidivistic and non-recidivistic spousal assaulters in another.

Concurrent validity of SARA ratings in respect to 3 other measures showed that correlations with the Number of Critical Items generally were small and not statistically significant. Only the correlation of SARA total score to PCL-R was statistically significant.

A predictive validity study on the SARA had been conducted also by Williams & Houghton (2004). They used a sample of 434 male spousal assaulters and completed SARA assessments at the time when the offenders were released. Re-offense rates were examined 18 month later. The study showed statistically significant predictive validity for SARA. The study of Hilton et al. (2004) also supports this finding.

## 4.2. RESEARCH ON DANGER ASSESSMENT (DA)

The initial studies (Campbell, 1986, 1995, 2007) have examined reliability and validity of the original 15-item DA, with acceptable internal consistency (0.70–0.80). In two studies where test-retest reliability was assessed, the internal consistency ranged from 0.89 to 0.94 (Campbell, 1995; Stuart & Campbell, 1989). Discriminant group validity was supported by significant difference in DA mean scores among contrasting groups of women (Campbell, 1995). Convergent construct validity has been supported in the majority of the studies, with moderate to strong correlations between the DA and validated instruments measuring severity and frequency of intimate partner violence and injury from abuse (Campbell et al., 2009).

Several independent predictive validity studies of DA (used as a re-assault measure) showed a successful prediction of re-abuse, DA was a stronger predictor than CTS2 (Dutton et al., 2001). Saunders (2000) pointed out that women's perception of danger was a stronger predictor than any of the 10 DA items available in the criminal justice records. Heckert & Gondolf (2004) mentioned that women's perception of risk plus DA is the best model for predicting re-assault (over SARA and K-SID), but women's perception of risk by itself is not quite good as DA (Campbell et al., 2003).

## 5. POTENTIAL RISKS OF RISK ASSESSMENT INSTRUMENTS

Even though the risk assessment instruments are viewed as a very positive step towards an effective protection of victims in danger of re-assault or severe/lethal violence, some authors are calling attention to the potential risks and limits. Humphreys et al. (2005) highlighted concerns that in poorly performing forces the risk assessment model could be used only as 'rationing device', leaving all but the high-risk cases without adequate service. Also Campbell et al. (2003) stated that services should never be denied on a basis of any risk assessment tool. High quality of risk assessment requires good training and supervision. Humphreys et al. (2005) raised the question of the potential to use a risk assessment models as a checklist procedure; this may undermine rather than facilitate the dialogue with a victim, which is necessary to appropriately assess risk. Sensitive issues such as threats to kill, controlling jealousy or isolation could not be easily assessed without a good dialogue with the victim. Further, there is a debate that the factors associated with risk are not predictive or casual. There are many false positives as well as highly dangerous situations where few risk factors are present. Dutton (2008) mentioned that risk assessments have a tendency to over-emphasise past criminal misconduct and draws attention to the 'catastrophic first offences', that appear to be 'coming out of the blue'. He pointed out that catastrophic first offenses do occur, typically in the context of abandonment of the relationship or mistreatment at the workplace and that current scales do not assess or give sufficient weight to severe emotional reactivity to abandonment. It is also essential to mention that the cultural context of prediction is important. As most of the risk assessment instruments have been developed in North America or western

European countries, there can be important cultural factors that need to be addressed when applying these instruments in different cultural environments.

## 6. VIOLENCE RISK MANAGEMENT

The process of preventing violence by influencing risk and protecting factors is referred to as risk management. A comprehensive risk management strategy should be personalised for each individual case and reflect both the nature and degree of risk in the respective case. We should ask: What can happen in this case, what might the violent person do? The answers should be based on the analysis of what the individual has done and what the individual is planning. The descriptions of 'possible futures' can be denominated as scenarios. Those scenarios are not predictions about what will happen, but rather projections about what could happen (Hart, 2008).

The risk management strategy should also reflect relevant risk factors, as according to Hart (2008), there are several ways in which a risk factor may be relevant to risk management. A risk factor may play a role as motivator or disinhibitor of violence, or can be an impeder of risk management. A motivator is a risk factor that makes violence an attractive or rewarding option for the person. A disinhibitor is a risk factor that makes the person less likely to be influenced by restraints, prohibitions or proscriptions against violence (e.g., alcohol or drug intoxication, extreme anger etc.). An impeder is a risk factor that decreases the effectiveness of the various tactics of violence prevention.

### 6.1. RISK MANAGEMENT TACTICS

Risk management tactics can be divided into four categories: monitoring, treatment, supervision and victim safety planning. Victim safety planning is most relevant in situations that involve 'targeted violence', where the identity of the potential victim is known, as is common in cases of intimate partner violence. The goal is to ensure that any negative impact on the victim be minimised, if violence recurs (despite all monitoring, treatment and supervision). Victim safety planning involves improving the victim's dynamic and static security resources. Dynamic security is a function of the social environment. It is provided by people (the victim and others) who can respond rapidly to changing conditions. Good cooperation with the victim is necessary for victim safety planning. Static security is a function of the physical environment and can be improved, e.g., by adding lights, installing video cameras, locks, security checkpoints, alarms etc. (Hart, 2008).

## 7. MULTI-AGENCY APPROACH TO RISK ASSESSMENT AND RISK MANAGEMENT

Single-agency interventions are less effective in preventing violence than a more holistic, coordinated multi-agency approach. As we can assess risk of repeat or severe violence, we need to have policies and tools to ensure the victim's safety and reduce future abuse. In order to provide quality services for high risk victims and their children, hundreds of domestic violence forums have emerged over the last ten or fifteen years. Some countries, such as the UK, have developed specialised services for high risk victims, such as the Multi-Agency Risk Assessment Conferences (MARACs) (Logar et al., 2006).

The **Multi-Agency Risk Assessment Conferences (MARACs)** are voluntary meetings where local authorities dealing with domestic violence cases are present. These meetings provide a forum for sharing information on the highest risk cases and taking actions that will reduce future harm to the most endangered victims and their children (Robinson, 2004). By bringing all agencies involved in a case together to share information, a coordinated safety plan can be built up more quickly and effectively (CAADA, 2010). The first MARAC in Cardiff, Wales was held in April 2003 and was attended by members of 16 agencies (Robinson, 2004). In 2010, there are now over 220 MARACs across England and Wales and it is estimated that 300

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are needed nationally (CAADA, 2010). High risk victims are referred to the MARACs usually by the police, but any participating agency could bring a case to the MARACs meeting.

There are different risk assessment tools, used to identify high risk victims, e.g., South Wales Police developed their own risk assessment form, which contains 15 questions (Robinson, 2004), CAADA developed the Risk Identification Checklist for use by Independent Domestic Violence Advisors (IDVAs) and other non-police agencies for MARACs case identification (CAADA, 2009). During a MARAC meeting, usually about 20 cases of high risk victims are discussed. High risk cases which will be referred to at the meeting are gathered on a list circulated by police in advance, so all participating agencies can check the list against their own agency's record before attending the MARAC to collate all the evidence available for the victims, perpetrators and the children. After information sharing, the specific action plan is agreed on and assigned to particular agencies to carry out. All agencies update their own files to reflect information shared and action taken at the MARAC (Robinson, 2006).

There are impressive results indicating that MARACs are successful at improving the safety of victims, since most victims are experiencing less violence after their referral to MARACs (Robinson, 2006). According to the police data, 97 of 146 women experienced no further incidents of violence or abuse. The majority of the victims in the sample of this study had no complaints (62%) or police calls (78%) on record 1 to 6 months after the initial incident. This success of MARACs is supported also by CAADA (2010) data, which confirm that at an average of six months after the MARAC meeting, circa 60% of the victims had not reported a repeat incidence of violence, threats of violence, sexual abuse, stalking or harassment.

Recent studies from the United Kingdom showed that **Independent Domestic Violence Advisors** play a significant role in providing protection and support to high risk victims and are important actors in the multi-agency approach. Independent Domestic Violence Advisors (IDVAs) are 'specialist case workers who focus on working predominantly with high risk victims, those at most risk of homicide or serious harm. They work from the point of crisis on a short to medium term basis. They also mobilize multiple resources on behalf of victims by coordinating the response of a wide range of agencies who might be involved with a case, including those working with perpetrators and children. They work in partnership with a range of statutory and voluntary agencies but are independent of any single agency.' (Howarth et al., 2009, p. 6).

In 2009, Howarth et al. published the study Safety in numbers - Summary of findings and recommendations from a multi-site evaluation of Independent Domestic Abuse Violence Advisors (IDVAs). In this evaluation, seven IDVA services from different parts of the United Kingdom participated. Data were collected over a period of 27 months. IDVAs gathered information from 2 567 high risk victims at the point of referral to the service. Where it was possible (in 1 247 cases), data were gathered on a second occasion, either at the closure of a case or after four months of providing support to the victim (data included information about interventions and types of support provided by IDVAs and, importantly, documented levels of victim safety and well-being). In 412 cases, IDVAs made short interviews with victims on their exit from the service, focusing on their opinion what factors had impacted their safety during the period of intervention. Six months after the closure of the case, a small group of 34 victims were re-contacted in order to examine the sustainability of any changes in their feeling of safety and well-being.

The study of Howarth et al. (2009) showed that the abuse experienced by victims accessing IDVA services was extremely serious and we can refer to them as high risk victims. The concept of high risk victims is relatively new and it is related to the risk of serious harm and homicide. 76% of the victims in the sample of this study were experiencing at least one form of severe abuse at the time of intake. Severe abuse included violent behaviour causing injuries, strangulation, rape or other sexual abuse, harassment and stalking and extreme jealous and controlling behaviour, including threats to harm children. Moreover, 86% of victims in this study experienced multiple forms of abuse. The majority of the victims were separated from their partners. This fact confirms again that intimate partner violence frequently does not end with separation. Another important finding refers to children living in circumstances of domestic violence. There was clear evidence of risks associated

with and directly affecting children. From those victims who have children (N=1774), 41% experienced conflict around child contact, 27% were afraid of harm to children and 11% experienced perpetrators' threats to kill children. Many more children may be affected by the violence in their family in a way which is disruptive to children's healthy development. This emphasises not only the direct threats to children's safety but also potential longer term psychological impacts. Even though it is not the role of IDVAs to work directly with children, this study confirms that working with victims to end abuse and access safety also has clear implications for the safety of children. Necessity of close cooperation between those who work with high risk victims and those who safe-guard children was pointed out.

Outcomes of this evaluation study present significant positive impact of IDVA service on the safety of victims. The analysis showed that the interventions used by IDVAs most frequently were safety planning (81% of cases), support in relation to child contact (51% of cases), support with housing issues (49%), support in relation to a criminal court case (43% of cases), referral to MARAC (34% of cases) and others.

After receiving the IDVA's support, 57% of all victims experienced a complete or near cessation of violence. Approximately 80% of victims had been suffering both multiple and severe abuse at intake. This fell to around 20% at the review point. Considering different types of abuse, the study showed a decline from 64% to 14% in relation to physical abuse and a decline from 62% to 15% in relation to jealous and controlling behaviour. Importantly, the cessation of abuse was also reflected in improved feelings of safety by victims at the review point. Fear of further injury fell from 58% of cases to 22% and fear of being killed fell from 48% to 7%. The number of victims who felt frightened fell from 83% to 17% after having received support from IDVA services.

Social isolation is one important characteristic of domestic abuse. Research showed that there were significant improvements in victims' social networks in 47% of cases, due to the intervention of IDVAs. IDVAs also reported significant improvements in victims' coping abilities in 63% of cases.

The impact of reduction in abuse is not restricted to adult victims only. The number of cases with conflict around child contact fell from 42% to 23% and from 30% of victims afraid of harm to children to 7% at the time of review (Howarth et al., 2009).

Obviously, there is more literature dealing with the topic of high risk victims and risk assessment. This overview is intended as an outline of major current studies and approaches, with the aim to focus on victim safety.

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## II.

### **B. REPORT ON RESEARCH RESULTS RELATED TO MAPPING OF 8 COUNTRIES CONCERNING THE PROTECTION AND SAFETY OF HIGH RISK VICTIMS OF GENDER BASED INTIMATE PARTNER VIOLENCE<sup>1</sup>**

The research questions are:

- (To what extent) Are empowering services and support available to (young) women and their children as well as girls at risk of serious violence, and what gaps can be identified?
- Have core agencies developed and implemented policies, guidelines and multi-agency initiatives to identify, protect and support high risk victims?
- Do they use risk/danger assessment and safety planning tools? Which instruments do they use, who uses them, what is the purpose and effect of using such tools, to what extent are such tools used?
- Are there any multi-agency good practice models in protecting and supporting high risk victims?
- Is there any systematic method of analysing homicides or attempted homicides (including homicides committed in the name of honour) in order to evaluate strengths and weaknesses in the prevention system?

Instead of an extensive survey – which would have gone beyond the scope of this project – it was decided to do a mapping of the participating countries. All partners were well aware that the information given does not stand for the whole country, but might describe some facets of many. It is also important to mention that the individual respondents may not represent all agencies, but just their own or even just the department/unit they are working for.

The partners in 7 countries (Austria, Bulgaria, Czech Republic, Germany, Italy, Slovakia and Spain) had to choose 10 interview partners from 10 core agencies (justice system, police, women's support services, intervention centres, immigrant women's services, social services, health services and child protection authorities). Ideally, different levels should have been addressed also: organisations operating on the national, state/province, regional/local level. Unfortunately these requirements could not be fulfilled in every country.

The mapping was done on the basis of interviews. These interviews consisted of 3 parts: 1. Identifying high risk victims, 2. Safety measures and planning and 3. Cooperation with other agencies.

The interview partners received an outline of the questions in advance. The interview itself was done by phone by an expert in this field of work from the partner organisation.

The results of the mapping per country are part of this report.

CAADA, our partner in the UK, joined the project PROTECT later on. They jumped in for another organisation. The time limitations were the reason for not involving CAADA in the UK mapping. Instead they were asked to hand in a short report on the MARACs and the involvement of the various organisations in them.

A comparison between the countries is not possible, because of the differences of the participating agencies, the interview partners on different levels of these agencies (director, case worker, manager, educator etc.). The summary of this part of the research tries to answer the above questions and give recommendations based on the interview results.

<sup>1</sup> A more detailed version of this report is available at the WAVE Website in the PROTECT Online Resource Centre.

## MAPPING RESULTS – AUSTRIA

### GENERAL OVERVIEW

Austria has 8.3 million inhabitants; most of them (1.7 million) live in Vienna. The proportion of men and women is nearly equal (about 200 000 more women than men). Austria is a federal democracy with 9 regions, but with a concentration of population, infrastructure, cultural activities, and social services in Vienna (capital and region).

### WOMEN'S SHELTERS

In Austria there are 30 women's shelters with 748 places. According to the Council of Europe recommendation 86 places are missing.<sup>2</sup> 26 of the shelters joined the Austrian Autonomous Women's Shelter Network. While the 4 shelters located in Vienna are funded by the City of Vienna based on a long-term contract, the shelters in the other regions are only partly funded by the State. 2009 the women's shelter in Hallein (Salzburg region) was at risk to be shut down due to lack of funding.

### INTERVENTION CENTRES

In 1997 the Anti-Violence Act was implemented in Austria; in accordance with this law, intervention centres were implemented – one in every Austrian region.

The Domestic Abuse Intervention Centre Vienna opened its doors in 1998. The number of cases has risen continuously over the last 12 years. In 2009 the Vienna police referred 4 702 cases to the Domestic Abuse Intervention Centre Vienna. Compared to the other Austrian regions, half of all eviction orders applied by the Austrian police are issued in Vienna. Thus we notice a sharp difference between urban and rural areas. The implementation of the Anti-Violence Act (eviction order) by the police in rural areas should be improved.

### POLICE

Until now it was only the Vienna Police who had special officers for domestic violence. By the end of 2010 special officers should be implemented all over Austria. The Ministry of Interior started a special programme for very high risk victims in June 2010. This programme applies to all kind of victims, but also includes victims of partner violence.

### JUSTICE

Apart from the Anti-Violence Act (1997) there have been further improvements within the legal framework concerning domestic violence / violence against women.

- Anti-Stalking Act (2006)
- Free psychosocial and legal support in criminal proceedings (2006)
- Dangerous threats turned into criminal offences liable to public prosecution (2006)
- Specialised prosecutors in prosecution offices with more than 10 prosecutors (2009)
- Free psychosocial support in civil proceedings (2009)

Since 2009 prospective judges have been obliged to do a 14-day internship in a victim's support service. Until June 2010 the Domestic Abuse Intervention Centre Vienna had only one (!) prospective judge as a trainee.

Although Austria has a very good legal background regarding the prevention of domestic violence, there are considerable gaps concerning the implementation of the law.

<sup>2</sup> See WAVE country report 2008.

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## THE INTERVIEW

The interview was implemented with 13 responding parties:

- Police (Ministry and regional)
- Justice (Ministry and regional)
- Women's Support Services (Network and regional)
- Intervention Centres (both regional)
- Health Services (Network and regional)
- Child Protection (regional)
- Immigrant Women's services (both regional)

Nine women and five men were involved with the interviews and all core agencies were covered as well as the different levels (state and region).

## IDENTIFYING HIGH RISK VICTIMS

Of the 13 interviewed parties, 12 stated that they identified high risk victims of gender-based violence in intimate partnerships, with one restriction, however: 'They don't use the term 'high risk victims', and they don't focus on these women. But they do assess dangerousness.'<sup>3</sup>

Another respondent explained:

*'The Austrian Ministry of Interior started a programme for high risk victims just one month ago. This programme is for all kinds of victims. High risk victims will be protected in the same way as witnesses of high risk (Witness Protection Programme = Zeugenschutzprogramm). The case worker decides if a victim is at high risk and refers the victim to the programme.'*

As 12 participants added, this identification is based on the personal contact with the victim and with her direct involvement. Written reports are additionally used by 8 organisations, 1 uses evidence at the scene of crime as well, and 7 also take the degree of severity of the injuries into consideration. Four respondents improve their state of information about the victim's endangerment by staying in contact with other institutions (women's shelters, intervention centres etc.).

When asked if any risk assessment instruments are used within this process, 8 respondents gave a positive answer and 5 answered 'no'. In one organisation this tool was never needed, 4 do not know any such tools, and one explained:

*'First, they use the '4-eye method', which means that 2 advisors talk to the client (in every case assessed). Second, cases are discussed with the supervisor. They have additional instruments for children, but not for adult women.'*

Those respondents who use tools of risk assessment name the following tools:

- Big 26 of the DAIP, in 3 organisations
- Danger Assessment (DA) by Campbell, in 4 organisations
- SARA, in 2 organisations
- other instruments, in 1 organisation
- self-developed instruments, in 3 organisations.

Only 2 organisations use just one instrument, the others apply at least 2 of them (Big 26 and DA; DA and SARA). What is interesting is the sequence of application as described by one participant: *'We use Big 26 systematically; if this results in many 'yes' answers, then we do a further assessment with DA Campbell or others.'*

<sup>3</sup> Interviewer's note

The respondents of the health sector have quite different approaches. In the answers one can find quite an inconsistency which might be due to the different interpretation of the term 'risk assessment instrument'. Both respondents stated that they do not know any instruments, but when asked about their practice, one said:

*'In the forensic section of 2 psychiatric hospitals we use our own instrument (HCR 20). In one hospital they use a special instrument for children, but not for women.'*

And the other stated:

*'We do have a certain method which I would not describe as an instrument, but it works. The woman is asked certain questions before she leaves the hospital: is she safe at home; does she need a place in a shelter; what is her situation when she leaves the hospital now. All nurses learn to ask these questions during the enrolment. They have written documents on this issue at the ward, with free access for every nurse.'*

Leaving the term instrument aside, the result is that 10 respondents are using some kind of method to assess high risk in intimate partner violence.

One of the respondents explains why they do not apply RAI:

*'We delegate the assessment to the intervention centre in order to leave it to the professionals on this issue.'*

The assessment of high risk is done in 10 organisations by a professional in the agency. But in only 3 organisations is this assessment solely carried out by the professional. In 5 organisations, the supervisor is also involved, and in 4 agencies a multidisciplinary team participates in the assessment.

One respondent explains:

*'The professional on standby makes the first assessment based on the Big 26. Then a further assessment is done together in small groups: talking again with the woman, talking to the police and so on.'*

Of those 10 agencies who apply a RAI (of whatever nature), 60% do so systematically.

The approach of one intervention centre is outstanding:

*'The standard is to apply the instrument systematically at the first contact with the victim and to repeat it regularly in all cases of partner violence. Between August 2009 and December 2009 we identified 107 victims at high risk by using the DA. We have applied the DA instrument more systematically since 2009. Before that we used the Big 26 of the DAIP project. We are serving a lot of victims of DV (we receive over 4 000 reports by the police per year). Since we have limited resources, it is very important to be able to identify high risk victims in order to prioritise support. We decided to apply an instrument that estimates lethal risk in order to be able to contribute to the prevention of homicides, attempted homicides and severe violence. DA is administered electronically and the information is integrated in the client database. If the client file is open, the result of the last DA is visible on the first page. This way staff can see the level of danger immediately and can react more appropriately.'*

Of the 40% who do not use an instrument systematically, one respondent gave an explanation in which cases exceptions are made:

*'We apply the instrument in cases where women try to downplay the danger and do not perceive themselves as being at risk.'*

Concerning the helpfulness of the applied instrument 8 respondents gave positive answers. In the majority (5 out of 8) the answers stress the helpfulness of the instrument in regard to the victim's self evaluation of the danger. One respondent mentioned that it 'helps to not forget any risk factor', another respondent appreciates 'to get a first overview'. And one

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intervention centre points out that the *'DA is very important in order to provide more effective support and protection to high risk victims and to inform and alert other agencies responsible for the protection of victims, such as law enforcement and the judiciary.'*

At the same time, 3 of the 8 respondents stated negative aspects. One comment mirrors the concerns of all negative answers: *'With DA Campbell we have the problem that the result does not correspond to the reality: the risk it shows is higher than the actual risk. We consider the instruments as a snap shot; assessment has to be done regularly. Another problem is that all these instruments only register partner violence and not other family violence (father against daughter etc.)'*

## SAFETY PLANNING

Concerning standards for protection and safety of high risk victims one respondent did not answer. The distribution of the other answers is 2/3 'yes', 1/3 'no' (8:4).

The standards (or what is considered as such) vary greatly:

**Table 1: What are the standards? (col. 3) Written guidelines/policies? (col. 4)**

Police	Ministry	3 = other (active protection of the victim: bringing her to a 'covert' dwelling)	yes
	regional	1 = setting up a safety plan; 2 = multi-agency approach	yes
Justice	Ministry	2 = multi-agency approach	yes
	regional	2 = multi-agency approach	no
Women's Support Services	network	1 = setting up a safety plan	no
	regional	1 = setting up a safety plan; 2 = multi-agency approach	yes
Intervention Centres	regional	1 = setting up a safety plan; 2 = multi-agency approach	yes
	regional	1 = setting up a safety plan; 2 = multi-agency approach	-
Immigrant Women's Services	regional	-	no
	Ministry	-	no
Health Services	network	2 = multi-agency approach; 3 = other (a victim support group is established in all the hospitals by law. But it refers to all kinds of victims, not only domestic violence)	yes
	regional	2 = multi-agency approach	yes
Child Protection Authorities	regional	-	no

Slightly more than half of the respondents (7 of 13) provide written guidelines/policies on standards for protection of high risk victims. They are part of the initial training. According to 4 respondents they are used in team meetings when discussing the high risk cases.

In 7 of the responding organisations the staff has regular training in working with high risk victims of domestic violence. In 7 agencies, also newcomers receive training. Especially interesting here is a new policy within the education of future judges:

*'Since 2009 future judges and prosecutors have been obliged to learn about victims of DV. Risk assessment is part of the exam. They are obliged to do a 2-week internship in an intervention centre. The Anti-Violence Act and the cooperation between justice, police, intervention centres and other institutions are obligatory subjects within their curriculum.'*

A different picture is drawn concerning judges who have finished their studies and are already working in their profession:

*'Further education on DV is offered to judges: in the last 6 months 2 seminars on DV and risk assessment with an external expert were provided – but those are optional.'*

The review and analysis of homicides, attempted homicides and cases of severe violence within the agency was stated by 7 of the 13 respondents. The distribution of the answers is as follows: the respondents of the justice system, health services and child protection do not engage in this kind of analysis at all, whereas the NGOs working with victims review the cases of severe violence. The police respondent on the regional level also responded positively to this question.

If this review and analysis is done at all, it happens on an irregular basis (whenever a case occurs).

## **COOPERATION WITH OTHER AGENCIES**

All Austrian respondents said that they share information with other agencies on the assessed high risk victims. No participant could give any numbers of cases, though. The intervention centres seem to be the key agencies, because they were listed by all other organisations, followed by the police and child protection authorities.

Whereas the state-run organisations work together with others on the basis of laws and protocols (either to share information and/or for a multidisciplinary and integrated intervention), the cooperation of the NGOs with others seem to be based on more informal agreements.

A similar distribution is found concerning the consent of the women to the sharing of information. Police, justice and child protection authorities do not require any consent, whereas the women's support services, immigrant women's services and the intervention centres need at least her verbal consent. The health services need her consent in general, but when there is acute danger or the woman has unequivocal injuries they are obliged by law to involve the police.

The exchange of information is practised in 9 responding organisations through case conferences and in addition via telephone conferences. Of these 9 participants, 8 also share written reports. Only 1 respondent stated that they exchange information via telephone conferences only, 3 respondents answered that they have telephone conferences and an exchange of written reports, but no meetings.

One answer is quite remarkable and worth quoting:

*'We write reports to the prosecutor office and courts, we inform them orally and we inform them in the frame of multi-agency risk assessment conferences.'*

Here again the exchange seems to work one way only, except for the conferences.

One intervention centre organized six multi-agency risk assessment conferences (MARACs) in 2009 involving other institutions like the police, child protection authorities and civil courts.

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Regarding the question who has access to the documentation of the high risk cases within the agency, the majority of the respondents (8 of 13) mentioned that both the case manager and the relevant units have this access; 3 stated that the case manager only has access and 2 said that only the relevant unit has access.

When asked whether they share information on high risk cases systematically within their agency, 7 said yes, 4 said no, and 2 did not answer. There is no difference between state organisations and NGOs, the yes and no answers are equally distributed between both.

As to the question if the agency has written policies/guidelines concerning high risk cases, the answers on federal level (ministries) are quite inconsistent compared to the answers regarding the basis of cooperation with others. This inconsistency points either towards a misunderstanding of the question (applying to high risk cases only and here, no specific guidelines are to be found) or the 'regular' protocols on cooperation are not applied in high risk cases. Either way these points have to be addressed and clarified.

Of 13 respondents, 7 stated that they do not consider the analysis of homicides or attempted homicides as part of the multi-agency work. One respondent did not answer and 5 participants see this as part of this work.

One stated:

*'In cases of homicides and severe violence we organise multi-institutional case conferences. We invite all involved parties – police, child protection authorities, district court – in order to analyse what happened. The goals of the homicide conferences are to identify possible gaps in the intervention system and to improve interventions.'*

In 2009 this agency analysed one homicide within a multi-institutional case conference.

## SUMMARY

Almost all of the respondents declared that they identify high risk victims of gender-based intimate partner violence. The danger assessment is done by personal contact with the victim. Most agencies apply risk assessment instruments systematically. There are different interpretations of the term 'high risk', for instance in the health sector.

2/3 of the respondents stated that they provided standards for protection and safety in high risk cases. Those standards vary greatly.

About half of the participants offer a regular training on high risk for their staff, about half do so also for newcomers to the organisation.

All agencies exchange information in high risk cases. The intervention centres play a key role in the information exchange process. While the state agencies cooperate on the basis of formal protocols, informal agreements are the basis of cooperation for most NGOs.

## MAPPING RESULTS – BULGARIA

### GENERAL INFORMATION

The total population of Bulgaria is 7 563 710 inhabitants (end of 2009). The gender ratio is 51.6 % women/48.4 % men. There is a tendency of decrease in the total population; the birth rate is very low. These processes are valid for the country as a whole and vary by regions.

The ratio of urban/rural population accounts for 71.4% (5.5 million urban population) / 28.6% (2.1 million rural population). The biggest city is Sofia (the capital), where officially 1/6 of the inhabitants of the whole country live – 1 249 798 inhabitants by the end of 2009. Including the people who study or work there, the population of Sofia is actually much bigger.

### STATISTICS ON DOMESTIC VIOLENCE AND VIOLENCE AGAINST WOMEN

The basic data on these cases is collected by the NGOs involved in activities and services for the victims of violence. There are various criteria applied to identify the cases of violence and the number of the victims (survivors of violence). The National Statistical Institute does not collect data on these phenomena.

The authorities that are legally bound to combat violence against women, and domestic violence in particular, are the police and the civil (family) departments of the courts of first instance.

In their evaluation, the police, the prosecutors and the penal courts usually concentrate much more on the potential danger of the perpetrator, the degree of social dangerousness of his personality and of the crime committed, rather than the risk for the victim. The penal doctrine and the respective judicial practice are based on the concept of the perpetrator as a central figure in the penal procedure. This approach was explicitly confirmed in the preliminary conversations that we had with the representatives of the mentioned institutions and is based on the existing legislation in Bulgaria. This derives from the Penal Code and the Penal Procedure Code, where the aim is to prosecute and to impose a punishment on the perpetrator rather than to protect the individual victim.

National NGOs involved permanently with activities for prevention, protection and support of victims of domestic violence and violence against women are:

1. Association Animus – in Sofia (with a shelter) and in Plovdiv
2. BGRF – Sofia and its three branches in Sofia, Plovdiv and Khaskovo
3. Demetra – Bourgas (with a shelter)
4. DIVA Foundation - Plovdiv
5. Ekaterina Karavelova – Silistra (with a shelter)
6. NAYA Foundation – Turgoviste
7. Opened Door – Pleven (with a shelter)
8. Skills of Positive Personality in Society – Pernik (with a shelter)
9. SOS Families at risk – Varna (with a shelter)

All the shelters are run by the NGOs but three of them act in their function on behalf of the State although they are not totally financed by the State budget.

There are also five other NGOs carrying out similar activities, but they have very small budgets and/or are having serious difficulties, and the range of their activities is limited.

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## THE INTERVIEW

The interviews were conducted with 8 agencies on the regional level (4 intervention centres, 2 women's support services, 1 police unit and 1 child protection service unit). The Network of Intervention Centres is the only responding agency working on a national level. The interview partners were 7 women and 2 men.

## IDENTIFYING HIGH RISK VICTIMS

All participants answered that they identify high risk victims of domestic violence through personal contacts with the victim. Additionally, 6 respondents used written reports, 4 took the severity of the injuries into account and 2 also assessed the evidence at the crime scene.

The indicated number of high risk cases of intimate partner violence ranges from 348 cases to 11 cases in 2009. One intervention centre was unable to give a case number:

*'The high risk victims are not counted separately – there are not many.'*

**Table 1: How many cases did you identify in 2009?**

Police	regional	16
Women's Support Services	network	59
	regional	348
Intervention Centres	regional	–
	regional	31
	regional	11
	regional	92
	Network (national)	336
Child Protection Authorities	regional	62

Of the 9 respondents, 7 are using risk assessment instruments. The police do not use such instruments because *'There is no need unless we receive such a complaint/signal'*<sup>4</sup>. One intervention centre did not answer this question.

Which instruments are used? The Big 26 (DAIP) was used by 3 respondents, 3 relied on the Danger Assessment developed by J. Campbell (DA) and 2 used the SARA tool. Five used a self-developed instrument, mainly a guideline for an indepth interview:

*'Self-developed method – Dynamic interview. In all the cases of domestic violence part of our work is concentrated on danger assessment and on safety planning for the victim in order to manage the risk. We examine the severity, frequency and the form and circumstances of the violence committed. We also examine the use of alcohol, and whether the children were witnesses*

<sup>4</sup> Interviewer's note: '...due to the legal definitions, the risk assessment is made by the police mainly and predominantly within the Penal Procedure where they consider the dangerousness of the perpetrator and of the crime committed as well as how grave the crime is. The criminal approach to the risk assessment is focused on the perpetrator and the objective results (harms and damages) of the crime, including the personality of the perpetrator and the level of his dangerousness.'

*of the violence. We ask if the victim sought help from institutions, were there witnesses, other people of agencies involved, in order to complete our information with theirs.'*

What is quite interesting is that all 3 respondents who used either Big 26, DA or SARA never used just one tool in their agencies, but at least two of those mentioned. This is due to the different experts they work with; the choice of method is up to the psychologist, not to the organisation, which would hardly apply 2 or more methods together.

In all responding organisations, the women experiencing violence were involved in the assessment. The risk assessment is effected by the case worker (all) and additionally in a multidisciplinary team (3 out of 7). With one exception (Child Protection Authority) risk assessment is done systematically. The Child Protection Authority does not use an instrument in cases of sexual violence and when they don't have the consent of the woman.

As to the question in how many cases an assessment tool was applied, the numbers vary greatly, and in many cases they are the same as in Table 1 (see above).

**Table 2: In how many cases did you apply a risk assessment tool?**

Police	regional	–
Women's Support Services	regional	59
	regional	300
Intervention Centres	regional	–
	regional	31
	regional	11
	regional	92
	Network (national)	336
Child Protection Authorities	regional	3

All participants stated that they found it helpful to use a risk assessment tool. It is significant to see in what way such a tool is regarded as helpful: 6 out of 8 participants stated that the tool helps to identify high risk, and all said it is helpful in the sense of avoiding further violence. One pointed out that she finds it very helpful because the risk assessment is done by the client herself together with an expert. One criticism was also voiced:

*'It is not helpful, because it takes too much time, the results do not coincide with my personal evaluations and because not all colleagues can apply it'.*

## SAFETY PLANNING

All Bulgarian respondents stated that their organisation/agency has standards for protection of high risk victims of intimate partner violence and that they are available as written policies/guidelines. Taking a closer look at the answers, it turns out that the understanding of policy/guideline is actually the existing law and not a special guideline the respective organisation has developed for itself. The Women's Support Services are an exception here: *'We have such standards and we apply them case by case depending on the facts of the case and with the consent of the victim.'*

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Eight out of 9 offer safety planning, and the same number use a multi-agency approach. Here again, it is not clear what the participants mean by multi-agency approach. It can be assumed to mostly mean that an organisation/administrative body is provided with information, but that an exchange on the work level as such does not take place.

When asked how these standards are communicated to the staff, the answers vary from: *'Yes, we have written guidelines which are revised periodically, and they are distributed among the staff members involved in direct work with the victims (but not all staff members, e.g. part of the administrative staff is not included).*' to *'The Head of the Department presents the guidelines to the staff at regular meetings.'*

All respondents said that their staff has regular training in working with high risk victims of intimate partner violence.<sup>5</sup> With the exception of the child protection unit all organisations offer training on working with high risk victims to newcomers.<sup>6</sup>

And the last question of this part, asking whether cases of homicides, attempted homicides and severe violence are regularly reviewed and analysed within the agency, was answered with *'yes'* by all interviewed persons except for the respondent of the police, who stated that this is done, but on the next higher organisational level.

## COOPERATION WITH OTHER AGENCIES

This last part of the questionnaire was answered by 8 respondents. The police unit's reason for not participating in this part is explained by the interviewer:

*'This part of the questionnaire is not answered by the police unit, because of the above mentioned understanding of the risk assessment and the lack of data based on the risk for the victim assessment. The legal framework is binding the police to report the information received to the prosecutor - so, this is the only institution with which they DO SHARE INFORMATION, for sure. The problem is that they don't have criteria for high risk victims in their statistical database. Concerning the sharing of information on high risk victims usually the information **is provided to** the police, rather than **required from** the police.'*<sup>7</sup>

The concept of cooperation seems to be viewed solely as an exchange of information by all responding parties. The results of the question regarding the basis of working together show a different picture.

All respondents worked together in case conferences and all shared written reports. 50% also stated telephone conferences as a form of cooperation. One intervention centre mentioned an additional other form of cooperation:

*'... at the training seminars, conferences, etc. with the participation of the representatives from the other institutions and organisations we present more cases and data about the high risk victims of violence in order to discuss the implementation of the legislation and to define the gaps in it.'*

All 7 respondents stated that they need to have the woman's consent to cooperate with other agencies: 3 needed at least a verbal consent, 4 need the consent in writing.

Access to the documentation is limited to the case worker in 5 out of 7 organisations, in one case it is available for all relevant units of the organisation and in one case to both (case worker and unit).

All 7 participants stated that they systematically share information on high risk cases within their own agency.

<sup>5</sup> Here the question comes up, if the interviewers stressed the point specifically asking for training on high risk in the field of domestic violence.

<sup>6</sup> See previous comment.

<sup>7</sup> Interviewer's note

The written policies/guidelines of cooperation in high risk cases refer mostly to the cooperation with the police, the justice system (courts, prosecution) and child protection.

The answers to the last question are surprising: all answering parties (7) said that the analysis of homicides or attempted homicides is part of their multi-agency work. Asked for the number of cases the answers were quite specific (with one exception):

**Table 3: How many cases of homicides or attempted homicides did you analyse in 2009?**

Police	regional	–
Women's Support Services	regional	No data available
	regional	10
Intervention Centres	regional	–
	regional	17
	regional	11
	regional	92
	Network (national)	336
Child Protection Authorities	regional	10

Comparing the numbers in Table 1 with Table 3 it is striking that the numbers match for three responding parties. Here the question of validity arises.

**SUMMARY:**

All organisations interviewed stated that they identify high risk victims. But in view of the very variable case numbers it can be assumed that no agreed-upon definition of high risk victims exists and that the classification is at the discretion of the participating respondent.

Furthermore, the involved organisations mostly use an assessment instrument, but here again there is no basis that was agreed upon jointly and in a coordinated way.

Looking at the standards for protection and safety measures for high risk victims a similar picture can be found: they are based on a specific law, but guidelines for the implementation of the law by the individual organisations are missing.

One gap in the safety net can be identified in the sense that there is no cooperation in high risk cases between the police/other government agencies and NGOs, and therefore an important connection between data exchange and the assessment of high risk is missing. Also, the cooperation among the NGOs seems to take place at a rather informal and low level.

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## MAPPING RESULTS – CZECH REPUBLIC

### GENERAL OVERVIEW

The Czech Republic has 10.2 million inhabitants, 50.9% are women. The capital of the Czech Republic is Prague, with 1.25 million inhabitants.

Concerning domestic violence against women, we still lack representative surveys, but according to a survey organised by the Academy of Science of the Czech Republic in 2003, 38% of women experienced some form of violence from partners during their lifetime.

As for the legislation, §199 of the Criminal Code applies to the abuse of a person living in the same residence, and since 2007, Act no. 135/2006 on the Protection against Domestic Violence has been in force. This law provides the police with a right to evict the perpetrator from the home for 10 days and with a right to issue an order prohibiting the perpetrator to contact the endangered person or to enter the home. Civil court can prolong the period up to one year. This law also establishes intervention centres in all regions of the Czech Republic. These intervention centres should be based on multi-agency cooperation. They are among the services of social prevention according to the regulation §60a of Act no. 108/2006 Sb. on social services.

Apart from intervention centres, there are specialised NGOs and shelters. Unfortunately those NGOs are mainly based in major cities, and only a few of them see the violence from the gender perspective, the 'gender-neutral'- approach is promoted by the State and the victim support organisation Bílý kruh bezpečí. As for the shelters, they are sufficient in number, but specialised shelters with a secret address are still lacking.

### THE INTERVIEW

The interview partners were 10 representatives of 7 different organisations. All respondents were women working on a regional level, but in different regions of the Czech Republic.

### IDENTIFYING HIGH RISK VICTIMS

With the exception of the respondent from the Health Services (University Hospital) all participants stated that they identified high risk victims of intimate partner violence.

The mode of identification varies from agency to agency.

The majority of the respondents (9 out of 10) stated that they use the personal contact to the victim to find out if she is at high risk or not. Evidence from a written report is an important source for 70% of the respondents, whereas the evidence at the scene of crime is noted by 50%. 40% take the degree of severity of the injuries into account.

In two agencies the evaluation of the profile of the violent person is also considered. Especially the Immigrant Women's Service faces a lot of difficulties:

*'Everything is based on confidence between me and the client. Sometimes when we see bruises etc. we ask our clients whether they are OK, whether everything is alright in their family. It is very difficult to confide for these women, it takes time. Sometimes they are afraid of being expelled from the country, sometimes they don't know what to do. Some of them even don't know what domestic violence is, they consider this behaviour as normal, some of them don't know shelters, because there are none in their country. So we can explain all possibilities to them. But we cannot decide anything for them, we can only advise them.'*

When asked if risk assessment tools are used, the group of respondents is split in half: 5 of them use a tool, 5 do not. One agency clearly named the reason for not using a RAI:

*'Domestic violence is not the main objective of our organisation; therefore we do not use any specific instrument. If we have a suspicion on domestic violence, we discuss the situation with the woman and we provide her with contacts to other organisations.'*

Three other respondents said that no instrument was needed. One of them explained:

*'We are trained in recognising the violence and we don't need any questionnaires, we rely more on the experience of our workers.'*

Of the 5 organisations which use a RAI, 3 are using SARA and 2 have a self-developed instrument. With one exception (an intervention centre) the victim is actively involved.

One self-developed instrument is a 'questionnaire on evaluation of risks and the perpetrator's profile'; the other is a 'questionnaire based on DA (Danger Assessment, Campbell) and SARA; questions are not numbered, they involve more than 15 criteria'. In all responding organisations, the assessment is done by a professional of the respective agency.

It is interesting to compare the questions *'How many cases of high risk did you identify in 2009?'* and *'In how many cases did you apply the RAI in 2009?'*:

**Table 1: Comparison of the questions 'How many cases of high risk did you identify in 2009?' (column 3) and 'In how many cases did you apply the RAI in 2009?' (column 4)**

Police	regional	28	28
Women's Support Services	regional	75	206
	regional	–	–
Intervention Centres	regional	60	20
	regional	–	150
Immigrant Women's Services	regional	3	–
Social Services	regional	–	291
	regional	–	–
Health Services	regional	–	–
Child Protection Authorities	regional	–	–

One of the interviewed Intervention Centres explained why their numbers of identified high risk cases are higher than the number of cases where they applied an instrument:

*'We are trained in SARA DA, but we don't use it in all cases of domestic violence, only in those where we already have a suspicion of a high risk. Sometimes we use it when the victim tells us she has already been to the police, but they haven't evaluated the violence as serious.'*

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The blanks in this table signify that most respondents do not count the high risk cases separately, if at all.

Looking at the evaluation of the risk assessment tools in use, all participants voiced a positive opinion. But critical comments were also stated, such as:

*'The tool (SARA) remains at a surface and doesn't go deeper. It is good in cases where there is drug or alcohol abuse, but not in cases of psychological abuse; in those cases we would need a different tool. It consists of 15 questions, some of them ask also if the perpetrator received psychiatric treatment at some point. But people with personal disorders often don't go to a psychiatrist. Also, a victim isn't able to evaluate the situation well, isn't able to answer whether she is in danger. We have a negative experience that the police use the tool too strictly, they just fill in the questionnaire with 'yes' or 'no', but they do not see the danger.'*

## SAFETY PLANNING

Standards for protection and safety for high risk victims of intimate partner violence are provided by 8 out of 10 respondents. Among them, 5 have written policies/guidelines. The respondent of the police described the regular standard of protection and safety of all kinds of victims (not limited to domestic violence). The others stated that these standards are part of the written rules of their organisations. A specific difference between victims and high risk victims is not made. The participants of social services, health services and child protection stated that they do not have written policies/guidelines concerning the protection of high risk victims.

When asked about the measures of protection and safety, seven respondents named safety planning, 5 referred to the multi-agency approach and 3 indicated other means (multiple answers were possible). One regional social service organisation explained why they use the multi-agency approach: *'We cooperate with the police; it is a guarantee the victim is not faking/making it up.'*

There seems to be a misunderstanding concerning the term 'multi-agency approach'. Two respondents used it in the sense of 'multidisciplinary team': *'We run a multi-agency team at ... (but we work for the whole city of ....)'*.

50% of the participants said that they do not provide regular training for working with high risk victims, specifying:

*'There is no regular training on high risk violence, but staff participate in domestic violence trainings, there are many seminars, conferences etc. We try to make sure that every employee attends at least one training and provides information to others.'*

And 9 out of 10 stated that they provide training for newcomers within the organisation. Due to the unspecific question this part is mostly understood as a general training and not specifically geared to high risk victims. Therefore the answers are not very valid. Example:

*'Newcomers are always trained. They participate in an accredited training provided by ..., then a basic training in crisis and phone intervention, they are obliged to participate in the trainings. We also organise upgrade trainings for them, we subscribe to professional magazines and buy professional literature.'*

Two out of 10 organisations review and analyse homicides, attempted homicides and severe cases of violence within their agency. One does so on a regular basis once a year, the other, whenever a case occurs. The interviewed police unit said that this is done on a different (higher) police level.

## COOPERATION WITH OTHER AGENCIES

Eight out of 10 respondents stated that they share information on high risk cases with others. One did not answer the question, whereas the Immigrant Women's Service said that they do not share information for reasons of data protection.

Most organisations work together with the police and the justice system. The police respondent named the justice system, intervention centres and child protection authorities as main cooperation partners.

In 6 out of 10 answers the basis for working together is an informal agreement to exchange information. The police added that a cooperation protocol to share information according to the police law is their basis. But if there is no eviction of the perpetrator, they cooperate *'only in a more informal way, e.g., with child protection authorities'*.

It looks like a protocol for multidisciplinary and integrated intervention is under way, regulating the cooperation for intervention centres and other organisations in the future: *'...with police and child protection authorities, everything is set by a law. As for multidisciplinary cooperation, we have a meeting once a month, up to now it is based on an informal agreement, but we are preparing a protocol.'*

One women's support service relies on an already developed protocol for a multidisciplinary and integrated intervention:

*'In the frame of interdisciplinary cooperation we meet with child protection authorities, police etc. For particular cases, we have a questionnaire that is filled in. A coordinator then sends it to all, so we can decide together how to solve the case.'*

The majority exchange information in case conferences (7/9) and/or written reports (5/9). Four respondents also exchange information via telephone. The answer 'other' entails regular meetings of organisations who deal with this issue.

Only 3 of the interviewed partners do not need the women's consent for sharing the information with others.

*'In cases of eviction, the cooperation with other subjects (mainly Police of the Czech Republic, justice and child protection authorities) is regulated by a law on protection against domestic violence. We ask for the written consent of the client mainly in low-severity violence cases. When solving emergent violence where the victim could be imminently endangered, a verbal consent is enough. In cases where there is also violence towards children, we don't need the consent for the intervention, the workers are obliged to disclose.'*

All the other respondents need the consent in writing or, in cases of danger, first verbal and later on in writing.

All relevant units of an organisation have access to the information gained in 7 out of 9 answering parties. In one organisation only the case worker has access, and in another agency both the case worker and the relevant unit have access.

Seven organisations share the information on high risk cases **systematically** within their agency. But only 2 respondents gave case numbers (3 cases and 291 cases, respectively).

Two respondents mentioned that there is a written policy of cooperation in high risk cases: the police proceed according to an internal document, and an intervention centre stated: *'We have written guidelines of contact with every endangered person in general, in cases of evictions as well as in cases with a lower level of danger. The procedures are binding for less serious as well as more serious cases.'*

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The analysis of homicides and attempted homicide as part of the multi-agency work was answered with 'yes' by one organisation, but the respondent also said, *'The analysis started in 2010, there was no case like that in 2009.'*

## SUMMARY

Almost all the interviewed organisations stated that they identify high risk victims in the context of gender-based intimate partner violence. But this is not a systematic process. Only half of the respondents indicated that their agency uses a risk assessment instrument (and this even for different purposes<sup>8</sup>), the other half rely on assessment based on work experience and a personal assessment of the worker in contact with the victim.

80% of the respondents confirmed that they have standards for protection and safety for high risk victims. But just half of those provide them in writing, and they do not differentiate between victims and high risk victims.

80% of the participants also pointed out that they exchange information on high risk cases with other agencies. However, this happens predominantly by informal agreement.

Reviews and analyses of homicides and attempted homicides as part of a multi-agency cooperation do not take place.

<sup>8</sup> Interviewer's note: „I was quite surprised by the contradiction of evaluation of SARA between these Intervention Centres. The director of one centre was more critical, she mentioned that the tool isn't ideal as to evaluation of high risk violence and she also mentioned inappropriate use of the SARA by the police. On the other hand I found it interesting how they decided to use SARA to convince police representatives that they overlooked a risk level of the case.'

## MAPPING RESULTS - GERMANY

### GENERAL INFORMATION:

The territory of Germany covers 357 021 square kilometres (137 847 square miles). With 81.8 million inhabitants in January 2010, it is the most populated country located entirely in Europe, has the largest population among member states of the European Union, and is also home to the third-largest number of international immigrants worldwide. Inhabitants are 91.5 % of German descent and 8.5 % other ethnic groups.

Germany is a federal parliamentary republic of sixteen states (Bundesländer). The capital and largest city is Berlin, with 3.4 million inhabitants.

**Lower Saxony (Niedersachsen)** lies in north-western Germany and is second in area and fourth in population among the sixteen states of Germany. The territory of Lower Saxony covers an area of 47 624.22 km<sup>2</sup>. Lower Saxony's major cities and economic centres are mainly situated in its central and southern parts. The capital is Hannover, with approximately 520 000 inhabitants.

In 2008 Lower Saxony had 7 947 244 inhabitants. Of these, 3 901 052 were men and 4 046 192 women.

The city of **Osnabrück**, where the partner organisation Frauenberatungsstelle Osnabrück is located, has about 160 000 inhabitants, making it the third-largest city in Lower Saxony. The catchment area of the Frauenberatungsstelle includes the district of Osnabrück, with another 350 000 inhabitants.

The federal state **North Rhine-Westphalia (Nordrhein-Westfalen, NRW)** is located in the western part of Germany, and has 17 872 763 inhabitants (31 December 2009), 8 719 694 of whom are men and 9 153 069 women. NRW has a high population density (524 inhabitants per km<sup>2</sup>). The economic centre is the region Rhine-Ruhr with about 10 million residents.

**Saxony (Sachsen)** is a state in eastern Germany and has 4 155 039 inhabitants. Of these, 2 033 122 are men and 2 121 917 are women. Dresden is the capital, with 253 599 male and 264 420 female residents. Leipzig is the largest city in the state, with 516 378 inhabitants, of whom 250 179 are male and 266 199 are female.

### INFRASTRUCTURE OF WOMEN'S SUPPORT SERVICES IN CASES OF VIOLENCE AGAINST WOMEN

#### Women's refuges

There are 346 women shelters in Germany and 18 women flats for protection. 42 of the women's shelters are located in Lower Saxony and 63 in NRW.

#### Counselling centres and help-lines

There also exist a lot of counselling centres, women's help-lines and special counselling centres for women affected by sexual abuse in childhood.

150 of these counselling centres and help-lines are organised in the National Association of Women's Counselling and Rape Crisis Programs – Women against Violence. Most of the members are NGOs. Women's Counselling and Rape Crisis Programs provide the major share of the counselling and support services in case of psychological, physical and sexualised violence available in Germany. Over the years, these organisations have developed a high level of competence in their counselling skills and in the further training provided to other institutions and to professionals.

Moreover, through public information and political work in recent years, they have played a decisive role in the field of education, information and prevention of violence, as well as in legislative reforms. All these measures have contributed to an overall

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improvement of the situation of abused women. The top priority of the association is the further improvement of the situation of abused women in Germany. This is to be achieved by greater effectiveness in the work, by quality development within the organisations, and through training, public relations, networking and political work outside of the organisations.

## Intervention Centres

In addition there are about 80 Intervention Centres for victims of domestic violence in Germany. Of these, 29 are located in Lower Saxony.

## THE INTERVIEW

The respondents were 15 persons from different core agencies on different levels: 3 represented the state level (ministries of the respective states) and 2 parties represented nationwide networks. Regional and/or local organisations were represented by 10 respondents; 12 women and 3 men were involved in the interviews.

The Ministry of the Interior of North Rhine-Westphalia (NRW) did not participate, because *'high risk cases are a sensitive matter and we are not allowed to talk about it. That concerns all high risk cases including domestic violence!'* Given this directive, no police representative in NRW could be found to participate, either. In contradiction to this the respondent of the regional level in the justice system said there is a new enactment in existence (since February 2010) which describes in detail the cooperation between police and courts concerning high risk assailants in the area of sexual and physical violence. This enactment is publicly known and has been published.

## IDENTIFYING HIGH RISK VICTIMS

Of the 15 respondents, 9 identify high risk victims of intimate partner violence in their course of work. Those who do not are the ministries (no direct contact to victims) and the participants of the health sector. One respondent decided to check nothing and added the following remark:

*'The child protection authority gets police reports about cases of domestic violence, if children are involved. With the help of the evidence from written reports an assessment of the family situation follows. If there is a high risk case children get protection by taking them out of the family.'*

All those respondents who work directly with victims do identify high risk cases as described in the following table:

**Table 1: Does your agency identify victims at high risk? (col. 3) If yes, how do you do that? (col. 4) Number of cases in 2009 (col. 5)**

Justice	Ministry	no	–	–
	regional	yes	1 = evidence of the victim from written report	–
	regional	yes	1 = evidence of the victim from written report	30
Women's Support Services	Ministry	no	–	–
	Network	yes	3 = personal contact with the victim; 4 = degree of severity of injuries; 5 = other (degree of traumatisation)	–
	regional	yes	3 = personal contact with the victim	10

Intervention Centres	regional	yes	3 = personal contact with the victim	25
	regional	yes	3 = personal contact with the victim	20
Immigrant Women's Services	regional	yes	3 = personal contact with the victim; 4 = degree of severity of injuries; 5 = other (degree of traumatisation)	30
Social Services	regional	yes	1 = evidence of the victim from written report; 3 = personal contact with the victim	3
Health Services	Network	no	–	–
	regional	no	–	–
Child Protection Authorities	Ministry	no	–	–
	regional	–	–	–
	regional	yes	1 = evidence of the victim from written report; 3 = personal contact with the victim	15

Among the respondents, 4 stated that they used a risk assessment instrument. Of the remaining 11 participants, 5 said that they do not know any RAI, 1 said they never needed any, and 4 had other reasons for not applying a RAI, namely that their main tasks are coordination, management etc., and therefore they lack direct contact with victims.

Of the 4 who use a RAI, 3 have developed their own instrument, and 1 uses the DA by Campbell. In all instances the woman/victim is involved in the assessment process. One organisation developed its own instrument according to the standards of risk analysis of the federal conference against forced marriage. In all cases a professional of the agency fulfils the assessment task. One respondent added specifically that the assessment is reviewed in a team conference. Another explained that not one, but more people are involved in the assessment process depending on the level of risk:

*'In every case two workers assess the risk, and if the risk rises to a medium level, then the case is carried up to the supervisor; the greater the danger, the higher the department level that is involved.'*

With the exception of one regional child protection authority no other respondent could confirm a systematic application of the instrument. When asked in which cases they decide to apply a RAI, 2 respondents explained:

*'It depends on the case and the discretion of the case worker whether they apply a risk assessment instrument,' and 'I use DA if there is severe violence and if there is a necessity based on my own and the victim's assessment.'*

The 4 respondents using a RAI found it helpful, mostly because it *'seems to objectify the personal impression which might or might not be realistic'*. Another reason is the awareness of the victim: *'I can tell the woman more easily of what she should be afraid of.'*

## SAFETY PLANNING

In this area the answers are quite devastating and meagre. Just 1/3 (5 out of 15) of respondents could confirm that they have standards for protection and safety for high risk victims. One regional child protection authority pointed out that *'the standards concern the safety and protection of children. Concerning the protection of women, the answer must be No.'* The remaining 3 respondents stated that setting up a safety plan is the main standard for the protection of high risk victims, and one added multi-agency meetings as a safety measure.

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Just 3 respondents mentioned written policies/guidelines concerning the protection and safety of high risk victims: One respondent of a regional justice organisation referred to an official guideline between the Ministry of Justice and Interior and their special units since February 2010 for ensuring the safety and protection of victims of sexual and intimate partner violence. The same respondent also pointed out that they do not provide special training, but they talk about cases and official regulations regularly in staff meetings. One respondent for the child protection sector said that they were bound by laws and official regulations (which include the witnessing of domestic violence as an endangerment of the child's welfare!) and an immigrant women's service pointed out:

*'There are written guidelines, but they are only for our own work, and not for the public. The reason is to protect women and to avoid that relatives know the procedure of the safety plan.'*

Only 3 respondents (out of 15) confirmed that they provide regular training on high risk victims for their staff and also for newcomers to the agencies. These respondents are a regional women's support service, a regional immigrant women's service and a regional child protection authority. Only the immigrant women's service reviews and analyses homicides, attempted homicides and cases of severe violence in team meetings. They do so whenever one of these cases occurs.

Maybe the approach of health sector is mirrored in the following answer explaining why they do not engage in safety measures for high risk victims of intimate partnership violence:

*'If an ambulance has been called to a DV case and there is substantial injury and the patient is taken to hospital, then no information gets outside and no visitors are allowed. That is the only measure for safety. Maybe on the ward the personnel will inform victims' services. But there is no policy that they have to do so.'* And a voice from the medical staff of the ambulance:

*'In 10 years of this work I never encountered a DV case!!! Many women had peculiar injuries, but they always said that they had had accidents.'*<sup>9</sup>

## COOPERATION WITH OTHER AGENCIES

In this part of the interview we have the same distribution of answers as in parts one and two of the interview. The ministries responded unanimously that they would not share information on high risk cases with others and most of them practically did not engage further in the interview. Lower Saxony has established an interministry working group concerning this issue.

Analysing the remaining 12 respondents, 9 of them share this kind of information and 3 do not. One of the latter group is the representative of a women's support service and the others are a regional social service and a network of the health sector. The women's support service clearly stated that they do not share information, in order to protect the anonymity of the women.

All of the 9 participants who share information on high risk cases do so with the police, the justice system (incl. family court), child protection and women's support services. Here it should be pointed out that both respondents who work for the child protection authority stated that they cooperate with the NGOs (either women's support services and/or intervention centres). When looking at the basis of cooperation the 9 parties responded as follows:

<sup>9</sup> Interviewer's note: 'Even if he was suspicious he did not inform anyone or give out information material to the women. He did not know of the existence of victims' services in the region. I do not know whether I encountered an especially ignorant doctor or he represents the state of knowledge of the whole staff of this hospital!'

**Table 2: If yes, what is the basis of working together with other agencies? (col. 3) How do you do that? (col. 4)**

Justice	Ministry	–	–
	regional	4 (regulated by family laws)	4 = Police and child protection get a copy of the decision
	regional	1 = An informal agreement to exchange information; 2 = A cooperation protocol to share information; 3 = A protocol for a multidisciplinary and integrated intervention depending on the cooperation partner	2 = telephone conferences 3 = sharing written reports
Women's Support Services	Ministry	–	–
	Network	1 = An informal agreement to exchange information	4= other (case conference with the woman present)
	regional	–	–
Intervention Centres	regional	1 = An informal agreement to exchange information	2 = telephone conferences
	regional	3 = A protocol for a multidisciplinary and integrated intervention	1 = case conferences 2 = telephone conferences
Immigrant Women's Services	regional	1 = An informal agreement to exchange information; 2 = A cooperation protocol to share information; 3 = A protocol for a multidisciplinary and integrated intervention	1 = case conferences 3 = sharing written reports
Social Services	regional	–	–
Health Services	Network	–	–
	regional	4 (legal requirement)	–
Child Protection Authorities	Ministry	–	–
	regional	1 = An informal agreement to exchange information; 2 = A cooperation protocol to share information	3 = sharing written reports
	regional	1 = An informal agreement to exchange information	1 = case conferences 2 = telephone conferences

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There seem to be some protocols on how to share information and cooperate, but those seem to be regional and not followed in a multi-institutional manner, just bilateral (i.e., between police and one intervention centre). Those protocols do not seem to be a state-wide strategy to prevent high risk cases, but based on regional/local endeavours of individual agencies.

Of the 9 respondents who cooperate with others, 3 stated that they do not need the woman's consent to share the information with others. The respondent of the health service said that they only cooperate with the police, and only if the victim is seriously hurt and they assume that a crime has happened. Then they are obliged by law to inform the police – also against the will of the victim. All other participants need the women's consent, either in writing (2) or at least verbal (1) or both (3) depending on the situation – a verbal agreement may be sufficient for the acute moment, but further on a written consent must be given.

Looking at the availability of the data of a high risk case, 9 respondents said that only the case manager has access to these data, 2 participants stated that both the case manager and the relevant unit have access.

A systematic sharing of information on high risk cases within an organisation was confirmed in 2 NGOs. They review such cases in their team meetings regularly. One could not give any numbers, the other mentioned 20 cases in 2009.

Three participants out of 12 (resp. 15) have written policies/guidelines concerning the cooperation in high risk cases. The respondent of the regional justice agency again referred to the new enactment describing the cooperation between police, the justice system and victims' support services. The immigrant women service said that a policy exists, but did not specify details. The representative of the health service sector pointed towards 'written material which gives doctors advice where to turn to if there is a case of domestic violence.' With the exception of the above-mentioned enactment, the other answers do not give any clue to high risk cases, unless every domestic violence/forced marriage case is considered a high risk case.

All 15 participants denied that the analysis of homicides or attempted homicides is part of their multi-agency work.

## **SUMMARY:**

Only those who work in direct contact with victims (on the regional level) identify high risk cases. The knowledge about risk assessment instruments seems to be rather limited. Almost half of the respondents who identify high risk victims did not know any instruments.

Mostly, self-developed instruments are in use, but with one exception (child protection authorities) they are not applied systematically.

According to the mapping results, up to now the ministries have no strategic coordinated plan on protection and safety for high risk victims of gender-based intimate partner violence. However, several ministries of Lower Saxony are presently working on a joint effort in form of a protocol on an inter-ministry level.

Some protocols to share information and to cooperate on the operational level seem to exist, but those protocols are apparently regional and not multi-institutional (at most bilateral).

None of the respondents sees the analysis of homicides and attempted homicides as part of their multi-agency approach, but especially the ministries were rather interested in that aspect.

## MAPPING RESULTS – ITALY

### GENERAL INFORMATION

Italy has 60 million inhabitants. As of 31 December 2009, the female population was around 31 million and the male population around 29 million.

Italy is divided into 20 regions. The capital town is Rome; other big cities are Milan and Turin in the North, Naples and Palermo in the South of Italy.

### The Emilia-Romagna Region

The Emilia-Romagna Region, situated between the north and the centre of Italy, is one of the best developed regions, with a good welfare level (regarding health care, education, social services, housing, employment, equal opportunities for women, etc.). It has 4 395 606 inhabitants: 2.259.640 women and 2 135 966 men. The chief town is Bologna. In the east of the region, about 70 km from Bologna, there is the town of Ravenna, with 135 000 inhabitants.

The Region Emilia-Romagna (along with Lombardy and Tuscany) is one of the Italian regions with the largest number of anti-violence centres. It has 12 independent Anti-Violence Centres (about one per Province), plus a Municipal Women's Centre in Forlì town. Most of them have been established since the 1990s, and 10 independent centres are associated in the network 'Coordinamento dei centri antiviolenza dell'Emilia-Romagna', that has a good cooperation with the administration of the Emilia-Romagna Region (for instance, a joint periodical research on women seeking help to anti-violence centres). The Istat research on violence against women comes to the conclusion that the region has the highest rate of physical and/or sexual violence in Italy: 38.2% as opposed to 31.9% on the national level.

In Italy it is almost impossible to provide **annual** data about domestic violence on the national level (only one research done in 2006), and consequently about high risk victims, because there is no national observatory on gender-based violence and no National Action Plan. At present the Italian Minister of Gender Policy, Mara Carfagna, is working on a proposal for an Italian NAP, but it hasn't been approved yet. The same situation characterises the research about data on homicides and attempted homicides in the family, since the Minister of the Interior does not provide specific data that could allow the analysis of the relationship between victim and perpetrator. Data are available only from Eures Institute of Research that collects them via Ansa Press Agency (Eures-Ansa, *L'omicidio volontario in Italia. Rapporto Eures-Ansa 2009*, Roma 2009: last data available for 2008) and those collected annually by Casa delle donne per non subire violenza through press releases ([www.casadonne.it](http://www.casadonne.it)). The same difficulty exists also on the regional and provincial levels. The only epidemiological research that considers the national level for gender violence was published in 2007 by the Istat (National Institute of Statistics): *La violenza e i maltrattamenti contro le donne dentro e fuori la famiglia. Anno 2006*. Here it is possible to find data about rape reports, domestic violence, harassments and stalking, but there are no reported homicides and attempted homicides. Moreover, it must be considered that in Italy the power of the police to arrest people is generally limited to serious injuries or flagrant crimes, and there are few instruments to restrain the perpetrators (Protection Order, Contact Prohibition and Stalking Warning).

The 10 AVC of the network in Emilia-Romagna provide totally 109 bed places (for women and children both), corresponding to about 36 family places (3 beds each). According to European standards, anti-violence centres should have about 586 family places in the shelters of the region, which means that only 6% of the required places are covered. Thus, it is evident that the protection of women is widely insufficient in the region.

Since 2003 the Emilia-Romagna Region mentions violence against women in its welfare law (Regional Law n. 2/2003), suggesting to local administrations to take care of this problem inside the local integrated social services system, through anti-violence centres and shelters, even if there isn't a formal commitment to do so by law. Every district has its own character-

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istics; often the policies on gender violence and the establishing of help centres are in the competence of the Municipal Equal Opportunity Department, for instance by agreement between the anti-violence centre and the Municipality. Sometimes it can happen that the social territorial planning is completely evaded.

The Regional Health and Social Plan 2008-2010 listed the housing services (among those, the shelters) among the four general goals of welfare, but actually only the Municipalities (the Local Agency for Health is co-responsible) are responsible to implement this in the Local Plan of Welfare (Piano di Zona): some of them consider the anti-violence services and some do not.

## THE INTERVIEW

The **PROTECT** questionnaire was submitted to all 10 Anti-Violence Centres (AVC) of the regional network in Emilia-Romagna and to 3 different units of the police on district level (Questura) in Ravenna. The Questuras in Italy have 3 sectors: one sector collaborates with the Court, another is responsible for the emergency calls (flying squads '113'), and the third investigates and works on crimes.

Additionally it was possible to have an interview with Clede Maria Garavini, Director of Health Woman Childhood Adolescence Programme of the Local Agency for Health of Bologna. All participating interviewees were women.

## IDENTIFYING HIGH RISK VICTIMS

All the AVC of the network confirm that the identification of high risk victims is carried out, almost all the centres (9/10) rely on the evidence of the victim from written reports and personal contact with her. Three AVC were not able to provide data about identifying high risk women, mostly because data are not collected under this entry. Those who could answer generally use the SARA instrument (except for one AVC that uses none). The data show a huge difference among the AVC of the network (from 5 cases up to 150 cases, in 2009) and also between the different sectors of the Questura (113 unit: 1 case in 2009, 6 cases in the sector that works for the courts and 80 cases in the investigative sector).

In all the cases the risk assessment is done by a professional and additionally in 6 agencies also by a multidisciplinary team. If an instrument is used (by 9 out of 14 respondents), it is always the SARA model. Besides using SARA, one organisation applies also the BIG 26 of the DAIP. 3 of those who use SARA do not apply it systematically in all cases of intimate partner violence. Reasons are:

*'We don't apply it when the woman is victim of psychological violence and never victim of physical violence.'*

*'The instrument is applied only when the woman's risk awareness is too low in relation with the violence that she experienced.'*

Analysing the interviews it is possible to find an incongruity about the use of the SARA model between the different sectors of the Questura: one of the 3 respondents stated that in Italy the police are not provided with training on risk assessment, the other two representatives mentioned that they have had a very good national training (1 week) in Rome that involved all Questuras in Italy. The interviewers assume that this incongruity is due to a lack of internal multiplication of this training.

Those who use a risk assessment instrument consider it very positive:

*'Helpful in the work with victims, because it can give an overview of the entire situation.'*

One agency also voiced a concern:

*'Sometimes SARA or Big 26 are too schematic and there is not enough space for the victim's fright or emotionality, to let her express the emotional and sentimental state involving the partner which will make it difficult to protect herself and to look for protection instruments, and regarding the actual phase of violence that the woman is in.'*

And one respondent of the police seems to be quite dissatisfied with the SARA instrument:

*'Even if I've done a proper training on SARA in Rome (it lasted for one week; one/two members from each Questura in Italy were attending), I find the instrument quite difficult to manage in my office.'*

## **SAFETY PLANNING:**

Of the 14 respondents, 13 have standards for protection and safety for high risk victims. But only 5 of those 13 provide them in writing. One agency stated:

*'The members of the staff have contributed to write it and they all have a copy.'*

All respondents use safety planning and a multi-agency approach as a measure to protect and ensure safety of high risk victims of intimate partner violence. One respondent considered the '24-hour availability of AVC operators for the hospital staff and police' as another safety measure. One respondent stated that the safety measures also apply to their own staff:

*'The operators are always working in teams of two, when they have to deal with women in dangerous situations'.*

One agency voiced a very pressing concern:

*'A gap in the safety planning exists: there are not enough places in the shelters available to address women who are in danger.'*

9 of 14 respondents regularly provide special training to work with high risk victims, and 7 of those 9 offer a special training on high risk victims for newcomers in their agency. 40% of the AVC respondents (4 out of 10) do not receive a regular training of this kind.

With the exception of 2 AVC all remaining respondents analyse homicide, attempted homicide and severe violence cases within their agency.

*'Yes, we analyse all DV cases at the First Aid in the 2 city hospitals. We have not had homicides and attempted homicides cases during 2009.'*

In 3 agencies this task was fulfilled by a professional of the agency only, in 2 agencies it was the supervisor and the professional, in 2 cases the multidisciplinary team, in 1 case the supervisor plus the multidisciplinary team and in 2 agencies all 3 parties (professional, supervisor, multidisciplinary team) are involved in the analysis.

Seven out of 12 are engaged in this analysis on an irregular basis whenever a case occurs. All 5 remaining respondents said that they do this kind of analysis at least once a year.

## **COOPERATION WITH OTHER AGENCIES**

Of the 14 respondents, 13 share information on the assessed high risk victims with other agencies; the only exception here is the investigative unit of the police. The interviewee said that this would be against the data protection laws.

The 3 representatives of the police sectors and 1 AVC stated that they do not need the victim's consent to share this kind of information. 50% of the remaining 10 responses need the consent of the women in writing. The other remaining 50% are satisfied with at least a verbal statement, but 2 of them require additionally a written consent later in the process.

The documentation of the case is available for the case manager only in 11 participating organisations. In 3 agencies the relevant unit plus the case manager have this access. One respondent of the police stated: *'There are special cautions (limitations of access) in cases where the perpetrator is a police member.'*

# RESEARCH REPORTS

In most cases (10/14) the exchange of working together with other agencies is based on an informal agreement. About 40% state that this action also relies on a protocol to share information, and 50% answered that a protocol for a multidisciplinary and integrated intervention is the basis of cooperation. One respondent explained that *'in the province of Ravenna, institutions together with the anti-violence centre of Linea Rosa are working on a written and integrated protocol of cooperation.'*

The following table shows how the responding partners exchange information. Interestingly, one women's support service stated they have to work together with others (not only on high risk cases) according to a protocol for a multidisciplinary and integrated intervention, but that the meetings to do so were cancelled, so the cooperation never took place!

**Table 1: How do you exchange information?**

Police	local	1 = case conferences; 2 = telephone conferences; 3 = sharing written reports
	local	1 = case conferences; 2 = telephone conferences; 3 = sharing written reports
	local	1 = case conferences; 2 = telephone conferences; 3 = sharing written reports
Women's Support Services	local	1 = case conferences; 2 = telephone conferences; 3 = sharing written reports
	local	4 = other
	local	1 = case conferences; 2 = telephone conferences; 3 = sharing written reports
	local	1 = case conferences; 2 = telephone conferences; 3 = sharing written reports
	local	1 = case conferences
Women's Support Services	local	1 = case conferences
	local	1 = case conferences; 2 = telephone conferences; 3 = sharing written reports
	local	2 = telephone conferences
	Network	1 = case conferences; 2 = telephone conferences; 3 = sharing written reports; 4 = other
Health Services	local	1 = case conferences; 3 = sharing written reports

The majority of the non-executive respondents name the police as cooperation partner, followed by the justice system and social services (especially when children are involved). The police cooperate with the justice system and women's support services mainly, but also with social services and child protection.

Three respondents (all of them AVC) stated that they have written policies/guidelines of co-operation in high risk cases.

Four of 14 respondents indicate that the analysis of homicides or attempted homicides is not part of the multi-agency work. And here again one can assume that the answers do not reflect the multi-agency aspect in the sense of 'multidisciplinary', but more the analysis of cases among different organisations of the same kind (in the 2 hospitals, within police, among all AVC etc.).

## **SUMMARY**

Almost all respondents stated that their agencies use risk assessment instruments to identify high risk victims. But the numbers differ very much from organisation to organisation. This leads to assume that they use different definitions of high risk. This is especially remarkable because most of the agencies use the same risk assessment instrument (SARA).

Of the 14 participants, 13 declared to use standards for protection and safety of high risk cases, but less than 1/3 include them in written guidelines and policies.

In this region there seems to exist a comparatively well-established system of regular trainings, specifically concerning high risk cases.

Almost all organisations confirmed to cooperate and to exchange information in high risk cases (exception: justice agency). This is not based on a formal policy, but on informal agreements.

# RESEARCH REPORTS

## MAPPING RESULTS - SLOVAKIA

### GENERAL INFORMATION

Slovakia consists of 8 regions, the capital city is Bratislava. On 31 December 2009 the population amounted to 5 424 925 inhabitants, 51% of which were women.

Every region has general social services available, but only 5 regions provide specialised women's support services (7 counselling centres).

In the whole country of Slovakia there is no shelter and no intervention centre specifically for women experiencing violence.

*'Social services facilities in Slovakia providing shelter to women experiencing violence and their children are not specialised shelters; their staff is often not specifically trained in the field of VAW and the services they provide don't reflect the specific needs of women and their children. The Social Services Act is at conflict with many of the EU minimum standards for provision of support services for women experiencing violence.'*<sup>10</sup>

### THE INTERVIEW

In the Slovak mapping 9 different respondents were involved, 5 of them on a Ministry level and 4 on the regional level. 5 women and 4 men were the interview partners.

### IDENTIFYING HIGH RISK VICTIMS

All 5 respondents of the Ministries stated that they do not identify high risk victims in the field of VAW.

The Ministry of Justice sees its tasks in *'dealing with the issue of domestic violence generally, but not specifically with protection and safety of high risk victims'*.

The Ministry of Interior approaches *'the problem in the sense of legislative norms, i.e., in terms of Code of Criminal Procedure, Penal Code, Police Force Act etc.'*

The Ministry of Health states that *'the terminology used in the Ministry of Health of the Slovak Republic is based on the legislation of the Slovak Republic, which does not entail the term high risk victims, so we do not deal with this issue on the ministry level'*.

The Ministry of Labour, Social Affairs and Family (Department of Gender Equality and Equal Opportunities) also replied that *'we do not use the term high risk victim; the UN definition speaks only about 'violence on women', not about high risk victims, so we do not monitor (use) the term high risk victim'*. They also elaborated that *'we are an institution with a different focus; we are concentrated on policy making'*. Nevertheless a process is in preparation to introduce the assessment tool SARA to the police. This is being discussed with the Ministry of Interior.

The Department of Social and Legal Protection of Children, Social Curatorship and Psychological Services of the Ministry of Labour, Social Affairs and Family makes it clear that the social and legal protection of children is their priority in family policy. 'In this sense we see the child who knows about violence committed against the mother also as a victim of domestic violence.' Asked why they don't use a risk assessment tool, they answered that they don't know any.

<sup>10</sup> Interviewer's note

On the regional level 3 key persons (police, women support and child protection service) said that they identify high risk victims. One of them stressed that they solely identify high risk cases with children involved.

*'Referring to the number of cases in 2009, where they identified high risk, the respondent said these were cases of violence against children, but it was likely that violence against the woman had been present also. It seems they identified and collected data on violence against children and didn't identify and collect data on violence against women. This particular institution has been claiming for a long time that its primary focus is on children, even though in the Act no. 305/2005 the social and legal protection is defined as "prevention of crisis situations in family, protection of rights and interests of children protected by the law, prevention of deepening and repetition of mental, physical and social development disorders in children and adult natural persons in order to eliminate socio-pathological phenomena'.'*<sup>11</sup>

Only the regional women's support service uses a risk assessment tool (BIG 26 of the DAIP). They are involving the women concerned, but they do not apply the instrument systematically. They identified about 80 high risk cases in 2009 and also applied the instrument in those cases. The instrument is positively valued because *'it helps to map the situation of women and their children'*.

Concerning the results of the survey with a regional police unit it becomes clear that the issue of domestic violence is not (yet) considered as serious:

*'Throughout the interview, the respondent used the word 'argument' instead of 'violence' and saw the causes as a consequence of an unfavourable economic situation in the country, alcohol abuse and other issues.'*<sup>12</sup>

## **SAFETY PLANNING**

The answers in this part of the questionnaire mirror the answers of the first part. Just two respondents answered yes when asked if their institutions provide standards for safety and protection for high risk victims: one was the regional women's support service and the other the Ministry of Interior, which refers to existing laws and official regulations concerning all high risk victims and no specialisation on domestic violence victims.

None of the respondents have written policies/guidelines concerning the protection and support of high risk victims, and none provide training for regular staff or for newcomers on the issue of high risk in domestic violence.

The Ministry of Interior, the regional police unit, the Ministry of Justice and the regional women's support service affirm that they analyse within their organisation cases of homicide, attempted homicide and severe violence against women regularly. All other participants did not answer this question at all or their answers were negative.

## **COOPERATION WITH OTHER AGENCIES**

The respondent of the regional police unit gave a significant answer to the question whether they share information about high risk victims with other agencies:

*'It is the perception of the police that our primary task is to protect personal data and not to provide them to other institutions. Exchange of information happens only during a case investigation within the police unit or with the courts. We also send some data to the Police Headquarters for the purposes of data collection.'*

<sup>11</sup> Interviewer's note

<sup>12</sup> Interviewer's note

# RESEARCH REPORTS

Here again, the regional women's support service is one of two respondents who share information about high risk victims with other agencies. It is not clear if they just have to provide the information or if indeed an exchange takes place.

*'If we identify high risk, we pro-actively contact the police and health care services and provide the information on high risk to them. We analyse and review cases (of particular high risk victims) regularly.'*

The regional women's support service mostly cooperates with the police, justice, health, social welfare and child protection systems. The number of cases is not provided.

Similar results can be found with the regional child protection unit. They cooperate with many different administrative bodies and NGOs, but they could not provide numbers of cases.

These cooperations on the regional level are all based on an informal agreement. They are done by case conference and by exchanging written reports (police and child protection unit). No case numbers are given here either. Except for the police all other respondents need to have the woman's consent (at least verbal, preferably in writing) to share information. All three respondents further explained that only the case worker has access to these data and they don't even share the information systematically within their agency – with the exception of the women's support service, which does have a systematic system to share information about high risk cases. In 2009 there were 80 such cases.

The questions 3 and 4 (Do you have written policies/guidelines of cooperation in high risk cases? Is the analysis of homicides or attempted homicides part of the multi-agency work?) were all answered with 'no' or were left blank, because of irrelevancy.

Interestingly the regional social service and the Ministry of Interior do not share information at all and therefore did not answer the questions in this part.

The Department of Gender Equality and Equal Opportunities of the Ministry of Labour, Social Affairs and Family states:

*'For sharing information between ministries the Governmental Committee for Crime Prevention is responsible, but also the competent State Secretary should pay more attention to the topic, s/he should be responsible for sharing information. It would be good to have one person dealing just with this. It is complicated, because we (and our work) are not accepted even within our own ministry, the topic is not seen as important or serious.'*

## SUMMARY

With the exception of the regional women's support service no standards for protection and safety are available for high risk victims of domestic violence in Slovakia. But the question arises why one would need to have standards for protection when there is not even one specialised shelter available for victims of violence in the whole country.

On the ministry level a connection of gender-based intimate partner violence and high risk victims is not perceived. Accordingly assessment instruments for identifying high risk victims are missing.

On the regional level an identifying process of high risk victims is taking place, but not systematically or only in the context of the endangerment of children. That is also mirrored in the fact that the women's support service organisation is the only one to apply a risk assessment tool.

This situation is resumed in the missing of standards for protection and safety of high risk victims and in the lack of policies and guidelines for the involved organisations.

Cooperation with others and the concept of 'multi-agency approach' seem to be regarded as extremely alien. Not even simple exchange of information takes place, and the knowledge on domestic violence and especially on high risk in this area seems to be very limited.

It needs some attention that an introduction of a risk assessment tool (SARA) is considered, but there seems to be no notion of risk assessment management.

# RESEARCH REPORTS

## MAPPING RESULTS - SPAIN, Region Murcia

### GENERAL INFORMATION

Spain became member of the European Union in 1986. As to its political system, Spain is a constitutional monarchy. The country is divided into seventeen autonomous regions, with a total area of 504 782 km<sup>2</sup>. The capital city is Madrid.

The current population is 46.8 million inhabitants, with a gender distribution of 23 628 819 women and 23 116 988 men, i.e., around 51% women and 49% men.

Murcia Region<sup>13</sup> is located on the south east coast of Spain, between the Mediterranean Sea and the southern regions of Spain. The current population, 1 446 520 inhabitants, represents around 3% of the total Spanish population. In the region, the gender distribution is 731 609 men and 714 911 women, so the ratio is quite balanced.

The most innovative resources for women's issues in the Murcia region are the CAVIS network ([www.cavis.es](http://www.cavis.es)) and the integrated system for unified management of the gender based violence cases (SIGUE in Spanish, which means *follow* in English).

### Statistics of femicide

In the first half of 2010, 42 women died of gender based violence committed by an intimate partner. The data show an increase of 26% in the number of deceased women over the same period last year. The profile of the victim of gender violence has changed from the early months of 2009: there are fewer complaints before the femicide, less protective order applications, fewer cases of homicide after / during restraining orders and an increase of homicides during cohabitation: 68.8% lived with their abuser, whereas in 2009 the percentage was 46.2%. Most victims and perpetrators were older than 30 years. The average age of offenders increased from 46 to 48 years, and that of victims, from 41 to 42 years.<sup>14</sup>

### THE INTERVIEW

The interviews were conducted within the Murcia region with an equal distribution on three levels: state, regional and local. All core agencies are covered, with the exception of the health sector. The respondents were 9 women and 1 man.

### IDENTIFYING HIGH RISK VICTIMS

Among the respondents 9 out of 10 stated that they identify high risk victims of intimate partner violence, and 5 of those are using risk assessment instruments (RAI).

It is remarkable that the respondent of the regional police answered only 3 questions in this part of the interview: they do not identify high risk victims of partner violence and they do not use risk assessment tools, because that is done on the next higher level, i.e., the State.

The personal contact with the victim is used by 8 out of 9 respondents to assess the risk. In addition, 4 of them use written reports. The police on the ministry level also look at the evidence of the crime scene.

The high number of high risk cases identified by one women's support service, the regional helpline, is remarkable. Here it is very obvious that the organisation seems to have only contact to the victims by phone and it is assumed that every caller is

<sup>13</sup> [www.carm.es](http://www.carm.es)

<sup>14</sup> Miguel Lorente, Government Delegate for Gender Violence, presented the balance of the Ministry of Equality on gender violence in the first half of 2010.

at high risk. Otherwise this exceedingly high number of cases could not be explained. The child protection authority in their statistic counted the number of cases where minors were involved, not the cases of violence against women.

Of the 5 interviewed parties who are not using RAI in their agency, 3 stated that they do not know any: *'There is no knowledge about them, either adapted to our language or to our working protocol.'*

Of the 5 respondents using a RAI, 2 are using a self-developed tool, i.e., a structured interview and an assessment tool for minor's abuse<sup>15</sup> respectively.

One respondent stated that they use the VPR Risk Prevention System and the VPER Risk Prevention Evaluation System<sup>16</sup>, another indicated use of a joint assessment in the team and by other core agencies as a tool.

Three respondents also said that they apply the RAI systematically. One respondent limited the application of RAI as follows: *'NO: when the victim refuses to denounce, it is not applied; YES: when an assessment of the aggressor is demanded.'*

Concerning the helpfulness of RAI one responding party stated that *'when victims refuse to denounce, when victims decide to rejoin with the aggressor'* the tool was not helpful.

The positive aspects of using RAI are mostly that *'it permits to identify the situations and factors for risk. It helps the victims to raise awareness about the risk.'* Also, *'it permits the professionals to design the protection plan in a more adequate and efficient way.'*

A voice from the justice system: *'Very useful to implement the protection measures by the police.'*

## **SAFETY PLANNING**

All respondents stated that they have standards for protection and safety for high risk victims. But just 4 of them have written guidelines/policies.

Seven out of 10 participants stated that setting up a safety plan is part of the standards. Additionally, two of them consider the coordination with other core agencies for the protection plan and the permanent contact with the victim to be part of their standards.

If the above-mentioned coordination is considered part of the multi-agency approach, then 5 named this as a standard for protection and safety for high risk victims. The permanent contact to the victim is certainly one standard, but the question that arises concerns the time frame of the term 'permanent'.

Looking at the training on high risk cases in the participating organisations, 60% stated that their workers do not receive a regular training on this issue, and only 30% train the newcomers to their agency in this field. One respondent voiced a concern:

*'Staff training is essential for our work, but mainly in Spanish, and it should be adapted to our usual working protocols.'*

<sup>15</sup> winterviewer's note: „As part of the integrated treatment of the women victim of VAW, the IMRM (Instituto de la mujer de la region de Murcia) considered mention of the DGFM (Dirección General de Familia y Menor) relevant because they have a self-developed RAI which could be useful to detect risk situation for women, mothers of those minors.'

<sup>16</sup> Miguel Lorente, Government Delegate for Gender Violence, presented the balance of the Ministry of Equality on gender violence in the first half of 2010.

# RESEARCH REPORTS

The review and analysis of homicides, attempted homicides and cases of severe violence is practised in an exceptionally great share of organisations: 60%. Only one participant stated that they are doing this analysis on an irregular basis, namely whenever a case occurs.

In 4 organisations this task is taken care of by a multidisciplinary team, in 2 agencies by a professional within the unit/agency and in one organisation both the team and a professional are engaged in this task.

## COOPERATION WITH OTHER AGENCIES

Information on the assessed high risk victims is shared with others by all participating agencies. The basis for working together is mostly (70%) an informal agreement to exchange information. The representative of the child protection sector stated that their exchange takes place on the behalf of the children, not necessarily on that of the woman. That is why they do not need her consent. The Immigrant Women's Service said that they have a cooperation protocol to share information with the security forces (Police, Guardia Civil) and the EC, but only on the basis of a written consent of the woman concerned.

**Table 1: What is the basis of working together with other agencies?**

Police	Interior Ministry Murcia	2 = A cooperation protocol to share information; 3 = A protocol for a multidisciplinary and integrated intervention
	regional	1 = An informal agreement to exchange information
Justice	Justice Ministry Murcia	1 = An informal agreement to exchange information
Women's Support Services	regional	1 = An informal agreement to exchange information
	Network	1 = An informal agreement to exchange information
	local	1 = An informal agreement to exchange information
Intervention Centres	local	1 = An informal agreement to exchange information
Immigrant Women's Services	regional	2 = A cooperation protocol to share information;
Social Services	regional	1 = An informal agreement to exchange information
Child Protection Authorities	regional	2 = A cooperation protocol to share information; 3 = A protocol for a multidisciplinary and integrated intervention

The police on the state level pronounced that a cooperation protocol is 'currently under development'.

*'In October 2009, the Murcia Local Police created the Team for Family Protection and Support (EFAP), to help the victims of VAW and Domestic Violence (both women and minors). As part of the Murcia Municipality, they follow the same strategies as the EMAVI (Team for Attention of Women Victims of VAW, part of social services) regarding the cooperation with other core agencies.'*<sup>17</sup>

<sup>17</sup> Interviewer's note

Those who mentioned the number of cases along with the list of the cooperation partners (5 out of 10) reported less than 5 cases in 2009 where they cooperated with individual organisations. The exception is the child protection authority, which reported about 390 cases where they cooperated in 2009.

Only 2 respondents listed the case numbers when asked how they exchanged information in 2009. Surprisingly, they reported exactly the same numbers in the same categories (each category = 4 cases in 2009)!

**Table 2: How do you exchange information? (col. 3) Do you need the woman's consent? (col. 4)**

Police	Interior Ministry Murcia	1 = case conferences; 2 = telephone conferences 3 = sharing written reports	1 = no consent
	regional	1 = case conferences; 2 = telephone conferences	1 = no consent
Justice	Justice Ministry Murcia	2 = telephone conferences	1 = no consent
Women's Support Services	regional	2 = telephone conferences; 3 = sharing written reports	1 = no consent
	Network	1 = An informal agreement to exchange information	2 = written consent
	local	1 = case conferences; 2 = telephone conferences 3 = sharing written reports	3= verbal consent
Intervention Centres	local	1 = case conferences; 2 = telephone conferences 3 = sharing written reports	2 = written consent
Immigrant Women's Services	regional	2 = telephone conferences; 3 = sharing written reports	2 = written consent
Social Services	regional	1 = case conferences; 2 = telephone conferences 3 = sharing written reports	2 = written consent
Child Protection Authorities	regional	1 = case conferences; 2 = telephone conferences 3 = sharing written reports	-

The distribution between those who need a written consent by the woman concerned and those who do not is even in those two categories. Just one organisation (women's support service) is content with a verbal consent.

Two respondents out of 10 reported that they solely use telephone conferences for exchanging information. All the others described some form of combination: all 3 forms (case and phone conferences, written reports) were reported by 5 out of 10 respondents; the exchange via phone conferences plus written reports was stated by 2 participants, and one organisation listed a combination of case and phone conferences.

# RESEARCH REPORTS

80% of the respondents systematically share information on high risk victims within their agency. 40% of the respondents stated that the case manager is the only one who has access to the gathered information on high risk victims within the respective organisation, in 10% access is limited to the relevant unit, and in the remaining 50% both the case manager and the relevant unit have access.

Four interview partners have written policies/guidelines of cooperation in high risk cases. One of them explained:

*'The 112 helpline is a regional government service, so the protocol is an internal document and only available for the public servants working in this specific service.'*

The police on the state level refer to *'formal regulation and legislation for the National Security Forces'*.<sup>18</sup>

The other 2 respondents cooperate with the security forces and the core agencies, but could not pass on the guidelines. It is assumed that here also the reasoning applies that those are internal documents and available for government workers only. With the exception of the police (state level), the analysis of homicides or attempted homicides is part of the multi-agency approach in none of the participating organisations.

## SUMMARY

Many of the interviewed parties are government agencies on different levels. The shelter organisations are NGOs, financed by the regional Government, like the CAVIS. That is very noticeable when they were asked to submit documents as basis for the cooperation with other agencies. As the interviewer remarked:

*'There is a lack of coherence between the purpose of the service, protection and support of families in cases of VAW and DV, and the isolation regarding the work with other core agencies. Cooperation only takes place among members of the same local agency (Municipality) in an endogenous exercise of information exchange.'*

The identification of high risk cases is part of the standard of working in the field of gender based intimate partner violence. Accordingly, in more than half (5 out of 9) of the responding agencies risk assessment instruments are being used. But these tools are not comparable, because they are self-developed by the agencies.

Identifying high risk victims as a part of combating domestic violence also leads to the fact that all participating parties provide standards for protection and safety for those victims. But here again, less than half provide these standards in writing.

The majority of the respondents declared that they exchange information on high risk cases and cooperate with others. This might also be due to the fact that all responding agencies are government organisations.

Obviously, the analysis of homicides or attempted homicides is not considered to be part of the multi-agency approach.

<sup>18</sup> These are:

- Ley Orgánica 2/1986, de 13 de marzo, de Fuerzas y Cuerpos de Seguridad ,
- Protocolo para la implantación de la Orden de Protección de las víctimas de violencia doméstica
- Protocolo de Actuación de las Fuerzas y Cuerpos de Seguridad y de Coordinación con los órganos Judiciales para la protección de las víctimas de violencia doméstica y de género
- Protocolo de Colaboración y Coordinación entre las Fuerzas y Cuerpos de Seguridad del Estado y los Cuerpos de Policía Local, para la protección de las víctimas de violencia doméstica y de género
- Instrucción de la SES nº 2/1998 sobre adopción de medidas relativas a la prevención, investigación y tratamiento de la violencia contra la mujer y asistencia a la misma
- Instrucción de la SES nº 18/2009 de la Secretaría de Estado y Seguridad que deja sin efecto la 14/2005 sobre actuación de dependencias policiales en relación con mujeres extranjeras víctimas de violencia doméstica o de género en situación administrativa irregular
- Instrucción de la SES nº 10/2007, por la que se aprueba el Protocolo para la valoración policial del nivel de riesgo de violencia contra la mujer en los supuestos de la Ley Orgánica 1/2004 y su comunicación a los órganos judiciales y al Ministerio Fiscal y en las Instrucciones nº 14/2007 y 5/2008 que modifican la anterior.
- Acuerdo entre el Ministerio de Justicia, Ministerio del Interior, Ministerio de Igualdad, el Consejo General del Poder Judicial y el Ministerio Fiscal para el establecimiento del Protocolo de Actuación para la implantación del Sistema de Seguimiento por Medios Telemáticos del cumplimiento de las Medidas de Alejamiento en materia de Violencia de Género de 8 de julio de 2009.

## REPORT ON DOMESTIC VIOLENCE POLICIES IN ENGLAND & WALES

This is a report reviewing the policies and guidelines that public services in England and Wales have in place for tackling domestic violence (DV), with particular reference to high risk victims (HRVs). This includes whether there is a risk assessment tool, safety planning and multi-agency cooperation protocol in place and whether it is actually implemented, especially at a local level. For the purpose of this report, high risk victims are women and their children at risk of experiencing: homicide or attempted homicide; violence by use of weapons or dangerous objects; violence causing severe injuries that require emergency medical treatment; violence causing repeat injuries; violence causing other serious harm. During this report it is important to note that any mention of 'interviews with practitioners' is often individual experiences which cannot be guaranteed to be representative of such large organisations.

The Government's definition of DV against both men and women (agreed in 2004) is:

*'Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.'*

Family members are defined as mother, father, son, daughter, brother, sister and grandparents, whether directly related, in-laws or step-family.

### MULTI-AGENCY RISK ASSESSMENT CONFERENCE (MARAC)

Over the past 3 years MARACs have been widely established across England and Wales, with over 200 operating as of early 2009. They are the primary focus of activity in relation to high risk victims and reflect the learning from numerous domestic homicide reviews.

In a MARAC, local agencies will meet to discuss the highest risk victims of domestic abuse in their area. Information about the risks faced by those victims, the actions needed to ensure safety and the resources available locally are shared and used to create a risk management plan involving all agencies.

The main aim of the MARAC is

- to reduce the risk of serious harm or homicide for a victim;
- to increase the safety, health and well-being of victims and their children.

Other aims include to

- determine whether the perpetrator poses a significant risk to any particular individual or to the general community;
- jointly construct and implement a risk management plan that provides professional support to all those at risk and that reduces the risk of harm;
- reduce repeat victimisation;
- improve agency accountability;
- improve support for staff involved in high risk DV cases.

The responsibility to take appropriate actions rests with individual agencies; it is not trans-ferred to the MARAC. The role of the MARAC is to facilitate, monitor and evaluate effective information sharing to enable appropriate actions to be taken in order to increase public safety.

# RESEARCH REPORTS

MARACs were first pioneered in Cardiff in 2003. Two independent evaluations of the Cardiff MARACs have been written since then by Dr Amanda Robinson of Cardiff University. They include an analysis of the number of women who suffered repeat incidents of violence that were reported either to the police or other agencies. There were 102 women included in the one year review. Of these 42% were living 'violence free' in the 12 months following the MARAC and those who did suffer further incidents reported them at a much earlier stage than previously. This is particularly significant since these women had been assessed as very high risk and had extended histories of domestic violence.

Agencies which typically participate in MARACs are:

- Police
- Probation Service
- Children Services
- Health
- Housing
- Independent Domestic Violence Advisors (IDVAs)
- Drug and Alcohol services
- Mental health services
- Refuge services

## **THE ROLE OF THE INDEPENDENT DOMESTIC VIOLENCE ADVISORS (IDVAs)**

The main purpose of an Independent Domestic Violence Advisor (IDVA) is to address and secure the safety of victims at high risk of harm from intimate partners, ex-partners or family members, and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans.

IDVAs are pro-active in implementing the plans, which address immediate safety, including practical steps for victims to protect themselves and their children, as well as longer-term solutions. These plans will include actions from a local MARAC (Multi-Agency Risk Assessment Conference) as well as sanctions and remedies available through the criminal and civil courts, housing options and services available through other organisations. IDVAs support and work over the short and medium term to implement plans that put victims on the path to long-term safety. They receive specialist accredited training and hold a nationally recognised qualification.

Since they work with the highest risk cases, IDVAs are most effective as part of a larger domestic violence service that works with multiple agencies. The IDVA's role in all multi-agency settings is to keep the client's perspective and safety at the centre of proceedings.

Studies have shown that when high risk clients engage with an IDVA, there are clear and measurable improvements in safety, including a reduction in the escalation and severity of abuse and a reduction or even cessation in repeat incidents of abuse. Up until 2005, the main focus on helping high-risk victims was refuge provision, with 17 500 women a year going to a refuge. However, refuge accommodation is not designed for the needs of high risk victims and provides a valuable but temporary solution to long-term domestic abuse. In 2005, CAADA developed the IDVA as a specialist role to help women facing a high risk of violence. Today IDVAs work with 50 000 high risk victims a year. When assessing victims of domestic violence to determine their needs, IDVAs almost universally apply the DASH risk indicator checklist (Domestic Abuse, Stalking, and 'Honour'-based violence), which was developed by CAADA.

CAADA offers IDVAs an intensive accredited training programme ('CAT'), the completion of which indicates the IDVA's skill and knowledge has been formally assessed. Those that pass the course are awarded certification that lasts for three years.

## RISK ASSESSMENT

The main tool for risk assessment with victims in the UK is the CAADA-ACPO-DASH risk identification checklist. This is available for download from the CAADA website<sup>19</sup> in 14 different languages with guidance attached.

## AGENCIES INVOLVED IN PREVENTING DOMESTIC VIOLENCE IN ENGLAND & WALES: THEIR POLICIES AND PRACTICES

### ASSOCIATION OF CHIEF POLICE OFFICERS (ACPO)

The Police are one part of the Criminal Justice System (CJS). They are tasked with preventing and investigating crime, as well as providing necessary support for the public. When a case of DV is reported to the Police, they will investigate and make an arrest should there be enough evidence to do so.

The police participate in and often chair MARACs and exchange information through case conferences wherever possible. However, in emergency cases of the highest risk, the process becomes informal and telephone conferences are held to act swiftly and decisively. As well as working with agencies which participate in MARACs, the Police work particularly closely with the other parts of the CJS, especially:

- Crown Prosecution Service (CPS)
- Probation Services
- Prison Services

### >> CROWN PROSECUTION SERVICE (CPS)

The CPS is part of the Criminal Justice System. They are a public prosecution service tasked with prosecuting cases investigated by the Police. When the Police have reasonable suspicion that a suspect has committed an offence involving DV, they must refer that case to a prosecutor, who will make a decision whether to charge the alleged offender with a crime.

The CPS has developed significantly in dealing with DV and has introduced measures such as: 141 Specialist Domestic Violence Courts (SDVCs) in England and Wales, though this number may be reduced in future due to the Government's Court Closure consultation.

SDVCs provide:

- specially tailored support and advice;
- specially trained magistrates and prosecutors;
- separate entrances, exits and waiting rooms for victims and perpetrators;
- Witness Care Units (WCUs) which provide support and guidance for the witness and/or victim;
- special measures, which a WCU officer can help the victim obtain.

Special measures are means to help a vulnerable victim or witness testify in court. These include:

- interpreters
- screens in court rooms
- clearing the public gallery (especially in cases of SV)
- giving evidence through an intermediary
- giving evidence via a live video link
- giving evidence through a video-recorded statement

<sup>19</sup> [http://www.caada.org.uk/practitioner\\_resources/riskresources.htm](http://www.caada.org.uk/practitioner_resources/riskresources.htm)

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As well as having completed specialised training, all prosecutors, associate prosecutors, and caseworkers in the CPS have been trained in tackling domestic violence to a degree.

In terms of court orders for safety planning, the Court can issue:

- a non-molestation order which makes it easier to prove abuse of any kind
- an occupation order where the perpetrator must leave the property which the victim occupies and cannot not enter or attempt to re-enter it, or come within a specified distance
- a restraining order
- community service
- penalties/fines
- prison sentences

If the case is dropped, victims are informed and given reasons why it has been dropped. Vulnerable or intimidated witnesses have letters sent to them within 24 hours of the decision being made and all other cases within five days. The letters contain information for the victim and/or witness to access support services such as help lines and local services.

## >> NATIONAL PROBATION SERVICE

The National Probation Service (NPS) is one part of the National Offender Management Service.

They are tasked with:

- minimising the impact of crime on communities and especially victims who have been touched by serious violent or sexually violent crimes
- rehabilitating offenders given community sentences and those released from prison
- enforcing the conditions of their court orders and release licences
- taking whatever steps in their power to protect the public

For risk assessment, the NPS uses:

- SARA (Spousal Abuse Risk Assessment) for victim risk assessment
- OASys (Offender Assessment System) for perpetrator risk assessment (i.e., how much of a risk are they to others as opposed to their own safety)

Both of these will be carried out by a probation officer. Women's support officers (part of the NPS) use CAADA DASH as their risk assessment tool. All three are systematically applied and will deal directly with either the victim or the perpetrator. SARA and OASys are useful tools in assessing high risk, but their effectiveness is dependent on the quality of completion for every case.

In the 2009-10 Annual Report of the National Probation Service by HM Chief Inspector of Probation, Andrew Bridges, offender managers were asked where they thought there could be improvements to the Probation Service. The following suggestions were made:

- to liaise more with the Police DV unit
- to use a 'what if' approach in risk assessment
- to have better contingency planning in risk management plans
- to do home visits where there may be child protection issues

## >> CHILDREN AND FAMILY COURT ADVISORY AND SUPPORT SERVICES (CAFCASS)

CAFCASS looks after the interests of children involved in family proceedings. They work with children and their families, and then advise the courts on what they consider to be in the best interests of individual children.

It is independent of all agencies including the Courts and Child Services but operates under the rules and directions of the Family Courts.

Its role is to:

- safeguard and promote the welfare of children
- give advice to the Family Courts
- make provision for children to be represented
- provide information, advice and support to children and their families

There is a major discrepancy between the policy of CAFCASS and the actual implementation of how they tackle DV. An Ofsted (Office for Standards in Education, Children's Services and Skills) report on CAFCASS in 2009 criticised their lack of effectiveness, and mentioned in particular poor practice. Their inspection deemed that their services were inadequate in:

- Greater London
- North Yorkshire and Humberside
- South Yorkshire
- Cheshire and Merseyside
- Far South West and Staffordshire and the Marches

Ofsted noted that not even minimum standards were being met in these areas.

Criticisms included:

- families having to wait for far too long
- inconsistent assessments
- out of date and inaccurate information
- safeguarding policies were not covering specialist services provided by the High Court

## >> DEPARTMENT OF HEALTH

The Department of Health (DH) exists to improve the health and well-being of people in England.

For all people, the DH aim to provide better:

- health and well-being
- care
- value

The DH definition of DV is that it is a term which:

*'...refers to a wide range of physical, sexual, emotional and financial abuse between partners/ex-partners – whether or not they are co-habiting.'*

As well as the DH, there are individual Royal Colleges which provide guidance for more specialist parts of health work and which physicians of that discipline can join.

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## >> CHILDREN AND YOUNG PEOPLE'S SERVICES (CYPS)

CYPS are local services which have responsibility for all the main education (including schools, health and social services) for the children and young people in the local borough to which they belong, whilst working alongside other partners such as the voluntary and community sector. They implement LSCB policy.

## >> Department of Communities and Local Government (DCLG)

The DCLG aims to foster prosperous and cohesive communities, offering a safe, healthy and sustainable environment for all. With reference to housing and DV, they are tasked with:

- tackling homelessness
- providing housing support

The DCLG definition of DV is identical to the Government's.

## SUMMARY

The table below summarises whether the involved agencies have a DV policy; identify and assess high risk; safety plans; cooperate with other agencies in sharing information on HRVs.

Agency	ACPO	CPS	NPS	CAFCASS	CYPS	DCLG
<b>DV Policy</b>	Yes	Yes	Yes	Yes	Nothing national found	Yes
<b>Identification</b>	Yes	No	Yes	Yes	Yes	No
<b>Referring</b>	Yes	Yes	Yes	Yes	Yes	Yes
<b>Risk assessment</b>	Yes	No	Yes	Yes	Yes	No
<b>Safety planning</b>	Yes	No	Yes	Yes	Yes	Yes
<b>Multi-agency</b>	Yes	Yes	Yes	Yes	Yes	Yes
<b>Date</b>	2008	2009	2007	2006	-	2009

Despite the criticism the MARAC system seems to be a very effective approach as a standard for protection and safety for high risk victims in gender-based intimate partner violence. However, some questions remain: What is the role of the women's support services? Who employs the IDVAs? Who can be trained as an IDVA? Do these persons have to have prior experiences in working with women who survived violence?

## SUMMARY AND RECOMMENDATIONS

### QUESTION 1:

(To what extent) Are empowering services and support available to (young) women and their children as well as girls at risk of serious violence, and what gaps can be identified?

One participating country does not provide any shelter for victims of VAW at all. A few others do not have enough shelter places, especially in rural areas. NGOs (shelters, support services etc.) are apparently not recognised as experts on this issue or are not valued as such, and the warnings (red flags) they could give on high risk victims are not picked up. A gender-neutral approach is detrimental, because it makes the crimes and their repercussions invisible.

### RECOMMENDATION:

Gaps in providing basic safety measures are to be closed. The EU minimum standard of one family place in a specialized shelter per 10 000 inhabitants should be provided. Women's support services (NGOs) must be recognised as equal partners and be securely funded to be able to concentrate on their work.

### QUESTION 2:

Have core agencies developed and implemented policies, guidelines and multi-agency initiatives to identify, protect and support high risk victims?

There seems to be no joint strategy between the core agencies. With the exception of Spain and the MARACs in England/Wales there is no state-wide joint strategy to be found to protect and support high risk victims. Policies/guidelines exist mostly on an individual organisational level, if at all. There is hardly any multi-agency approach. A multi-agency approach is found among agencies which belong to a similar governmental setting, whereas NGOs are mostly excluded.

Many respondents on the state level did not even recognise that there might be high risk victims of gender-based intimate partner violence.

### RECOMMENDATION:

Comprehensive and coordinated policies need to be developed on EVERY level which includes all organisations working on this issue, especially women's support services (NGOs).

### QUESTION 3:

Do they use risk/danger assessment and safety planning tools? Which instruments do they use, who uses them, what is the purpose and effect of using such tools, to what extent are such tools used?

Unfortunately, most respondents use just risk assessment tools without appropriate risk assessment management. A wide variety of risk assessment tools is used: mainly the DA by Campbell, as well as SARA and also many self-developed instruments. NGOs which use a tool stated in most answers that they are trying to show the woman her degree of endangerment more clearly. One NGO uses an instrument to filter the women who should have priority because of the high risk (they deal with more than 4 000 women a year). Only a minority of the interview partners uses the RAI systematically in all cases.

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## **RECOMMENDATION:**

All relevant agencies working with victims should use some risk assessment on a systematic and regular basis, at least as a part of a safety planning. Using a risk assessment tool is not enough! It should be imbedded in a risk management and safety management approach. A misuse of a risk assessment instrument should be excluded. Risk factors for violence against women should be addressed.

## **QUESTION 4:**

Are there any multi-agency good practice models in protecting and supporting high risk victims?

The MARAC system (with core goals such as developing and improving the coordination of services and information-sharing through protocols, interdisciplinary training and coordinating risk assessments, practices and operations among all criminal justice personnel and victim services) used in England/Wales seems to be a very effective approach as a standard for protection and safety for high risk victims in gender based intimate partner violence.

One NGO in Austria started with this approach in 2009. As yet, the approach is still based on informal agreements. This should be changed to binding protocols.

## **RECOMMENDATION:**

The MARAC system as a good practice model should be introduced as a basic measure to identify and protect high risk victims. It should be based on binding protocols and not on informal agreements. NGOs working for/with women should be an integral part.

## **QUESTION 5:**

Is there any systematic method of analysing homicides or attempted homicides, including homicides committed in the name of 'honour', in order to evaluate strengths and weaknesses in the prevention system?

NO! NGOs are mostly the ones who scrutinise these cases when they occur. State agencies do not use this method to look at gaps in protecting women from serious crimes. It seems as if the individual agencies do such an analysis only to protect their own organisations. Many respondents found this an interesting aspect of the multi-agency work.

## **RECOMMENDATION:**

This method should be an integrated part of a multi-agency approach of looking at gaps in the prevention system.

## GENERAL FINAL COMMENTS:

There are several aspects which need to be emphasised:

- Practitioners need regular specialised training in working with high risk victims of gender-based violence
- Cooperation needs binding protocols
- High risk victims of gender-based intimate partner violence must be recognised on the state level
- A coordinated, comprehensive strategy involving all parties on an equal level (that means sufficient resources for the engaged NGOs) must be developed

A comment of a respondent:

*'This interview makes it very clear that we have to address the issue of high risk victims of domestic violence in our member organisations. And we have to develop standards for their protection and safety! These questions show the gaps very clearly. We would like to get the final report and even have a presentation on the findings in one of our meetings next year!'*

A comment of an interviewer:

*'It was interesting to do these interviews. I could acquire a better knowledge about the procedures in the responding agencies, I could renew old contacts and also find new ones. I hope that this has triggered a better cooperation for the future.'*

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## II.

### **C. AVAILABILITY OF RELIABLE, SYSTEMATICALLY COLLECTED AND ANALYSED, DATA ON GENDER-BASED INTIMATE PARTNER HOMICIDE / FEMICIDE IN EUROPE**

Femicide, 'the killing of females by males because they are female' (Russell. et al. -2001, p. 13–14), is one of the most extreme manifestations of violence against women (VAW). Women of all age groups are most at risk of being murdered by someone they know: by a family member or an intimate partner.

Although international attention on VAW as a health issue and human rights concern has increased within the last decades, femicide and the protection of high risk victims of intimate partner violence are still not well investigated. Many murders of women and young girls by males are still unreported, uncounted, unconsidered and invisible in our societies. For this reason an investigation was carried out within the project PROTECT to analyse the availability of femicide data at a European and national level.

Femicide has been addressed in different contexts, including intimate partner violence, stranger violence, sexual violence, female infanticide, so called crimes in the name of honour and dowry practices, as well as murders associated with gang activity and political violence. As a result, different definitions and conceptual framings have been proposed by researchers and activists.<sup>20</sup>

Within the project PROTECT intimate partner violence as a broader context of femicide was applied to analyse the availability of femicide data at a European and national level. In the analysis, less attention was given to specific issues of femicide such as crimes in the name of honour. Since 'honour killing' and similar crimes in the name of honour are not specified crimes in the judicial system of most EU member states, candidate and applicant states, there are no systematically collected and analysed data available on so-called honour crimes at national and at European level. According to the glossary agreed upon in this project, femicide is defined here as intimate partner homicide of women, taking into account that there is no uniform definition of homicide. According to the United Nations CEDAW Committee, intimate partner violence against women can be defined as a form of gender-based violence which is 'directed against a woman because she is a woman or that affects women disproportionately'. (CEDAW Committee 1992: Art 6).

#### **1. RELEVANCE OF GENDER-DISAGGREGATED STATISTICS ON GENDER-BASED HOMICIDE / FEMICIDE**

Data and statistics on the real extent and nature of femicide are a necessary tool in the work to reduce and prevent the most serious forms of gender based violence against girls, women and their children and to protect high risk victims of violence. The lack of consistent information about the number of women and children killed by an intimate partner or family member limits our ability to gauge the magnitude of VAW relative to other social problems. Systematising information and knowledge on the dimension of femicide that is reliable, neutral and analytical is the basis for political arguments; it serves a public interest, reveals the costs of VAW and supports a claim for public funding (Römkens, 2007, p 64).

Systematic collection and analysis of gender-disaggregated statistics on the causes, nature, and seriousness of femicide strengthens our competences to monitor changes and differences in the incidence, to evaluate the effectiveness of prevention and intervention activities, to recognise gaps in the services provided, and to estimate the number of cases related to VAW. Furthermore these data enable identification of those groups of women and children at highest risk who might benefit most from focused intervention or improved services (Saltzman et al., 2002, p. 1).

<sup>20</sup> Four aspects can be identified which lead to a variation in conceptualising femicides: (a) definition and relation between victim and perpetrator: murders by current and former intimate partner/husband, by family members, friends, and acquaintances, or by strangers; including or excluding female perpetrators, same-sex partners; (b) form of violence that leads to death: inclusion or exclusion of deaths resulting from interpersonal or other violence such as AIDS, genital mutilations, armed conflicts or femicide-suicide; (c) terminologies used by official statistics and administrative data such as police, healthcare sector, legal systems; (d) responsibility of the state with regard to femicide.

Data related to VAW are highly sensitive and can be misused. In the worst case, such data in the hands of abusers and perpetrators can cause the death of a woman. Despite the great benefits of new information technology in terms of data collection, efficient security standards regarding usage of new information technology should be considered. In accordance with that, the following questions should be raised once more: Which data are really needed to protect women? Who can access this sensitive information, and which security standards are needed to share, but simultaneously protecting, these data from being misused?<sup>21</sup>

VAW and femicide are global problems that cannot be solved in isolation by a single state or society. Therefore it is important to systematically collect reliable data on femicide that are comparable over time and between countries – at European and at international level. Good practice examples in prevention and protection of victims of violence – especially those at high risk – should be identified and protection measures should be extended at European / international level.

## 2. POLITICAL EFFORTS FOR SYSTEMATIC COLLECTION OF GENDER-DISAGGREGATED DATA ON VIOLENCE AGAINST WOMEN AND FEMICIDE IN EUROPE

Following the Beijing Platform for Action<sup>22</sup> in 1995, clear EU political recommendations were articulated towards a systematic collection of gender-sensitive data on VAW and on femicide in Europe:

The *Council of Europe Recommendation Rec (2002)5* on the protection of women against violence<sup>23</sup> addresses advice for the Council of Europe Member States on the preparation of statistics sorted by gender, on integrated statistics and on common indicators to better evaluate the scale of VAW.

As part of the Council of Europe Campaign to Combat Violence against Women, including Domestic Violence (2006–2008)<sup>24</sup>, several activities on the same subject were defined as concrete actions by the Task Force: the Blueprint once more highlights the importance towards the Council of Europe Member States to *'ensure the systematic collection of statistical data disaggregated by sex, by type of violence as well as by the relationship of the perpetrator to the victim in all fields'*<sup>25</sup>.

Accordingly the Regional Seminar on Data Collection as a Prerequisite for Effective Policies to Combat Violence against Women, including Domestic Violence,<sup>26</sup> was organised in Lisbon in July 2007 and the survey on *Administrative data collection on domestic violence in Council of Europe member states* (Ruuskanen et al., 2008) was published as a further activity of the Campaign. Besides fostering a systematic statistical data collection and analysis on domestic violence against women both activities came to the conclusion that although more and more Council of Europe member states are carrying out population-based surveys on VAW, there is a general lack of systematically collected, service-based administrative data (e.g., police, judiciary, public health sector) on violence against women.

<sup>21</sup> For more information: e.g. Safety Net Project: the National Safe & Strategy Technology Project: National Network to End Domestic Violence: <http://www.nnedv.org/component/content/article/111.html>, 10.03.2010.

<sup>22</sup> Beijing Declaration and Platform of Action, Fourth World Conference on Women, September 1995, p. 46: [http://www.unesco.org/education/information/nfsunesco/pdf/BEIJIN\\_E.PDF](http://www.unesco.org/education/information/nfsunesco/pdf/BEIJIN_E.PDF), 08.03.2010.

<sup>23</sup> The Protection of Women against Violence, Recommendation Rec(2002)5 of the Committee of Ministers to member States on the protection of women against violence, Division Equality between Women and Men, Directorate General of Human Rights, Council of Europe, STRASBOURG CEDEX 2002: [www.profeministimiehet.net/whiterib/content/texts/rec20025.doc](http://www.profeministimiehet.net/whiterib/content/texts/rec20025.doc), 08.03.2010.

<sup>24</sup> Council of Europe Campaign to Combat Violence against Women, including Domestic Violence: <http://www.coe.int/t/dg2/equality/DOMESTICVIOLENCECAMPAIGN/>, 08.03.2010.

<sup>25</sup> Task Force to Combat Violence against Women, including domestic violence (EGTFV) Blueprint of the Council of Europe Campaign to Combat Violence against Women, including Domestic Violence: [http://www.coe.int/t/dg2/equality/domesticviolencecampaign/Source/Blueprint\\_8\\_rev\\_5\\_EN.pdf](http://www.coe.int/t/dg2/equality/domesticviolencecampaign/Source/Blueprint_8_rev_5_EN.pdf), 08.03.2010. The Blueprint was adopted by the Committee of Ministers on 21 June 2006.

<sup>26</sup> Regional Seminar on Data Collection as a Prerequisite for Effective Policies to Combat Violence against Women, including Domestic Violence, Lisbon, July 2007: [http://www.coe.int/t/dg2/equality/domesticviolencecampaign/regional\\_seminars/](http://www.coe.int/t/dg2/equality/domesticviolencecampaign/regional_seminars/), 08.03.2010

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In the Final Activity Report: Council of Europe task force to combat violence against women, including domestic violence (EG-TFV) published in 2008, the Task Force recommends to appoint an observatory – femicide watch – at international level to collect data on murders of women by their husbands, ex-husbands, intimate partners and relatives. At national level Council of Europe member states should:

- institute a method for collecting specific data on the number of such murders of women per year disaggregated by age, number of perpetrators disaggregated by age and sex of the perpetrators as well as the relationship between the perpetrator and the victim or victims;
- collect information concerning the prosecution and punishment of perpetrators. Each case of such a murder should be carefully analysed to identify any failure of protection in view of improving and developing further preventive measures;
- co-operate with NGOs working in this field in the collection, analyses and publication of such data. Such data should be made publicly available at the national level and by the Council of Europe and published during the 16 Days on Activism against Gender Violence. The Secretariat General of the Council of Europe should ensure the publication of such data;
- entrust this task to the existing national structures mandated to work on violence against women or to the proposed national observatories on violence against women<sup>27</sup>.

Violence against women and femicide are crimes that states must address and prosecute in the public interest<sup>28,29</sup>. There is a strong political recommendation to improve data on the dynamics and magnitude of femicide as a critical component of advocacy and prevention. In 2007, Raül Romeva i Rueda (MEP) highlights the importance of a global strategy to ‘... enable the EU and its partners to undertake joint actions and efforts intended to eradicate and prevent violent deaths of women everywhere’ (Romeva i Rueda, 2007, p. 4).

### 3. AVAILABILITY OF GENDER-SENSITIVE DATA ON GENDER-BASED INTIMATE PARTNER HOMICIDE / FEMICIDE IN EUROPE

As there are clear EU political recommendations in the sense of a systematic collection of gender-sensitive data on violence against women and on femicide in the EU member states and at the European level, there are several questions that arise: Are there reliable gender-sensitive data that are systematically collected and analysed – segregated by sex, age, type of violence (according to the criminal code) and relationship between victim and perpetrator – on gender-based intimate partner homicide / femicide available in the EU member states, candidate states and applicant states? Are these data comparable over time and between countries and available at the European level? If that is not the case, what are the challenges in providing such statistics and which actions need to be taken to overcome these obstacles?

Besides different frameworks, definitions, and classifications to conceptualise femicide, there are several sources of information used to collect data on femicide: criminal statistics (data from official state agencies), police reports, court data, police statistics, medical examiner systems (administrative data), and media reports. Accordingly, a range of methodologies has been used to collect data on femicide, including population-based studies, analysis of service records (homicide, police, hospital, court, and mortuary statistics, domestic fatality reviews, verbal autopsies, and review of newspaper articles).<sup>30</sup> The methodological differences in the collection of data also lead to different interpretations of data.

<sup>27</sup> Final Activity Report: Council of Europe task force to combat violence against women, including domestic violence (EG-TFV): Gender Equality and Anti-Trafficking Division Directorate General of Human Rights and Legal Affairs, Strasbourg, September 2008: p. 18, 79, 81: [http://www.coe.int/t/dg2/equality/domesticviolencecampaign/Source/Final\\_Activity\\_Report.pdf](http://www.coe.int/t/dg2/equality/domesticviolencecampaign/Source/Final_Activity_Report.pdf), 08.03.2010.

<sup>28</sup> See first legal definition of femicide in Mexico as a result of the tremendous femicide in Juarez: Violent femicide in Mexico: Mexican Congress, Chamber of Deputies - 59th legislative term. Ad hoc Information and Monitoring Committee on the Investigations into Femicide in Mexico and the Legal Services Responsible. Mexico, 2006: <http://www.topicsandroses.com/spip.php?article96#nb10>, 08.03.2010.

<sup>29</sup> Diana Russell also states that culture promotes femicide: Helen Tierney, Women's Study Encyclopaedia Revised and Expanded Edition A - F, Greenwood Press, Westport: 1999. p. 470

<sup>30</sup> Strengthening Understanding of Femicide: Using Research to Galvanize Action and Accountability, Program for Appropriate Technology in Health (PATH), InterCambios, Medical Research Council of South Africa (MRC), and World Health Organization (WHO), Washington DC, 2009: p 2.: [http://www.path.org/files/GVR\\_femicide\\_rpt.pdf](http://www.path.org/files/GVR_femicide_rpt.pdf), 08.03.2010.

Survey data such as the WHO multi-country study on violence against women<sup>31</sup> or the British Crime Survey (Walby et al., 2004) show that only a very small percentage of women report violence to the services or authorities and that VAW goes widely underreported. This leads to limitations on the use of statistics from law enforcement, health services and other agencies. Administrative data are not representative and say very little about the extent and characteristics of VAW. However, administrative or service-based data are very important to monitor the effectiveness and quality of the response of agencies to VAW (Walby, 2005, p 194ff.; Jansen, 2008, p. 31–39). Therefore it is widely acknowledged among experts that both kind of data are needed and have to be gathered regularly using common indicators, in order to be able to assess the problem properly and to plan and implement what is known as a 'knowledge-based policy' (Walby, 2005, p 194ff.; Römken, 2007, p 64).

In order to investigate the availability of femicide data at the EU level as well as in the EU member states, candidate states and applicant states, existing data on homicide have been analysed. A focus was set on administrative data, where the collection and analysis of homicide data is already a financed and routine part of public service: (a) homicide data of crime statistics generated by the criminal justice system and collected by the police (b) homicide data generated by the healthcare system and collected by physicians based on the *European shortlist of causes of death*<sup>32</sup>. Both types of data are available at EU level through Eurostat statistics and at national level in the EU member states, candidate states and applicant states.

Additionally data based on surveys (research) have been analysed to investigate the availability of femicide data at the EU level. This analysis also builds on the findings of the EU Daphne project 'Estimation of Intimate-Partner Violence related mortality in Europe - IPV EU\_Mortality' carried out by Psytel<sup>33</sup>.

### **3.1 AVAILABILITY OF GENDER-SENSITIVE DATA ON GENDER-BASED INTIMATE PARTNER HOMICIDE / FEMICIDE AT EUROPEAN LEVEL**

#### **3.1.1 HOMICIDE DATA AVAILABLE IN EUROSTAT DATABASE ON CRIME AND CRIMINAL JUSTICE<sup>34</sup>**

The Eurostat statistic on Crime and Criminal Justice does not provide homicide data segregated by sex and age. The type of violence as well as the relationship between victim and perpetrator is not considered, either. There is no data on gender-based intimate partner homicide / femicide available at EU level in the Eurostat crime statistics.

Measuring the development of crime at European level is a difficult task, due to differences in the national information sources. There are different legal and criminal justice systems in the national states and differences in the list of offences that are included in the overall crime figures. A lack of consistent definitions and indicators as well as gaps in systematic data collection increases the challenge to generate data comparable between countries and leads to differences in measuring the crime at the national level. Also, the rate of crimes reported to the police and recorded by police officers differs greatly between national states. This issue is well known when it comes to cases of femicide: a police officer who is not aware about the dynamics of VAW will perceive the same situation differently than an officer with specific training in this matter.

Several initiatives have been taken at European level to overcome these challenges and to generate reliable and comparable statistics on crime and criminal justice. In 1993, the *Group of Specialists on Trends in crime and criminal justice: statistics and other quantitative data on crime and criminal justice systems* was established by the European Committee on Crime Problems

<sup>31</sup> WHO Multi-country Study on Women's Health and Domestic Violence against Women: Initial results on prevalence, health outcomes and women's responses, 2005: [http://www.who.int/gender/violence/who\\_multicountry\\_study/en/](http://www.who.int/gender/violence/who_multicountry_study/en/), 08.03.2010.

<sup>32</sup> European shortlist of causes of death: [http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST\\_NOM\\_DTL&StrNom=COD\\_1998&StrLanguageCode=EN&IntPcKey=&StrLayoutCode=HIERARCHIC&CFID=4564696&CFTOKEN=58f0e61775aac1ab-F35FE685-05DB-AD8C-F3106725C335A174&jsessionid=1e51d05fd6ea7693868fd6734257635225464TR](http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST_NOM_DTL&StrNom=COD_1998&StrLanguageCode=EN&IntPcKey=&StrLayoutCode=HIERARCHIC&CFID=4564696&CFTOKEN=58f0e61775aac1ab-F35FE685-05DB-AD8C-F3106725C335A174&jsessionid=1e51d05fd6ea7693868fd6734257635225464TR), 08.03.2010. This shortlist is based on the WHO's International Statistical Classification of Diseases and Related Health Problems (ICD): World Health Organisation: International Statistical Classification of Diseases and Related Health Problems: <http://www.who.int/classifications/icd/en/>, 08.03.2010.

<sup>33</sup> Société civile Psytel: [www.psytel.eu](http://www.psytel.eu), 08.03.2010, Synthesis in English for download at <http://www.psytel.eu/violences.php>

<sup>34</sup> EUROSTAT: Crime and Criminal Justice, 2009: <http://epp.eurostat.ec.europa.eu/portal/page/portal/crime/introduction>, 08.03.2010.

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(CDPC) to develop methods to handle problems such as varying offence definitions and different counting rules in the Council of Europe Member States. A first draft version of the *European Sourcebook of Crime and Criminal Justice Statistics*<sup>35</sup> was presented in 1995<sup>36</sup>, which included both statistical data from 36 European countries and information on the statistical rules and the definitions behind these figures. The fourth edition, covering the years 2003–2007, was published in 2010.

In 2001, the *EU Crime Prevention Network*<sup>37</sup> was set up by an EU Council Decision to promote the activity of crime prevention in member states across the EU, and to identify and share valuable good practice examples in preventing crime, mainly traditional crime.

Based on the *Hague Programme*<sup>38</sup>, the *EU Action Plan for the Development of a Comprehensive and Coherent EU Strategy to Measure Crime and Criminal Justice (2006-2010)*<sup>39</sup> was implemented by the Commission in August 2006 to take concrete action in developing a comparable system of crime and criminal justice statistics. An expert group was established by Commission Decision (2006/581/EC) to advise on the implementation of this Action Plan. In parallel, a Eurostat working group was set up to progress recommendations of the expert group. A number of expert sub-groups and task forces have been implemented to examine particular tasks.<sup>40</sup>

Surprisingly, neither the *Sourcebook(s) of Crime and Criminal Justice nor the Action Plan for the development of a comprehensive and coherent EU strategy to measure crime and criminal justice*<sup>41</sup> consider or contain any action on developing indicators to measure violence against women and gender-based intimate partner homicide/femicide.

### 3.1.2. HOMICIDE DATA AVAILABLE IN EUROSTAT DATABASE ON PUBLIC HEALTH<sup>42</sup>

Based on the *European Shortlist of Causes of Death*<sup>43</sup>, the Eurostat statistic on Health (Public Health) provides homicide data separated by sex for female and male in the tables: *Death due to homicide, assault, by gender - [tps00146]; Standardised death rate by 100 000 inhabitants*. However, there is no age-disaggregated information on homicide available. Also, the exact type of violence which results in death as well as the relationship between victim and perpetrator remains unconsidered. The homicide data of the Eurostat health statistic does not provide data on gender-based intimate partner homicide / femicide at EU level, either.

The general orientation of the *European Shortlist for Causes of Death by the International Statistical Classification of Diseases and Related Health Problems*<sup>44</sup> (ICD) of the WHO is seen here as a valuable strategy to generate data on femicide that is comparable (not only) between EU member states. In contrast to the *European shortlist for Causes of Death*, the ICD considers

<sup>35</sup> European Sourcebook of Crime and Criminal Justice Statistics: <http://www.europeansourcebook.org/>, 08.03.2010.

<sup>36</sup> In contrast to other periodical international surveys on crime and criminal justice carried out by the United Nation Office on Drugs and Crime (United Nations Survey on Crime Trends - CTS) or INTERPOL, which rely on the provision of data by national sources which were asked to follow standard definitions, the methodology adopted in the European Sourcebook of Crime and Criminal Justice Statistics is based on a co-ordinated network of national correspondents. Each country has one person responsible for collecting and initially checking the data.

<sup>37</sup> Eu Crime Prevention Network: <http://www.eucpn.org/>, 08.03.2010.

<sup>38</sup> The Hague Programme: [http://europa.eu/legislation\\_summaries/justice\\_freedom\\_security/judicial\\_cooperation\\_in\\_criminal\\_matters/116002\\_en.htm](http://europa.eu/legislation_summaries/justice_freedom_security/judicial_cooperation_in_criminal_matters/116002_en.htm), 08.03.2010.

<sup>39</sup> Commission communication COM/2006/437 final: EU Action Plan for the development of a comprehensive and coherent EU strategy to measure crime and criminal justice: [http://europa.eu/legislation\\_summaries/justice\\_freedom\\_security/judicial\\_cooperation\\_in\\_criminal\\_matters/133264\\_en.htm](http://europa.eu/legislation_summaries/justice_freedom_security/judicial_cooperation_in_criminal_matters/133264_en.htm), 08.03.2010.

<sup>40</sup> E.g., an expert sub-group was established in 2008 to identified policy needs of data in the areas of effectiveness of criminal justice systems, juvenile criminal justice, judicial cooperation in criminal matters and the cost of criminal justice.

<sup>41</sup> The Action Plan was adopted in the same year that the Council of Europe Campaign to Combat Violence against Women started.

<sup>42</sup> EUROSTAT: Health (Public Health / Health and safety at work), 2009: <http://epp.eurostat.ec.europa.eu/portal/page/portal/health/introduction>, 08.03.2010.

<sup>43</sup> European Shortlist of Causes of Death: [http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST\\_NOM\\_DTL&StrNom=COD\\_1998&StrLanguageCode=EN&IntPckKey=&StrLayoutCode=HIERARCHIC&CFID=4564696&CFTOKEN=58fce61775aac1ab-F35FE685-05DB-AD8C-F3106725C335A174&jsessionid=1e51d05fdea7693868fd6734257635225464TR](http://ec.europa.eu/eurostat/ramon/nomenclatures/index.cfm?TargetUrl=LST_NOM_DTL&StrNom=COD_1998&StrLanguageCode=EN&IntPckKey=&StrLayoutCode=HIERARCHIC&CFID=4564696&CFTOKEN=58fce61775aac1ab-F35FE685-05DB-AD8C-F3106725C335A174&jsessionid=1e51d05fdea7693868fd6734257635225464TR), 08.03.2010. This shortlist is based on the WHO's International Statistical Classification of Diseases and Related Health Problems (ICD): World Health Organisation: International Statistical Classification of Diseases and Related Health Problems: <http://www.who.int/classifications/icd/en/>, 08.03.2010.

<sup>44</sup> World Health Organisation: International Statistical Classification of Diseases and Related Health Problems: <http://www.who.int/classifications/icd/en/>, 08.03.2010.

<sup>44</sup> E.g., External causes of morbidity and mortality (V01-Y98), subcategory Assault (X85-Y09).

a larger variety of types of violence<sup>45</sup>. Furthermore, the ICD attempts to include the relationship between victim and perpetrator in the list of indicators.<sup>46</sup> This approach has not been adopted at the EU level in the European Shortlist for Causes of Death, which leads to assumption that the EU does not consider UN recommendations precisely in every respect.

### 3.1.3. HOMICIDE DATA AVAILABLE BASED ON SURVEYS

Data based on research provide more general sociologically oriented insights into the prevalence, nature, determinants and consequences of intimate partner violence (Römkens, 2007). Surveys are a valuable tool to monitor the implementation of EU political recommendations. For this reason three femicide studies at European level are mentioned here:

**(a) Protecting Women Against Violence. Analytical study of the results of the second round of monitoring the implementation of Recommendations Rec (2002)5 on the protection of women against violence in the Council of Europe** (C. Hagemann-White, 2008)

The latest report on monitoring the implementation of the Council of Europe Recommendations Rec (2002)5 on violence against women analyses in the Council of Europe Member States whether *police statistics systematically record in standardised categories according to criminal offences the sex of victim, sex of perpetrator, and the relation between perpetrator to victim. If so are they available in national reports?* According to the answers provided by the Council of Europe Member States<sup>47</sup>, 27 out of 40 member states report that police statistics systematically record data on sex of perpetrator, sex of victim and their relationship in reporting on the most common criminal offences within the family. Furthermore 21 countries state that statistics are available which combine all three categories – sex of perpetrator and victim and their relationship – according to criminal offences.

Due to practical experience of experts working in the field of VAW and because of missing methods on systematic collection of gender-sensitive intimate partner homicide, the correctness of the answers given by representatives of the Council of Europe Member States is questioned by the researchers who conducted the survey.

**(b) 3<sup>rd</sup> International Report: Partner Violence against Women: Statistics and Legislation, by Instituto Centro Reina Sofía (ICRS) - (Esplugues et. al., 2010)**

This survey compares femicide data between countries in Africa, America, Australia and Europe<sup>48</sup> in total numbers for the year 2006, such as: Femicide Total in 2006 (p. 67f.), Domestic Femicide in 2006 (p. 80f.), and Partner Femicide in 2006 (p. 87); furthermore, femicide data disaggregated by age group of victims in percentages in 2006 as well as type of weapons used to commit femicide in 2006 are presented in tables. The statistical data *'regarding women killed (in general, by family members and by partners)'* (Esplugues et. al., 2010, p. 65) were collected from official national organisations such as Ministries of Justice, Ministries of Interior, Ministries of Social Affairs, from police departments and from national statistical agencies of the various countries.

Although the researchers who conducted the survey are aware of the fact that *'many countries still do not have crime data disaggregated by sex (not even in the case of serious crimes like homicides) and even less by victim-offender relationship'* (Esplugues et. al., 2010, p. 65), such data were passed on by several official state organisations to Instituto Centro Reina Sofía. Simultaneously, researchers and practitioners working in the field of VAW clearly state that such data are not systematically

<sup>45</sup> E.g., External causes of morbidity and mortality (V01-Y98), subcategory Assault (X85-Y09)

<sup>46</sup> One example is category Y07: other maltreatment syndromes Ibid: Y07 Other maltreatment syndromes, which includes mental cruelty, physical abuse, sexual abuse, torture and excludes neglect and abandonment (Y06) and sexual assault by bodily force (Y05) aggregated by spouse or partner [Y07.0], parent [Y07.1], acquaintance or friend [Y07.2], official authorities [Y07.3], other specified persons [Y07.8], unspecified person [Y07.9]

<sup>47</sup> C. Hagemann-White, 2008: see Table 17. Content of police statistics and availability in a national report, p. 44.

<sup>48</sup> Africa: Algeria, America: Argentina, Bolivia, Colombia, Costa Rica, El Salvador, Guatemala, Honduras, Mexico, Panama, Paraguay, Puerto Rico, Dominican Republic; Canada; United States; Europe: Germany, Andorra, Austria, Bulgaria, Croatia, Cyprus, Denmark, Scotland, Slovakia, Slovenia, Spain, Estonia, Finland, the Netherlands, Hungary, England & Wales, Ireland, Iceland, Italy, Liechtenstein, Lithuania, Luxemburg, Malta, Monaco, Norway, Portugal, Czech Republic, Turkey.

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collected in their countries. This suggests that official state organisations do not always provide reliable data – especially when it comes to data on VAW.

## **(c) Estimates on intimate partner violence homicides in Europe, EU Daphne Project, by Société Civile Psytel<sup>49</sup>**

In the EU Daphne project 'Estimation of intimate partner violence homicides in Europe', Société Civile Psytel provides estimated numbers of intimate partner violence related homicides in 27 EU member states, as well as a cost estimate of these homicides.

The estimated numbers of femicides related to intimate partner violence in EU member states are based on a triple approach to collect and analyse macro-, meso- and micro-data according to an expanded definition of intimate partner homicide as well as on an algorithm specially developed for the project.

Through the meso-data approach conducted in the Daphne project '*Estimation of intimate partner violence homicides in Europe*', the Société Civile Psytel collected results of studies and related scientific surveys on intimate partner violence as well as official statistics on intimate partner homicide by sending a questionnaire to women's NGOs and national statistics agencies in 27 EU member states.

## **3.2 AVAILABILITY OF GENDER-SENSITIVE DATA ON GENDER-BASED INTIMATE PARTNER HOMICIDE / FEMICIDE IN THE EU MEMBER STATES, CANDIDATE STATES AND APPLICANT STATES**

Based on the slightly modified questionnaire (see Annex 1) developed by Société Civile Psytel in the meso-data approach, in order to build on existing results and to generate information comparable not only between the 27 EU member states, WAVE conducted a survey to analyse the availability of gender-based intimate partner homicide/femicide data in EU candidate states, EU applicant states, and potential EU candidate states.<sup>50</sup>

Apart from already identified good practice examples in systematically collecting, analysing and publishing gender-sensitive data on intimate partner homicide/femicide among the European countries – e.g., Spain, United Kingdom, France, Cyprus and Denmark – most EU member states, EU candidates, applicants and potential applicant states do not regularly provide reliable, systematically collected and analysed, gender-sensitive data on gender-based intimate partner homicide / femicide which are segregated by sex and age of, and relationship between, victim and perpetrator as well as by type of violence.

Data on homicide is collected in all countries throughout Europe. Although some countries lack a systematic collection of data on gender-based intimate partner homicide/femicide according to criminal offences in standardised categories (such as sex/age of victim, sex/age of perpetrator, and the relation between victim and perpetrator), often data collected by the police are segregated as to sex and age of perpetrator and victim, sometimes also according to a definition of the relationship between victim and perpetrator as well as by type of violence. However, these data are often not accessible and can only be requested from the police in accordance with laws (e.g., in Serbia) or with specific research questions (e.g., in Croatia). For reasons that remain unclear, most countries do not analyse and publish this data regularly and in a way that reveals the number of femicides.

The police is the primary source of information on intimate partner homicides and other types of femicide. The criminal justice sector has the potential to collect information on both victims and perpetrators. Because these sectors operate on the basis of a code of law, it should be possible to organise data by criminal code sections.

<sup>49</sup> Société civile Psytel: [www.psytel.eu](http://www.psytel.eu), 08.03.2010, Synthesis in English for download at <http://www.psytel.eu/violences.php>

<sup>50</sup> PROTECT Report on availability of reliable, systematically collected and analysed, data on gender-based intimate partner homicide /femicide in Europe, Vienna 2010.

However, there are still countries in Europe (e.g. Bulgaria, Albania) where domestic violence, family violence, intimate partner violence is not recognised as specific offence. Most countries in Europe do not have a specific regulation on intimate partner homicide / femicide and generally lack gender-sensitive language in their legislation. Since police is collecting information on the basis of existing laws it is a challenge for the police to identify the cases of domestic violence if there is no crime termed as 'domestic violence' in the criminal code.

Besides that, there exists no unified definition of terms like 'domestic violence', 'violence against women', 'intimate partner violence' which limits comparability of data between EU countries that was collected according to such terms. Some countries also have specific laws on domestic violence, while others address domestic violence under laws on assault, grievous bodily harm, sexual assault, stalking, homicide and other crimes. This again challenges the combination of gender-based intimate partner homicide / femicide data at EU level.

Furthermore, definitions applied in legislation related to domestic violence or family violence can limit the appropriate collection and analysis of data on gender-based intimate partner homicides / femicides.

Many definitions included in laws lack a clear segregation by relationship between victim and perpetrator and exclude existing forms of relationships. In Croatia, for example, non-marital and non-cohabiting partnerships are not included in the protection law; so this type of victim–perpetrator relationship is not considered in the data collection of police. In Turkey the Law No. 4320 on 'Protection of Family' is only applied to officially married couples. In Albania the new Law on Protection from Domestic Violence only considers crime committed by family member as domestic violence. NGOs such as WAVE Focal Point SOS Hotline Niksic strongly recommended using the term intimate partner violence instead. They were informed by the members of the parliament that 'intimate partners cannot be treated as family members.' This shows the importance to raise awareness about the dynamics of VAW among policy makers and to apply appropriate measures to protect all victims – especially those at high risk.

In Serbia, the definition of the group of people who can apply for protection in accordance with the Criminal Code<sup>51</sup> differs from the definition of the group of people who can request protection in accordance to the Protection Order related to the Family Law<sup>52</sup>. This inconsistency in definitions applied in legislation has a negative effect on systematic statistical work but also excludes people from protection measures. Besides, definitions in laws often do not meet statistical standards, are uninformative and do not lead to meaningful results of statistical analyses.

Another challenge is that even within an individual country, different Ministries such as the Ministry of Justice and the Ministry of Health may record the same crime differently, in light of different interests and responsibilities. However, this fact also involves the opportunity to identify VAW as cause of death on different levels. Since it can be assumed that cases of femicide are blanketed, for instance by covering them up as accidents, the 'light of different interests and responsibilities' can help to assess the cases of gender-based intimate partner homicides from different angles.

Although data on homicide are collected in all countries by the police, they are often not identified as gender-based intimate partner homicides/femicides. As mentioned above, on the one hand this is caused by legislation, on the other it is based on a lack of awareness and knowledge on dynamics of VAW. It is very important to provide special trainings on VAW to police

<sup>51</sup> Criminal Code: 1. marital or extra-marital partner, their children, spouse's parents, adopter and adoptee; 2. brothers and sisters and their spouses and children, previous spouses and their children, and previous spouses' parents, if they reside in the same household; 3. persons who have been or still are in emotional or sexual relationships, that is, persons who have a common child or a child expected to be born, even though they have never lived in the same family household.

<sup>52</sup> Family Law: 1. marital and ex-marital partners; 2. children, parents, and other related cousins (in blood, in law and adoption) and persons related by guardianship; 3. persons who live or lived in the same family household; 4. extra marital partners or ex-extra marital partners; 5. persons who were or still are in emotional or sexual relationship, or who have or are expecting a child, even though they have never lived together in a shared household.

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officers and to include this important topic in the curriculum of police education. Many women survivors of violence do not trust police and are afraid of reporting this crime. Also in this regard it is essential to have female police officers sensitised on VAW. The same applies for other professionals working in the social field – such as healthcare professionals, social workers, lawyers, etc.

As described above, although homicide data are collected in all countries by police based on criminal codes, this data can often not be analysed in a way to get meaningful and comparable information on femicide. In order to measure femicide and generate reliable data which is comparable over time and between countries it is important to apply unified and systematic methods, definitions and indicators for data collection as well as a standardised method to analyse these data, which has not been established and implemented Europe-wide so far.

In most countries, it is not possible to gain a complete picture of the magnitude of femicide because existing (criminal) statistics are not segregated according to the sex/age of victim and perpetrator. Existing homicide figures available in crime statistics do not describe the relationship between victim and perpetrator. For example the Austrian crime statistic does not provide such information yet, despite some efforts that were made by including three new indicators: crime committed in the common household, relationship without common house-hold and degree of acquaintance. Unfortunately, these new indicators have two major problems: firstly, the statistics do not show the gender of the victim and secondly, the relationship between the victim and the perpetrator is not defined.

Nearly in all European countries there is a need to improve the statistical work in this regard. Again this should be recognised as an opportunity to establish and implement a unified and standardised methodological system of data collection and analysis on gender-sensitive data on intimate partner homicide/femicide in all European countries, allowing us to generate gender-sensitive data on intimate partner homicide/femicide which are comparable over time and among countries according to standardised definitions and indicators.

The European Union and all countries in Europe have the obligation to combat VAW and to protect women survivors and their children in the best way possible. Providing reliable data on VAW and femicide is an important measure in this regard.

#### **4. RECOMMENDATIONS TO IMPROVE THE AVAILABILITY OF RELIABLE, GENDER-SENSITIVE DATA ON GENDER-BASED INTIMATE PARTNER HOMICIDE/FEMICIDE AT NATIONAL AND EUROPEAN LEVEL**

Although there are several attempts at EU level to implement a systematic collection of reliable data from the police and justice systems as well as from the health-care system, data on gender-based intimate partner homicide/femicide are neither available in most EU member states, EU candidate, applicant and potential applicant countries, nor at European level.

A few effective actions can considerably improve the generation of reliable data on femicide at national and at European level: Taking VAW and femicide into account in all initiatives which intend to improve national and European statistics, such as: European Sourcebook of Crime and Criminal Justice Statistics, EU Action Plan for the Development of a Comprehensive and Coherent EU Strategy to Measure Crime and Criminal Justice (2006-2010) by:

- considering and implementing the European recommendations on the generation of data on VAW and femicide – e.g. Council of Europe Recommendation Rec (2002)5 on the protection of women against violence and Council of Europe Campaign to Combat Violence against Women (2006 - 2008);
- including the rich interdisciplinary expertise of researchers and practitioners working in the field of VAW;
- including gender-based intimate partner homicide/femicide as an autonomous category in the Eurostat statistics of crime and criminal justice as well as in crime statistics of all European countries;

- development and implementation of unified definitions and indicators to measure femicide which are comparable over time and between countries and which are applied in all European countries as well as at the European level;
- statistics of crime and criminal justice can be improved considerably by making a few changes: classifying all violent crimes according to gender of victim, gender of perpetrator, age of victim, age of perpetrator, type of relationship between victim and perpetrator, and providing for correlation of these categories;
- due to different definitions of type of relationship between victim and perpetrator in legislation of EU member states, candidate states and applicant states, the development of clear and unequivocal categories presents a specific challenge. It is important to continue scientific discussion regarding this issue, and at the same time, to find pragmatic solutions for core data collection criteria;
- increase efforts to promote the use of a consistent set of indicators at national level by raising awareness on VAW and on femicide among policy makers and to encourage them to support the generation of reliable and comparable data on femicide in their countries.
- Development and implementation of a systematic method in collecting, analysing and reporting data on gender-based intimate partner homicide/femicide, which considers both: the generation of comparable data at the national and the European level.
- At national level the data collection of the police should be improved because: (a) the criminal justice sector is hierarchically structured, which simplifies the implementation of a systematised methodology of data collection; (b) police is already the primary source of information on gender-based intimate partner homicides and other types of femicide. The collection and analysis of homicide data is already a financed and routine part of this public service; (c) the criminal justice sector has the potential to collect information on both victims and perpetrators. Police has the potential to track repeat victimisation and repeat offending. By collecting this information high risk victims of violence can be identified and protection measures can be applied; (d) the data can be easily analysed and published in the annual national crime statistics.
- Training on VAW should be provided to police (but also to other professionals in the social sector, such as health-care professionals, lawyers, judges, social workers, etc.) by experts working in the field of VAW so that police officers can identify VAW and femicide cases and improve data collection and methods of measuring both.
- Establishing critical observatories (e.g. autonomous feminist women's NGOs) in all EU member states, EU candidate, applicant and potential applicant countries to analyse the data collected by the police and other public services on the magnitude and nature of VAW, thereby especially focusing on the number of women who were killed by their intimate partners and relatives. The results should be summarised in a report and published annually.
- At the EU level the collection and analysis of gender-based data on intimate partner homicide/femicide should be conducted by Eurostat.

In order to seriously work towards ending the killing of women by males because they are female we need global data on femicide. For this reason it is important to consider UN recommendations and definitions in collecting, analysing and reporting femicide data both at the national and at the European level.

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## III. CONCLUSIONS

Given the limited time of just twelve months to complete this project, we have focused on some preliminary conclusions which we hope to explore further in PROTECT II.

### PRINCIPLES

The following major principles are based on the representations and discussions during the Partner and Expert Group Meetings as well as on the findings in the research parts of the projects:

- The NGOs providing women support services need to be developed, strengthened and financially secured without jeopardising their autonomy. States need to recognise the value of the work of women support services such as women's shelters, help lines, advisory centres, women's centres and similar organisations. These services need to be financially secured (receive long-term state funding) to be able to provide quality service to victims of violence.
- The identification of high risk victims must not lead to less support for victims who are not identified as high risk, especially in times of financial crisis, and especially since risk levels are always relative and may change over time.
- Children living with intimate partner violence must be acknowledged as victims of these crimes, too. Exposure to gender-based partner violence seriously endangers the well-being of children; this must be acknowledged by courts as well as by welfare agencies. In particular, any decisions on contact with the father or child custody should take into consideration the safety of the mother and possible harm to the child. Children should never be coerced by court rulings to see a father who has abused the mother severely. The father's right to see the child must not weigh more than the child's right to protection. Joint custody may be inappropriate when there has been violence against the mother, and must in any case be monitored for the potential risk of renewed violence.
- Immigrant women are often at high risk, especially when their status is undocumented. Therefore specialised support services are needed. Immigrant women must have the right to have access to all protective services and safety measures. Immigration law should offer women who escape from violence by a partner the right to an independent legal status.
- The so-called honour related crimes should not lead to further discrimination. Rather than singling out certain forms of violence they should be (re)located in the frame of violence against women and girls and addressed as such.
- Clear policies and guidelines about how to identify and protect high risk victims and how to deal with high risk perpetrators are required (e.g., chain of intervention, care pathway). It is important to apply risk management (including risk assessment and safety planning) systematically. It is vital to address the immediate safety of the victim(s) and stop the violence exerted by the perpetrator.

## RESULTS

The following major results sum up the findings and take into consideration the differences between the countries:

- Refuges and shelters for women are vital to their and their children's safety. The number of places available varies greatly from country to country. This inconsistency needs to be addressed.
- Many countries have developed multi-agency work in combating violence against women. But only few focus on high risk victims. The use of the multi-agency approach needs to be encouraged when high risk victims are concerned.
- Practitioners who encounter women victims of violence in their work need regular specialised, gender-sensitive training on violence against women and especially in working with high risk victims of gender-based violence.
- Data on violence against women are inadequate or missing entirely. Not even femicide, the most extreme outcome of this crime, is statistically acknowledged, and data are non-existent.

## GOOD PRACTICE MODELS

Some good practice models were identified which can be used by others according to the specifics of the respective countries. The good practice models are open for further discussions, because the number is not limited and they also may entail disadvantages:

- Specialised units/specialised staff are considered a good practice in many agencies/organisations. One of the goals is to have these specialists on violence against women in every large organisation. A disadvantage may be that whenever a 'non-specialist' encounters a case s/he does not feel responsible and just hands the case over to the specialist.
- It is considered to be a good practice to involve the woman (victim) in the risk assessment process. The literature review quotes several studies which show that women's perceptions of threat of re-assault are quite accurate, with the exception of femicide.
- The MARACs are a good practice model as a basic measure to identify and protect high risk victims. Developing and improving the coordination of services and information-sharing through protocols, interdisciplinary training of practitioners and coordinating risk assessments, practices and operations among all criminal justice personnel and victim services are some core goals of the multi-agency work. The legal frame-works for sharing information are very different from country to country and the model needs to be adapted accordingly.
- The Spanish observatory can serve as a good model of monitoring and evaluation measures to launch preventive strategies in regard to gender-based violence and to generate and publish data.

This project has shown that the topic of high risk in gender-based intimate partner violence has many different facets which need to be further explored in order to provide better protection and support for high risk victims all over Europe.

# ANNEX

## IV.

### ANNEX 1: QUESTIONNAIRE USED WITHIN PROJECT PROTECT

- 1.) In your country is intimate partner violence a specific offence?
- 2.) Is intimate partner homicide a specific, ordinary or aggravated offence?
- 3.) Is it currently known in your country the mortality numbers related to intimate partner violence?
- 4.) Who publishes this information? Police services, health services, law services?
- 5.) Is there a specific institution in charge of these statistics? A public observatory or associated one, a specialised service, specialised university centres?
- 6.) Which definition exists for homicides? Can you provide it? (femicides related to intimate partner violence, homicides, violence leading to death, collateral homicides, suicides by perpetrators, or of the victims, homicides and attempted homicides mixed)
- 7.) Do the numbers available identify the sex of the perpetrators and victims, age class of the perpetrators and victims, relation between perpetrator and victim (e.g. wife / husband, ex-husband / ex-wife, girlfriend / boyfriend, ex-boyfriend / ex-girlfriend) as well as type of violence?
- 8.) Do you have information on estimation methods or how the numbers are generated?
- 9.) Do the health services publish deaths by homicides and suicides (death certificate results distinguishing if possible the type and the age?)
- 10.) Do you know of any studies in your country which show the link between suicide and intimate partner violence?
- 11.) In your country are so-called crimes in the name of honor a specific offense? Do you have statistics on so-called crimes in the name of honor in your countries? If yes, can you please send us the latest numbers?
- 12.) Would you be available for collaborating on our project to be able to respond to questions for which you do not have the answers and thus improve the data collection of intimate partner mortality in your country? (Please send us contact details - mail, telephone number - for the concerned ministries and the associations tackling intimate partner violence, expert interviews in the field).
- 13.) To improve the definition of intimate partner violence do you think other categories should be included?  
If yes, which ones?

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## V. LITERATURE

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