Northern Territory

DOMESTIC AND FAMILY VIOLENCE RISK ASSESSMENT AND MANAGEMENT FRAMEWORK

NORTHERN TERRITORY GOVERNMENT

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Emergency contacts

Get help for domestic, family and sexual violence in the Northern Territory by following this link to the available services.

https://nt.gov.au/law/crime/domestic-family-and-sexual-violence/get-help-for-domestic-family-and-sexual-violence

If you, or someone you know, is in immediate danger call the Police on 000 for emergency assistance. If you have experienced domestic, family or sexual violence and require assistance, call 1800 RESPECT (1800 737 732) to talk to a counsellor from the National Sexual Assault and Domestic and Family Violence hotline.

ACKNOWLEDGMENTS

Aboriginal acknowledgment

The Northern Territory Government respectfully acknowledges the First Nations people of this country and recognises their continuing connection to their lands, waters and communities. We pay our respects to Aboriginal and Torres Strait Islander cultures, and to their leaders past, present and emerging.

While this Framework uses the term 'Aboriginal', we respectfully acknowledge that Torres Strait Islander peoples are First Nations people living in the Territory. Therefore, strategies, services and outcomes relating to 'Aboriginal' Territorians should be read to include both Aboriginal and Torres Strait Islander Territorians.

Survivor acknowledgement

We acknowledge the courage and dignity of all those who stand up and say no to domestic and family violence, who take action to challenge the violence and who hold people who commit domestic and family violence accountable.

We acknowledge the women and children who have died from domestic and family violence (DFV) in the Northern Territory. This document has been informed by the experiences of women who have died as a result of DFV. We are committed to honouring the lives of those killed, learning from these tragedies and translating those learnings into action so as to prevent future harm.

Acknowledgement of contributors and sources

The RAMF has been developed in partnership with government and non-government agencies, and in consultation with the Northern Territory domestic, family and sexual violence specialist and legal sectors, and other agencies.

Northern Territory Government acknowledges the RAMF has been informed by work on domestic and family violence screening, needs and risk assessment and management in other jurisdictions including:

- Western Australian Family and Domestic Violence Common Risk Assessment And Risk Management Framework (Second edition);
- Victorian Government's Family Violence Multi-Agency Risk Assessment and Management Framework;
- South Australian Government's Family Safety Framework; and
- New Zealand Family Violence Risk Assessment and Management Framework: A Common Approach to Screening, Assessing and Managing Risk.

Northern Territory Government acknowledges Australia's National Research Organisation for Women's Safety Limited (ANROWS) and Jackie Burke Psychology and Consulting in the development of this RAMF.

Northern Territory Government drew on the Northern Territory Department of Health Clinical Guidelines for Identifying and Responding to DFV, and principles and practice approaches from the Signs of Safety and the Safe and Together© models in the development of the RAMF.

The quotes in the RAMF come from

- Exploring the voices and experiences of victim/survivors of Domestic and Family Violence in the NT Justice System, Journey Mapping Workshop Report, February 2019, Alex Richmond for the Domestic Violence Justice Reform Network
- Putt J., Holder R., & O'Leary C. (2017). Women's specialist domestic and family violence services: Their responses and practices with and for Aboriginal women: Final report (ANROWS Horizons 01/2017). Sydney: ANROWS.
- Bevis M., Atkinson J., McCarthy L., & Sweet M. (2020). Kungas' trauma experiences and effects on behaviour in Central Australia (Research report, 03/2020). Sydney, NSW: ANROWS
- Walden I & McFerran L. 2013 Report on a scoping study into the effects of sexual violence on employees and the workplace, Safe at Home, Safe at Work project, Gendered Violence Research Network, UNSW Australia.

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2019 SHARING AND STRENGTHENING OUR PRACTICE CONFERENCE STATEMENT

Sharing and strengthening with us, for us

We, the Aboriginal and Torres Strait Islander participants of the first 'Sharing and Strengthening our Practice Conference' would like to make a statement. This statement is on behalf of all the participants as leaders, experts, workers, community members, mothers, fathers, sisters and brothers.

We have come from across the Northern Territory and Australia. We come from different countries, different mob, different cultures but with a same focus. A focus on making our families, our communities safer for our women and children and strengthening our family structures.

We want everyone to stop. Listen. Trust. Act.

Stop doing for us without us.

Listen to us. Practice deep listening. Listen with your heart.

We are the experts. We have the knowledge and lived experiences. Trust us to try new ways of doing things, our way. We will all learn together. Act with us not for us.

Understand healing and work with us to provide the space for it to happen. We can and will develop a practice to heal intergenerational trauma.

We have our own cultural family structures built on thousands of years of equality, respect and love. Learn from this and work with us to build programs and services to support it. We want our women and men to work together. This is how our families and communities operate.

Don't guide us. We will guide you. If we are not at the table with you, stop. Provide us with a genuine safe place to be involved, then we can move forward.

Incorporate and practice cultural safety in our workplaces and communities.

Remember we are more than statistics. We are people. People that have heartache for our families and communities each time we hear these statistics.

This is our statement as participants of this conference. As leaders, experts, workers, community members, mothers, fathers, sisters and brothers. We've shared this with you. Now strengthen your practices with this knowledge.

(Statement presented by Aboriginal and Torres Strait Islander participants at the Sharing and Strengthening our Practice conference, Darwin, May 2019)

STRUCTURE OF THE RISK ASSESSMENT AND MANAGEMENT FRAMEWORK DOCUMENT

The Risk Assessment and Management Framework (RAMF) is colour coded to assist the reader to quickly access the information they need.

PART A – INTRODUCTION

The section is themed in light blue and provides information about:

- What the RAMF is and why it was developed
- Who the RAMF is for
- The evidence base for domestic and family violence (DFV) risk assessment and management
- How this document can work for you and your service.

PART B – A COMMON UNDERSTANDING OF DFV

The section is themed in dark blue and aims to build a shared understanding of DFV across the service system, including:

- What is DFV?
- Nature, prevalence and impacts of DFV
- High risk DFV factors.

PART C – PRACTICE GUIDES

The section is themed in green and provides seven practice guides to assist workers through the different stages of DFV screening, risk assessment and management, including:

- PRACTICE GUIDE 1: Screening for DFV
- PRACTICE GUIDE 2: Assessing the risk of DFV
- PRACTICE GUIDE 3: Managing DFV risk
- PRACTICE GUIDE 4: Shared legal responsibilities
- PRACTICE GUIDE 5: Referrals
- PRACTICE GUIDE 6: Record keeping
- PRACTICE GUIDE 7: Safe, supported and capable workforce.

PART A

INTRODUCTION

All forms of violence are unacceptable and inexcusable. The Northern Territory (NT) has the highest rates of domestic, family and sexual violence (DFSV) in Australia. Aboriginal women and children disproportionately experience this violence. Reducing domestic and family violence (DFV) is a key commitment of the NT Government.

A coordinated and evidence based response to identifying and responding to DFV risk is critical to reducing the impacts of DFV. This is why the RAMF has been developed for use across the NT to facilitate this coordination and evidence-based assessment and intervention.

The RAMF and practice guides are based on current evidence and best practice in DFV risk assessment and management.

Alignment with the RAMF is mandatory for Information Sharing Entities (ISEs) under the NT's DFV Information Sharing Scheme. However, the RAMF and Common Risk Assessment Tool (CRAT) are intended to guide and support all DFV and related organisations and services, whether or not they are ISEs, to better assess, respond to and manage DFV risk.

If we speak the same language, use the same tools, have the same understanding, and work together in a way that is informed by the latest evidence, we will provide more effective support for victim survivors.

1. WHAT IS THE RISK ASSESSMENT MANAGEMENT FRAMEWORK AND WHY DO WE NEED IT?

In October 2018, the NT Government amended the Domestic and Family Violence Act to provide for a new DFV Information Sharing Scheme. The amendments allow for information about people experiencing or committing DFV to be shared without consent in certain circumstances.

The amendments included a requirement for NT Government to develop a framework for DFV risk assessment and risk management. In addition, a key action under the NT's Domestic, Family and Sexual Violence Reduction Framework 2018-2028 Safe, Respected and Free from Violence (the DFSV Framework), is the development and implementation of a CRAT.

The fundamental purpose of the RAMF is to increase the safety and wellbeing of children, young people and adults who are victim survivors of DFV, and to increase the accountability of people who commit DFV, by providing a consistent and evidence-based way to identify, assess, respond to and manage DFV risk.

When assessing and managing the risk of DFV, a consistent and evidence-based understanding, language and approach is important. This will enable services to work together more effectively so people get the help they need.

The RAMF includes foundational information about DFV to enhance a common understanding across the service system. It also provides practice guides and tools to guide workers to identify, assess and manage DFV risk, in order to support victim survivors' safety and accountability of people who commit DFV. The core elements of the RAMF are:

Screening for DFV: a process of consistent and routine enquiry using a common set of questions or prompts to find out if someone is experiencing DFV, before serious physical or psychological harm has occurred. Practice Guide 1 provides information, tools and practice tips for workers on DFV screening.

DFV risk assessment: the process of identifying the presence of risk factors that affect the likelihood and severity of future violence. Practice Guide 2 provides information, tools such as the CRAT, and practice tips for workers on DFV risk assessment.

DFV risk management: a range of actions and plans that aim to improve the safety of victim survivors, and reduce or remove the likelihood the person committing DFV may commit further violence. Practice Guide 3 provides information, tools and practice tips for workers on DFV risk management.

The RAMF sets out all the elements of an integrated system that work together to improve DFV risk assessment and management approaches in the NT. These elements include legal, policy and practice approaches and are described in Section 8.

The RAMF outlines common expectations in assessing, responding to and managing risk, so that they are recognised as shared responsibilities across the service system. This shared approach promotes collaboration across agencies responding to DFV and enables an integrated service response.

2. WHO IS THE RISK ASSESSMENT AND MANAGEMENT FRAMEWORK FOR?

The RAMF applies to the entire service system, as all workers have responsibilities in relation to DFV risk assessment and management. Victim survivors of DFV may enter the service system at a number of different points. It is important that they receive a consistent message and service from the different places they approach for help. This consistency will help identify, assess and manage DFV risk as early as possible. Every worker across the service system has a shared responsibility for identifying and responding to, DFV risk, even if DFV is not the worker's core business.

Services will have different roles and levels of responsibility in implementing DFV risk assessment and management, depending on the function of the service and the skill and experience of the worker. Non-specialists may not have the training or expertise to respond to high-risk or complex situations in the same way as specialists may respond.

The service system is broadly grouped into three categories:

- Universal services (also called generalist services): services who may encounter victim survivors or people who commit DFV as part of their work providing health, education, or social services, but for whom DFV is not their core business. This includes services working in the areas of health, education, alcohol and other drugs, mental health, family support, housing and homelessness, financial support, disability, general practice, generalist legal support and youth support.
- Services with statutory responsibilities: government agencies, services and individuals whose responsibilities include providing statutory or legal responses to victim survivors and/or people who commit DFV as part of their work, such as police, Sexual Assault Referral Centres, child protection, youth justice, judiciary and courts, corrections and mental health.
- DFV specialist services: services for whom the prevention of and response to DFV is their core business, such as women's safe houses, DFV refuges, DFV counselling services, DFV outreach and advocacy services, men's behaviour change services, and specialist legal services. Workers in these services usually have specialist skills in DFV.

DFV Service System

Victim survivors of DFV may enter the service system at a number of different points, and should receive a consistent response. Every worker across the service system has a shared responsibility for identifying and responding to DFV risk, even if DFV is not the worker's core business. Services will have different roles and levels of responsibility in implementing DFV risk assessment and management, depending on the function of the service and the skill and experience of the worker.

Integrated service delivery

An integrated service system is one where services have their own clear roles and responsibilities, and work together in a coordinated and collaborative manner, using consistent risk assessment and management processes and language. This leads to:

- an increased focus on safety;
- reduction in secondary (systems-created) trauma, through limiting the need for victim survivors to repeatedly recount their story;
- increased accountability of people who commit DFV;
- more cohesive, consensus-based responses to risk;
- increased cost-effectiveness through minimising duplication of services.

Effective leadership, governance and policy arrangements which support integration are essential.

In the NT this includes:

- governance arrangements such as the Domestic, Family and Sexual Violence Cross Agency Working Group;
- shared strategic policies– such as the DFSV Framework, the Sexual Violence Prevention and Response Framework, the DFV Information Sharing Scheme, the RAMF, and the Workforce and Sector Development Plan;
- legislation that provides the authorising environment for DFV system reform;
- formal interagency risk assessment and management – such as the Family Safety Framework (FSF) which provides an action-based integrated service response from multiple agencies for those experiencing DFV who are at high risk of serious injury or death; and,
- formal interagency information sharing and service delivery meetings such as the Multi Agency Community and Child Safety Teams (MACCST).

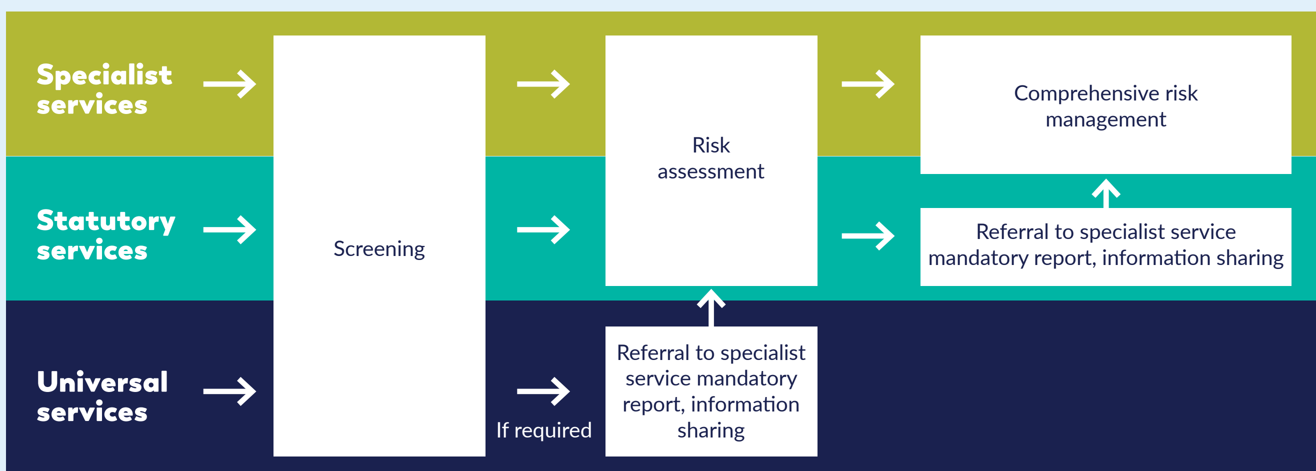
Roles and responsibilities of the DFV service system in risk assessment and management

The RAMF proposes a staged screening and assessment process, appropriate to the roles and responsibilities of the different service types that make up the service system.

Workers in universal, specialist and statutory services have a duty to undertake screening for DFV. Workers in universal and statutory services should be able to provide an initial response, including linking those impacted with specialist services for a risk assessment and comprehensive risk management response, making a mandatory report and sharing information if required.

Specialist workers and services, and statutory workers with the skills and training, should be able to undertake risk assessment and comprehensive risk management responses, with specialist services leading ongoing risk and case management.

This process is important so that victim survivors are responded to at each stage by the workers who are most qualified and able to help them.



3. HOW WAS THE RAMF DEVELOPED?

The RAMF was developed following a broad and structured consultation process in 2019 conducted by the Australian National Research Organisation for Women's Safety (ANROWS) and Jackie Burke Psychology and Consulting. Consultations were held with a range of stakeholders including Aboriginal Community Controlled Organisations, non-government organisations, peak bodies, legal services, government agencies, and workers in DFV specialist services, including those working in remote Aboriginal communities.

This document has been produced and developed from the outcomes of the consultation process, the evidence base on DFV risk assessment and management, including other established models. The evidence base drawn on includes:

- 2016-2017 Territory Families Family Safety Framework Review;
- NT Coronial Inquests into DFV related deaths (1981–2019) of Anne Chantell Millar, Jodie Palipuaminni, Wendy Murphy (also referred to as Kwementyaye Murphy), Natalie McCormack (also referred to as Kwementyaye McCormack), Kwementyaye Nelson, Kwementyaye Coulthard, Kwementyaye Driver and Kwementyaye Bigfoot;
- 2017 NT Department of Health clinical guidelines for identifying and responding to domestic and family violence;
- ANROWS' National Risk Assessment Principles for Domestic and Family Violence (NRAP), 2018;
- Australian Domestic and Family Violence Death Review Network 2018 data report;
- Data from the Australian Bureau of Statistics (ABS), Australian Institute of Criminology (AIC), and the Australian Institute for Health and Welfare (AIHW);
- Western Australian Government's Family and Domestic Violence Common Risk Assessment And Risk Management Framework (Second edition);
- Victorian Government's Family Violence Multi-Agency Risk Assessment and Management Framework;
- South Australian Government's Family Safety Framework; and
- New Zealand Family Violence Risk Assessment and Management Framework: A Common Approach to Screening, Assessing and Managing Risk.

4. ORGANISATIONAL IMPLEMENTATION

Under the Domestic and Family Violence Act, organisations can be prescribed as Information Sharing Entities (ISEs) in order to participate in the DFV Information Sharing Scheme. ISEs are required to align their policies, procedures, practice guidance and tools with the RAMF.

Although some organisations and services working in DFV in the NT have their own risk assessment and management methods, there is not a common approach to risk assessment across the NT. The purpose of the RAMF is not to override existing good practice, but to outline minimum and common expectations for all services. For organisations and services who already have their own tools, policies and practice guides to respond to and manage the needs and risks experienced by DFV victim survivors, the RAMF is designed to support the work already done and to provide additional resources.

Implementing the RAMF requires significant system reform and culture change which will occur over a number of years and will require effort at all levels of the service system. The process of aligning to the RAMF will be different for each service, recognising the complexity of the service system and the variable starting points and stages of DFV practice development across services. Flexibility and an awareness of the time needed for culture change and system reform is required, so that services can begin the alignment process in the manner they deem to be most appropriate.

The RAMF and CRAT are intended to guide and support all DFV and related organisations and services, whether or not they are ISEs, to better assess, respond to and manage DFV risk.

It is important to note that the ongoing development of the evidence base and the understanding of what constitutes good practice means that alignment with the RAMF should be seen as an ongoing process for all organisations.

Resources and training will be available to support workers and services in aligning with the RAMF.

Alignment with the RAMF may include:

- identifying relevant governance structures to support implementation, embedding and oversight of the RAMF;
- ensuring governance bodies, management and staff are aware of the RAMF and CRAT and how it applies in their organisations;
- aligning organisational policies, guidelines, tools and procedures with the RAMF and CRAT;
- providing regular and ongoing professional development opportunities in relation to DFV screening, risk assessment and management;
- monitoring compliance with policy, guidelines and procedures including developing review mechanisms;
- providing adequate support to staff who are working with clients experiencing DFV; and
- providing adequate support to staff who are or have experienced DFV.

5. REVIEWING AND GROWING THE RAMF

New evidence on risk factors and best practice in service responses is continually emerging, particularly following coronial and other inquiries into deaths due to DFV.

As a living document the RAMF will be developed in phases and reviewed and adjusted in line with the emerging evidence and practice, including testing in the field.

Phase 1 of the RAMF is the production of this document, including the CRAT, practice tools and guides.

Phase 2 will focus on developing additional guidance and tools for priority groups:

1. Children and young people: screening for, assessing and managing risk for children and young people, understanding children and young people as victim survivors in their own right, and the impact of DFV on parenting;
2. Young people who use DFV: screening for, assessing and managing DFV risk, and accountability for young people who use DFV;
3. Adapting the CRAT for those working with victim survivors from Culturally and Linguistically Diverse Communities; Lesbian, Gay, Bisexual, Transgender, Queer and Intersex communities (LGBTQI); Seniors; and, people with disability;
4. People who commit DFV: understanding tactics used by people who commit DFV in the screening for, assessing and managing of DFV risk, and increasing service practice and skills in addressing accountability for people who commit DFV; and
5. Risk assessment and response to sexual violence outside of the DFV context.

The RAMF will be reviewed two years after introduction, and will include how the RAMF works with victim survivors and people who commit DFV in remote Aboriginal communities.

6. TERMINOLOGY

The language used in working with DFV victim survivors is important. Language is always evolving and varies between communities and services. It is good practice for workers to use language their clients are comfortable with.

Some of the common terms used in the RAMF are:

Terminology	Explanation
Aboriginal	The term Aboriginal is inclusive of Aboriginal and Torres Strait Islander peoples.
Aboriginal Cultural Security	Aboriginal Cultural Security means the provision of a safe environment where Aboriginal people are empowered to make decisions that affect their lives without fear of judgement or discrimination. It commits an organisation to design and deliver services that honour the legitimate cultural rights, values, and expectations of Aboriginal people.
Case management	Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the client's needs. It can involve intake, needs assessment, service coordination, evaluation and advocacy. Case management involves building a positive relationship with the client in order to collaboratively develop client centred plans that address their needs, strengths, and goals.
Case coordination	Case coordination responses are where multiple agencies work together to share information, develop comprehensive risk assessments, and jointly construct and implement multi-agency safety plans to mitigate risks and work towards child and adult victim safety and perpetrator accountability. There is usually a case coordinator who manages the process.
Children	Includes infants, children and young people under the age of 18.
Client	Term used in the practice guides to indicate the professional relationship between the worker and the person they are helping and working with in order to prevent or respond to DFV – regardless of the service type.
Cultural safety	Cultural safety is "an environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning, living and working together with dignity and truly listening." (Williams, 1999)
DFSV	DFSV is used to describe both the diverse forms of domestic and family violence, as well as the co-occurrence of sexual violence and sexual assault that occurs both inside and outside the domestic or family context.
DFV specialist service	A service for whom the prevention of and response to DFV is the core business, such as women's safe houses, DFV refuges, DFV counselling services, men's behaviour change programs, and specialist women's DFV legal services. Workers in these services usually have specialist skills in DFV.

Terminology	Explanation
Domestic Violence, Family Violence, Domestic and Family Violence (DFV)	The terms domestic violence, family violence, and domestic and family violence can be used interchangeably by services and people. While domestic violence is typically used to refer to acts of violence that occur between people who have or once had an intimate relationship, the term family violence describes violence targeted at spouses and partners as well as people in broader family relationships, including relatives according to Aboriginal family structures. Consistent with the Domestic and Family Violence Act, the RAMF uses the term domestic and family violence (DFV). Domestic and family violence is defined in DFSV Framework as: *the combination of tactics and forms of violence which are often used to exercise control over women, children, and other family members. The violence can take the form of physical, sexual, stalking, emotional, psychological, technology-facilitated and financial abuse and it can include criminal and non-criminal behaviour* and as *a pattern of behaviour aimed at controlling a partner, ex-partner or family member through fear, for example by using behaviour which is violent and threatening, and to place at risk their immediate and longer-term safety and wellbeing.*
DVO	A domestic violence order (DVO) is a protection order made by the police or the court to protect a victim survivor against DFV or threats of DFV. It can stop someone from contacting, harming, threatening or stalking the victim survivor. There are different types of DVO with different rules, including full non-contact orders, non violence orders or full non-contact while intoxicated orders.
Evidence-based practice	Evidence-based practice is practice that is guided by the best available current research. In DFV risk assessment and management, the evidence-base comprises known risk factors (sourced from criminal justice and health records, and coronial findings), statistical data, qualitative experiences of victim survivors, reported and unreported data, and research.
Generalist or universal services	Services who may encounter victim survivors and/or people who commit DFV as part of their work providing health, education, or social services, but for whom DFV is not their core business. Includes health, education, alcohol and other drug services, mental health services, family support services, financial support/counselling, disability services, general practitioners, generalist legal services, youth services and housing and homelessness services.
Integrated case management or case coordination responses	Integrated case management or case coordination responses are where multiple agencies work together to share information, develop comprehensive risk assessments, and jointly construct and implement a multi-agency safety plan to mitigate risks and work towards child and adult victim safety and perpetrator accountability. It creates transparency and accountability between agencies about their roles and responsibilities in responding to DFV.
Intimate Partner Sexual Violence (IPSV)	IPSV refers to any unwanted sexual contact or activity by a current or former intimate partner (spouse, de facto, partner, boyfriend or girlfriend) forced on the other partner through fear, violence or coercive control.

Terminology	Explanation
Non-offending parent	A non-offending parent is a term commonly used by child protection practitioners to refer to the parent or caregiver who is not perpetrating the DFV against the child(ren).
Perpetrator	For brevity, the CRAT uses the term perpetrator to refer to the person who uses violence, abuse or coercive control against a current or former intimate partner, or a member of their family or household, regardless of whether they have been convicted of a crime.
Person who commits DFV	A person who commits DFV refers to the person who uses violence, abuse or coercive control against a current or former intimate partner, or a member of their family or household, regardless of whether they have been convicted of a crime. To reflect feedback, we primarily use this term rather than terms such as perpetrators or offenders. The language in this framework will not apply to everyone and some people or professionals may identify with or use different terms.
Service	Refers to all government agencies and non-government organisations that provide, or may provide, a service to DFV victim survivors and/or people who commit DFV, whether it is their core business or not.
Statutory service	Agencies, services and individuals whose responsibilities include providing statutory or legal responses to victim survivors and/or people who commit DFV as part of their work, such as police, judiciary and courts, corrections, mental health, youth justice and child protection.
Unconscious biases	Unconscious biases are stereotypes about groups of people that individuals form outside their own conscious awareness. Characteristics like gender, ethnicity, disability, sexuality, age, all influence the assessments that we make of people and the world in general. Bias can also influence the way we do things, including how we deliver services to people and what happens in the workplace.
Victim survivor	A victim survivor is a person against whom DFV has been perpetrated including a child or young person. The term is often used to recognise a victim survivor's agency and individual capacity.
Worker	Anyone working on the prevention of and/or response to DFV, whether they work for a specialist, statutory or universal service. A worker may be working on the prevention of and/or response to DFV as their primary role or as their secondary role, such as a nurse or community development worker.

7. ABORIGINAL ENGLISH TERMS USED IN THE NORTHERN TERRITORY THAT CAN REFER TO DFV

Some of the different terms used by Aboriginal people in the NT to describe or refer to types of DFV are listed below. If you are not familiar with local terms used, ask a colleague who has been working in the local area for a number of years. Sometimes words that sound harmless can signify serious DFV.

Phrase	Meanings
Talking rough to me	Threatening, disrespectful, abusing.
Cruel	Mean, nasty, aggressive, aggressively disrespectful or destructive.
Growling	Intimidation, aggression, put downs or insults, telling the other person off (criticise).
Bossing over me	Coercive control, controlling.
Being cheeky	Violent, dangerous, sexually aggressive. Also used by people who commit DFV to describe when victim survivors resist or stand up for themselves.
Bothering me	Sexual aggression/threatening, coercive control, being a nuisance.
Keeping me up all night	Sexually coercive controlling behaviour, arguing/fighting all night.
Jealousing	Can mean making someone else jealous, such as alleging infidelity/ cheating by the other partner. Jealousy is associated with anger and is a widespread cause of aggression especially when invoked to provoke anger and motivate aggression.
Humbugging me	Stalking, asking questions, wanting the victim survivor to do things they don't want to do, including repeatedly asking the victim survivor for sex. Demanding money from the victim survivor to buy alcohol and or drugs and looking to start an argument or fight.
Laying down together	Sleeping on the bed, sharing a bed, may or may not mean having actual sex.

KEY COMPONENTS OF THE RAMF

Component	A common understanding of DFV, including principles to guide risk assessment and response practice	A consistent and evidence based approach to risk assessment and management practice
Purpose	A common understanding contributes to the goal of consistency in risk assessment and management practice. If we speak the same language, use the same tools, have the same understanding, and work in a way that is informed by the latest evidence, we will provide more effective support for victim survivors.	If we work in a way that is informed by the evidence , we will provide more effective support for victim survivors
Further resources and info	The Northern Territory's Domestic, Family and Sexual Violence Reduction Framework 2018-2028 Shared principles for effective DFV risk assessment and management practice (Practice tool 1). A common understanding of DFV is provided in Part B of the RAMF.	The RAMF, the CRAT and all practice guides have been developed based on the current evidence in relation to DFV risk assessment and management. The key sources used are listed in Part A: How was the RAMF developed?.

When assessing and managing the risk of DFV, it is important that all services share a consistent and evidence-based understanding, language and approach. The RAMF describes all of the elements that work together to improve risk assessment and management approaches in the NT. When considered together, the following key components make up the DFV risk assessment and management framework or "structure":

A coordinated, collaborative and integrated service system, whereby all relevant agencies and services work together, including mechanisms such as the Family Safety Framework.

When all services work in a coordinated and collaborative manner, using consistent risk assessment and management processes and language, it leads to:

- an increased focus on safety;
- reduction in secondary (systems created) trauma, through limiting the need for victim survivors to repeatedly recount their story;
- increased accountability of people who commit DFV;
- more cohesive, consensus based responses to risk
- increased cost-effectiveness through minimising service duplication.

Practical information about collaborative practice and an integrated service system can be found in:

- Practice Guide 3: Managing DFV Risk
- Practice Guide 4: Shared Legal Responsibilities; and
- Practice Guide 5: Referrals.

Legislation that supports shared responsibility for risk identification, assessment and management, including information sharing and mandatory reporting

Sharing information and sharing the responsibility to report serious DFV harm or risk increases the safety of victim survivors and the accountability of people who commit DFV.

Mandatory reporting requirements reinforce the moral responsibility of all adult community members to report, and help to create a culture of shared responsibility.

For more information about mandatory reporting and information sharing in practice, see:

- Practice Guide 4: Shared Legal Responsibilities; and
- Practice Guide 5: Referrals

A supported, safe and capable workforce

An effective DFV response needs a workforce with the necessary knowledge, skills and support. The RAMF aligns with the DFSV Workforce and Sector Development Plan, providing a foundation and tools to guide effective practice by workers and services in the specific area of screening, assessing and managing DFV risk.

For more information about worker capability and safety, see Practice Guide 7.

The NT Government's DFSV Workforce and Sector Development Plan focusses on:

- Practice Guide 3: Managing DFV Risk;
- Practice Guide 4: Shared Legal Responsibilities; and
- Practice Guide 5: Referrals.

PRACTICE TOOL 1: PRINCIPLES FOR DFV RISK ASSESSMENT AND MANAGEMENT

DFSV FRAMEWORK VISION:

Territorians are safe, respected and free from violence wherever they choose to live, work, learn and play.

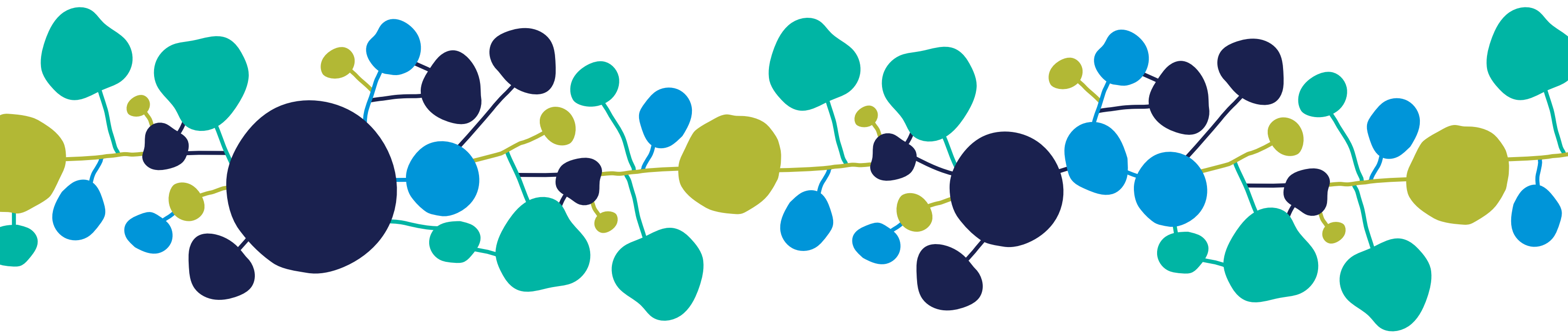
DFSV Framework principles	RAMF principles
Women and children's safety and wellbeing is at the centre	→ **PRINCIPLE 1:** Safety from DFV is the main priority in responding to DFV risk.
	→ **PRINCIPLE 2:** Risk assessment and management is part of a continuum of service delivery, ongoing responses are needed as risk and needs may change over time.
	→ **PRINCIPLE 3:** The agency and dignity of the person experiencing DFV should be respected by workers partnering with them as active decision-making participants in risk assessment and management, providing this does not compromise safety.
Shared responsibility, partnerships and local responses	→ **PRINCIPLE 4:** An integrated response (including systemic collaboration between people, communities and services) creates better DFV risk responses.
	→ **PRINCIPLE 5:** All DFV is a risk which requires a response.
	→ **PRINCIPLE 6:** Professional support and safety for workers is essential to effective DFV risk assessment and management.
Evidence and needs-based, and outcomes focussed	→ **PRINCIPLE 7:** All risk assessment tools and frameworks must be informed by the evidence.
	→ **PRINCIPLE 8:** Evidence based risk assessment takes into account the DFV victim survivor's assessment of their own safety.
	→ **PRINCIPLE 9**: Sexual violence within DFV must be specifically considered in risk assessment and management.

DFSV Framework principles	RAMF principles
Accessibility, equity and responsiveness	→ **PRINCIPLE 10:** DFV risk responses to priority populations must be culturally safe and free from discrimination based on race, age, gender, sexuality, religious beliefs, or incarcerated status, so that the heightened risk and diverse needs of particular groups are taken into account.
	→ **PRINCIPLE 11:** Risk responses should recognise children as victim survivors in their own right. DFV has serious impacts on the current and future safety and wellbeing of children who experience it (including witnessing DFV).
Challenging systemic racism and inequality	→ **PRINCIPLE 12:** Risk responses to Aboriginal people, migrant and multicultural community members affected by DFV must acknowledge the impacts of structural violence, racism and discrimination, colonial practices and intergenerational trauma.
Shared awareness and understanding of DFSV	→ **PRINCIPLE 13:** People who commit DFV are responsible for harming others and must be held accountable for their behaviour and supported to change. Their current and past behaviours and actions are relevant in assessing and management risk.

PART B

A COMMON UNDERSTANDING OF DFV

If we speak the same language, use the same tools, have the same understanding, and work in a way that is informed by the latest evidence, we will provide more effective responses to victim survivors and to those who commit violence.



1. WHY DO WE NEED A COMMON UNDERSTANDING?

Victim survivors of DFV may enter the service system at a number of different points, encountering workers with diverse understandings of DFV and service responses which are grounded in those diverse understandings.

Building a shared understanding of DFV that is based on the evidence is key to developing consistent, effective and safe responses. This helps the entire service system keep people who commit DFV in view and accountable, keep victim survivors safe, and work towards a joined-up system.

This section covers the following aspects of a common understanding of DFV, including:

- What constitutes DFV;
- DFV prevalence and impacts;
- Attitudes and facts about DFV;
- Impacts and drivers of DFV; and
- Resistance and identifying the person committing the DFV.

2. WHAT IS DOMESTIC AND FAMILY VIOLENCE?

The DFSV Framework describes DFV as:

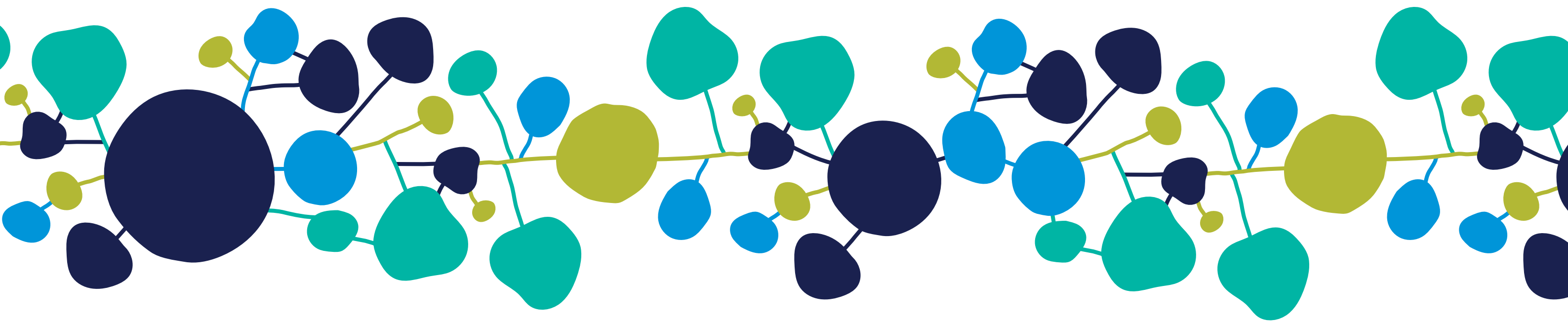
a combination of tactics and forms of violence which are often used to exercise control over women, children, and other family members. The violence can take the form of physical, sexual, stalking, emotional, psychological, technology-facilitated and financial abuse and it can include criminal and non-criminal behaviour

and

a pattern of behaviour aimed at controlling a partner, ex-partner or family member through fear, for example by using behaviour which is violent and threatening, and to place at risk their immediate and longer-term safety and wellbeing.

Under the *Domestic and Family Violence Act*, DFV includes violence between:

- people who are relatives according to Aboriginal tradition or contemporary social practice;
- people who are, or have been, fiancés, spouses, de factos or intimate partners (including same sex partners);
- a current or past carer and a person in their care (regardless of whether the care is paid or unpaid);
- people who currently or previously lived together;
- relationships where one person has or has had the custody or guardianship of another;
- people (including young people) who are dating regardless of whether they have had a sexual relationship, this includes same sex relationships; and
- family members, including a stepchild, parent, step-parent, grandparent, aunt or uncle, nephew or niece, cousin, half-sibling, and in-laws.



3. FORMS OF DFV

DFV can take a number of forms. Behaviours that may constitute DFV include physical violence, sexual violence, psychological and emotional violence, stalking and intimidation, violence against pets and property, economic abuse and coercive control. Behaviour may constitute DFV even if it does not constitute a criminal offence.

Coercive controlling violence within DFV

The RAMF and its tools (in particular the CRAT) emphasise the importance of understanding and recognising coercive control as an important aspect of DFV.

Coercive control can exist without physical or sexual violence being present, and physical or sexual violence can also exist as part of a pattern of coercive control. A situation in which there is no physical or sexual violence, but a high level and pattern of coercive control, may still have a high risk of lethality.

The predictive nature of coercive control is often overlooked by our laws, which focus on physical assaults on an incident-by-incident basis. Risk assessments have often focussed on the assumption that people who commit DFV who murder the victim survivor are physically violent before that. However, many DFV homicides are not preceded by any physical violence.

Coercive control has been recognised as a common element that runs through all DFV, and may in fact be the best predictor of the risk of homicide, better than assessing danger by physical assaults alone.

Sexual violence within DFV

Sexual violence is a tactic that is commonly used by people who commit DFV. It may be used alone or in combination with other forms of violence, or may be part of a pattern of coercive control.

Sexual violence within a DFV relationship is a significant indicator of escalating frequency and severity of DFV. Victim survivors who are sexually abused by their partners are at a much higher risk of being killed, particularly if they are also being physically assaulted.

More so than other forms of DFV, sexual violence within a DFV relationship is under-reported and often not disclosed. Commonly held assumptions that sexual violence within a DFV relationship is less serious than sexual violence perpetrated by a stranger, or that discussing sex and sexual assault is "taboo" and should remain private, contributes to the particularly acute shame that many victim survivors of DFV-related sexual assault experience.

Because sexual violence within a DFV relationship is a high risk factor for serious harm and lethality, sexual violence must be specifically considered in all risk assessment and management processes and practices.

PRACTICE TOOL 2: DIFFERENT FORMS OF DFV

Most DFV victim survivors will be subjected to a range of the following behaviours. These examples, which are not exhaustive, are drawn from the evidence of forms of DFV experienced by predominately adult women victim survivors of DFV from their adult male current or former partner.

Form of DFV	Tactics used by people who commit DFV
Psychological/ emotional violence (also called coercive control)	• deliberately undermining the victim survivor's confidence (for example, that leads them to believe they are 'stupid', a 'bad parent', 'useless'); • verbal putdowns or acts that humiliate or degrade; • threats to harm themselves, the victim survivor or another family member, or to take the children; • threats to report the victim survivor to authorities such as Centrelink, Immigration or Child Protection; • ridiculing and shaming the victim survivor's body, beliefs, skills, friends, occupation or cultural background; • using fear and intimidation to limit, control or interfere with social activities and relationships; • dictating what the victim survivor does, who they see and talk to, what they wear, or where they go; • preventing the victim survivor from going to work; • not allowing the victim survivor to express their own feelings or thoughts; • refusing to give the victim survivor any privacy; • forcing the victim survivor to go without food, water or sleep; • acts of jealousy and aggression towards men who are viewed as 'competition'; • isolating the victim survivor from social networks and support (by preventing them from having contact, continually putting friends and family down so the victim survivor is slowly disconnected, or by verbally or physically abusing the victim survivor in front of others); • spreading lies about the victim survivor through their support networks or at their place of work in order to discredit them; • making the victim survivor think that they are crazy ("gaslighting"); • denying or minimising the violence and victim survivor-blaming; • using children to relay messages; and • enforcing rigid and sexist gender roles, such as treating the victim survivor like a servant, making all the big decisions, acting like the big boss.
Physical violence **Acts can be physically abusive even if they do not result in physical injury.**	• smashing property, destroying possessions and throwing things; • using intimidating body language such as angry looks, threatening gestures and raised voice; • recklessly driving a vehicle with a victim survivor (including children) in the car; • pushing, shoving, hitting, slapping, hair-pulling, punching and biting; • choking, strangling and suffocating; • using a weapon(s) or object(s) to inflict violence; • threatening physical harm to the victim survivor, children, pets or other family members; and • murder.

Form of DFV	Tactics used by people who commit DFV
Sexual violence	• any sexual act without consent such as unwanted touching, rape (sexual intercourse without consent), exposure of genitals, making someone view pornography against their will, making someone perform unwanted sexual acts; • causing injury to the victim survivor's sexual organs; and • disclosing or threatening to disclose intimate knowledge, including sharing private photographs or information about sexual orientation, to generate fear.
Harassment, stalking, intimidation	• excessive questioning; • monitoring the victim survivor's activities, movements, internet use and social communications; • persistent telephone calls, emails, mail, text messages, social media messages; • giving or sending offensive materials; • following the victim survivor or loitering around places the victim survivor is known to frequent, such as their workplace; • handling guns or other weapons in the presence of the person; and • using aggressive body language, such as angry looks, gestures, or raised voice.
Economic abuse	• denying the victim survivor access to money, including their own; • unreasonably disposing of property without consent; • unreasonably preventing the victim survivor from taking part in decisions over household expenditure or property; • withholding money needed for the victim survivor or children; • monitoring the victim survivor's spending; • demanding that the family live on inadequate resources; • incurring debts in the victim survivor's name; • making significant financial decisions without consulting the victim survivor; • stealing money; • preventing the victim survivor from getting or keeping a job; and • making the victim survivor ask for money.
Cultural/Spiritual violence	• ridiculing the victim survivor's beliefs and culture; • preventing the victim survivor from practicing their faith or participating in their cultural group, practises or ceremonies; • preventing the victim survivor from having contact with people who speak their language or share their culture; • manipulating religious teachings or cultural traditions to excuse the violence; • harming or threatening to harm women or children in religious or occult rituals; and • forcing the victim survivor to participate in religious activities against their will.

NATURE AND PREVALENCE OF DFV IN THE NT

A SNAPSHOT - (all data is from ABS 2018 statistics for the NT unless otherwise referenced)

The rate of DFV related assaults was **3X** higher than any other Australian jurisdiction

The rate of sexual assaults was **50%** higher than the national rate

In 2017 - 18 the NT had the highest DFV homicide rate in Australia, with 2.04 homicides per 100,000, over 6 times the national rate.*

The NT has the highest rates of DFV in Australia.

*Australian Institute of Criminology Homicide in Australia 2017-18.

81% of all victim survivors of DFV related assault were women and girls

93% of all victim survivors of DFV related sexual assault were women and girls

Women and girls make up the majority of all victim survivors of DFV related assault and DFV-related sexual assault in the NT.

74% of DFV assault survivors were Aboriginal women and girls

62% of DFV related sexual assault survivors were Aboriginal women and girls

Aboriginal women and girls in the NT disproportionately experience DFV.

71% of DFV assaults were by a current or former intimate partner

25% of DFV assaults were by a family member

In most cases, people who commit DFV related assaults are the victim survivor's current or former intimate partner.

15% of DFV assault victims in the NT were Aboriginal men and boys, compared to 1.5-4% in other jurisdictions

The NT has the highest proportion in Australia of Aboriginal males (men and boys) who are victim survivors of DFV related assaults.

4. NATURE AND PREVALENCE OF DFV IN THE NT

DFV is serious and widely prevalent in the NT with the ABS reporting that the NT has the highest rates of DFV and sexual assault in Australia.

In 2018, the rate of DFV related assaults was approximately three times the rate of any other jurisdiction while the rate of sexual assaults was almost 50% higher than the national rate. The NT also has the highest rates of DFV related homicide in Australia.

Reported DFV in the NT is predominantly characterised by male-on-female violence, a level of serious physical harm and the use of weapons.

DFV can begin both early in relationships and when people who commit and experience DFV are at a young age.

Women and girls make up the majority of victim survivors of all DFV related assaults and DFV related sexual assaults in the NT. The vast majority of violent offenders are male. Aboriginal women and children in the NT disproportionately experience DFV.

Women are also recorded as committing violent offences ranging from minor to serious harm and homicide. However, the significant majority of male victim survivors experience DFV committed by other male family members.

The key difference between men and women's use of DFV is that men's perpetration of violence forms part of a repeated pattern of violent behaviour involving a range of tactics which puts their victim survivors at a higher risk of serious harm and or death.

Male-on-female homicides are characterised by multiple and blunt-forced injuries from a prolonged assault using a weapon or number of weapons whereas female homicides are characterised by a minimal number of wounds inflicted from a short assault.

Alcohol can be a key contributing factor to the severity of physical harm in DFV. Research indicates the harm is higher when both offenders and victim survivors have been using alcohol, and crimes are more likely to occur when both the victim survivor and offender or the offender alone is intoxicated.

High levels of non-disclosure and under-reporting mean that it is very difficult to measure the true extent of DFV in the NT. Non-disclosure and under-reporting levels are even higher within Aboriginal communities due to a complex interplay of systemic and socio-cultural reasons which include a lack of available and accessible specialist services, shame, pressure to protect the person committing DFV and family relationships, fear of children being removed and/or fear of other social and cultural repercussions.

Despite this, the number of DFV incidents reported to police in the NT has been steadily climbing every year since 2010 and the NT also has the highest rate in Australia of applications for a DVO, representing 80% of all civil cases in the Magistrate's Court.

The NT does not have statistical evidence about rates of DFV for people from migrant and refugee backgrounds, seniors, people with disability and LGBTQI people.

5. DFV SERVICE DELIVERY IN THE NT

For people accessing services in the NT, their diversity can affect both their experience of DFV and the services they receive.

Services should be aware and respectful of the diversity of the NT community, and take measures to ensure that their services are inclusive, accessible and non-discriminatory when applying DFV risk assessment and management practices. The following population and service delivery considerations must be taken into account when delivering DFV risk assessment and management services in the NT:

- The NT population has the largest proportion of Aboriginal people compared to any other jurisdiction, with Aboriginal Territorians accounting for over 30% of the NT population. 77% of Aboriginal Territorians live in remote or very remote areas of the NT.
- The NT is home to migrants (including refugees and asylum-seekers) from over 120 different countries, and around 1 in 4 people in the NT was born overseas in a non-English speaking country.
- The NT population is geographically dispersed and often highly mobile over a vast region including urban populations, towns, communities and remote homelands.
- Territorians live in communities which can be very remote and have extremely limited access to services especially during seasonal weather related isolation.
- Low income, no or limited public transport, and limited access to private vehicles can make it challenging for many people to attend specialist programs or appointments.
- Territorians can and will travel, often long distances, away from support and family to access the services needed.
- The availability and reliability of technology, including internet and social media access, and good signal coverage, is limited in many remote areas across the NT.

6. HIGH RISK FACTORS

Research shows that certain factors have been linked to a higher risk of serious DFV harm or lethality.

The co-occurrence and relationship between these high risk factors and risk of re-assault or lethality is not always straightforward, and no one factor can be considered as the cause of DFV related harm or death.

Risk factors need to be understood and assessed as they develop at different points in time and in the broader context of dynamic relationships. Importantly, not all forms of DFV involve risk of physical violence or lethality, but they can still have a devastating impact on victim survivors' lives, including death.

Practice tool 3 lists the high risk factors used in the CRAT and has been developed based on the current evidence for DFV risk assessment and management, including:

- 2016-2017 Territory Families Family Safety Framework Review;
- Published evidence-base about the prevalence and nature of DFV in the NT and Australia;
- NT Coronial Inquests into DFV related deaths from 1981–2019;
- ANROWS' NRAP;
- Australian Domestic and Family Violence Death Review Network 2018 data report;
- Data from the ABS, AIC and the AIHW.

PRACTICE TOOL 3: HIGH RISK DFV FACTORS

While there is significant evidence that the factors in the table below indicate high risk of serious harm or death, all risk factors are important in any case of DFV and should be responded to, regardless of any intent of homicide.

High risk factor	Key facts
History of DFV	The most consistently identified risk factor for intimate partner lethality and risk of re-assault is the previous history of violence by the person who commits DFV against the victim survivor(s), including children. Homicide is rarely a random act and often occurs after repeated patterns of physical and / or sexual abuse and psychologically coercive and controlling behaviours.
Intoxication and drug and/or alcohol misuse	The misuse of alcohol or drugs by people committing DFV increases risk associated with physical violence. DFV related assaults are more likely to occur when either or both the victim survivor and perpetrator are intoxicated.
Age of the person committing DFV and/ or age of victim survivor	The most common age for a person committing DFV related homicide is 35 to 39 years, and the most common age for a victim is 30 to 34 years. However, there is evidence that in the NT, combined with other factors, perpetrators 25 years and under are at a higher risk of committing serious harm against their partners. The normalisation and inter-generational patterns of the use of DFV in intimate partner relationships, gender inequality and rigid gender roles and identities increases the risk. For victim survivors aged 18 years and under, the very early age at which relationships start, the normalisation of DFV, gender inequalities and educational limitations increases their risk of serious harm.
Early onset of DFV in the relationship	There is evidence of a common sequence in relationships ending in DFV related homicide, where relationships can develop quickly, with early declarations of love, possessiveness and jealousy. Following an event which threatens their control (such as separation), the evidence shows that the sequence can include the perpetrator's motivation moving from having control over the victim survivor to revenge. This leads to an escalation of DFV, including revenge-motivated planning to seriously injure or kill to the victim survivor.

High risk factor	Key facts
Separation (actual or pending)	Women are most at risk of being killed or seriously harmed during and/or immediately after separation from their male partner. Separation is particularly dangerous when the person who commits DFV has been highly controlling during the relationship and continues or escalates violence following separation in an attempt to reassert control or punish the victim survivor. Children (and pets) are also at heightened risk of harm during and post-separation.
Intimate partner sexual violence	Intimate partner sexual violence (IPSV) is a uniquely dangerous form of exerting power and control due to its invasive attack on victim survivors' bodies and the severity of mental health, physical injury and gynaecological consequences. More than other factors, IPSV is under-reported by victim survivors. Shame and stigma caused by commonly held assumptions that discussing sex or sexual assault within relationships is "taboo", are significant barriers to seeking help for IPSV.
Non-lethal strangulation, choking or suffocating	Strangulation is one of the most lethal forms of DFV. When a victim survivor is strangled, choked or suffocated, they may lose consciousness within seconds and die within minutes. The seriousness of choking, strangulation or suffocation as an indicator of future lethality is often misidentified, or not responded to proportionately, as a consequence of the often minimal visibility of physical injury. However, many victim survivors suffer internal injuries or may be unconscious for a period of time without being aware, both of which may result in confused recollections of the event and / or serious or fatal harm. Most people who commit DFV do not choke, strangle or suffocate to kill, but to show that they can kill. Non-lethal strangulation, choking and suffocation is a powerful method of exerting control over victim survivors. Through credible threats of death, people who commit DFV coerce compliance.
Stalking	Stalking behaviours (repeated, persistent and unwanted attention) including technology-facilitated surveillance, GPS tracking, interferences with property, persistent phoning/texting and contact against court order conditions, increases risk of male-perpetrated homicide. In some situations, people who commit DFV may engage close family members or friends to stalk the victim survivor when they are not able to do so themselves, for example when the person committing DFV is in prison.
Threats to kill	People who commit DFV who threaten to kill their partner or former partner, themselves or others including their children and pets, are particularly dangerous. Threats of this nature are psychologically abusive.

High risk factor	Key facts
Access to, or use of weapons or objects by person who is committing DFV	Use of a weapon (any tool or object that could injure, kill or destroy property) indicates high risk, particularly if used in the most recent violent incident, as past behaviour strongly predicts future behaviour.
Escalation (frequency and/ or severity) of violence over time	The escalation in frequency and severity of violence over time is linked to lethality and often occurs when there are shifts in other dynamic risk factors, such as attempts by the victim survivor to leave the relationship.
Coercive control	Reports from death review committees and Coroner's Courts highlight the prevalence of patterns of coercive and controlling behaviours prior to male-perpetrated intimate partner homicide, including verbal and financial abuse, psychologically controlling acts and social isolation. People committing DFV may also use other people to watch and control the victim survivor or misuse systems such as Domestic Violence Orders (DVO) and family court proceedings. Coercive and controlling patterns of behaviours are particularly dangerous and can heighten the risk of lethality in contexts where other high-risk factors are present, such as attempts by the victim survivor to leave the relationship.
Threats or attempts to self-harm or suicide	Threats or attempts to self-harm or suicide by the person committing DFV are a risk factor for an outcome of murder (of the victim survivor) and suicide (of the person committing the violence). This factor is another very severe way of controlling another person.
Upcoming or recent release from prison of person committing DFV	DFV risk can escalate very quickly when circumstances change. DFV homicides in the NT have occurred soon after the person committing the violence is released from prison.
Previous or current breach of court orders/ DVO	Breaching a court order, or any other protection order, indicates a disregard for the law and authority. Such behaviour is a serious indicator of increased risk of future violence.
Pregnancy and new birth	Violence perpetrated against pregnant women by a partner is a significant indicator of future harm to the woman and child, and is the primary cause of death to mothers during pregnancy, both in Australia and internationally. Women with a disability, women aged 18-24 years and Aboriginal women, in particular, are at significant risk of experiencing severe violence from their partner during pregnancy. Violence often begins when women are pregnant, and when previously occurring, it often escalates in frequency and severity during the pregnancy.

7. ATTITUDES ABOUT DFV

Our beliefs and attitudes are shaped by many influences and can be held without conscious thought. Some of our attitudes may be based on myths or misconceptions, rather than the facts. These attitudes influence how we think and feel about DFV, and this can affect how we respond to DFV as workers.

We can identify the following commonly held but prejudicial myths and constructively question their influence on our attitudes, behaviours and practice.

None of the following myths are borne out by the evidence:

- DFV only happens to poor, uneducated women and women from certain cultures.;
- Most people who commit DFV are under the effects of alcohol or drugs;
- Some people deserve to be abused; they are responsible for the violence or they provoke it. If the victim survivor didn't like it, she would leave;
- Abusers are mentally ill, psychopathic or have a personality disorder;
- DFV is a private matter;
- Stress and anger lead to violence. The person committing DFV just snapped because they were angry; and
- Forced sexual activity within a marriage is not rape.

These attitudes can also lead to support for the person committing DFV, while minimising the risk to and needs of the victim survivor. People who commit DFV are often skilled at hiding their violence, blaming the victim survivor, and showing other people a positive image of themselves. Because of this, outsiders may view the abusive actions as being impulsive and "out of character" behaviour.

Some statements made about people who commit DFV are:

"He was an outstanding member of our community. I would never have thought he could do something like this. Stress must have caused him to behave out of character."

"He seemed like such a caring person. He was devoted to his family. I cannot understand how this could have happened."

"He wrestled with his demons for a long time, but they finally overcame him."

"He witnessed his father abusing his mother, so this was all he knew."

"Anger always got the better of him. He could not seem to control his impulses."

"Once he had a few drinks, the alcohol took over and he became a scary guy."

These attitudes still influence the way victim survivors of DFV see themselves and, on a broad level, may inform the responses of services which may:

- Fail to acknowledge the seriousness of the violence, which is a crime, and instead treat it as a 'problem' or 'relationship issue';
- excuse the violent behaviour or collude with the justifications of the person who commits DFV;
- individualise the 'problem' by ignoring the social, cultural and historical contexts in which violence towards women, children and, families occurs;
- fail to use culturally inclusive and safe principles and practices;
- fail to focus on stopping the violence of the person committing DFV or recognise how broader systems and attitudes collude with the violence and disempower victim survivors, their families and communities; and
- inappropriately require the victim survivor to take responsibility for the violence, blame the victim survivor, minimise the harm, and expect the victim survivor to address their own safety and that of their children, instead of focusing on the shortfalls of a system that has failed to keep them safe.

8. IMPACTS OF DFV ON ADULT VICTIM SURVIVORS

What victim survivors say

"All these horrible feelings and anxiety and uncertainty. Your mind just races 100 miles an hour because you think, "Oh, my goodness, I'm in a danger zone. Red light. Red light." Your senses become so sharp, like, your hearing and skin feels like something's crawling all over it. It's just that anxiety level just builds up so much and you smell, you smell something; it's like, "That cologne on him, I just can't stand it."

DFV has profound short-term and long-term physical, psychological, social and economic effects on victim survivors. While each victim survivor will experience DFV uniquely, there are many common effects.

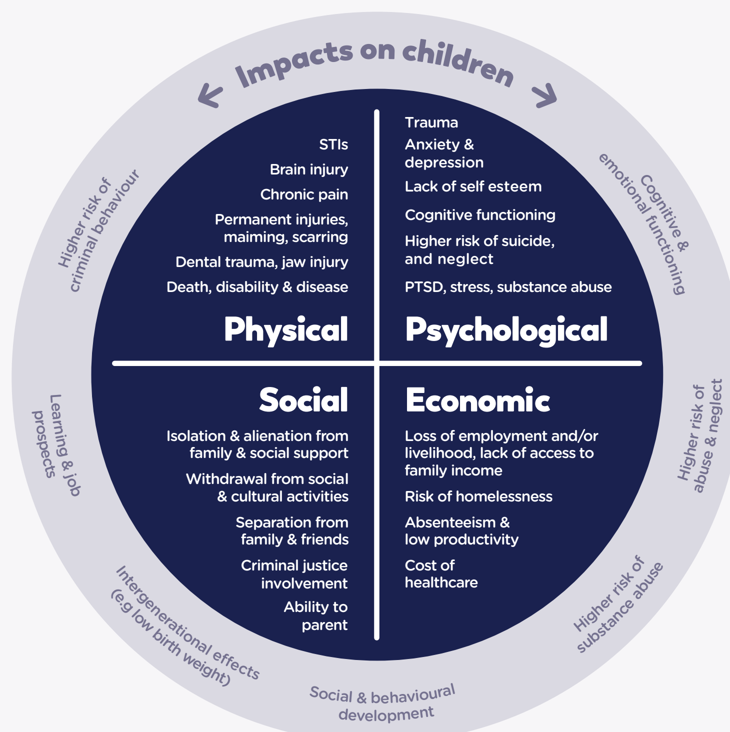
The obvious physical effects of DFV are injury and death. Yet there are other impacts on physical health, such as insomnia, chronic pain, physical exhaustion, and reproductive health problems, which are not necessarily the result of physical injuries.

Victim survivors of DFV:

- are more likely to experience trauma, depression, panic attacks, phobias, anxiety and sleeping disorders;
- have higher stress levels and are at greater risk of suicide attempts;
- are at increased risk of misusing alcohol and other drugs, including minor tranquilisers and pain killers;
- are often unable to act on their own choices because of physical restraint, fear and intimidation;
- may live in persistent fear of further violation, and may feel silenced and unable to express their point of view or experience;
- often make their partners' needs and feelings the constant focus of their attention as a survival strategy, which may result in an inability to attend to their own and their children's health and wellbeing; and
- often experience social isolation, including from their own extended family. This can happen within small rural and/or remote kin or family based communities, and within cultural and linguistically diverse communities.

Seeing the effects of DFV on children can be profoundly distressing for mothers. Their capacity to parent their children can be affected by the physical, emotional and cognitive effects of their own experiences of the violence, and by the person who is committing DFV's deliberate attempts to undermine their parenting roles and responsibilities. This can have serious effects on their identity and confidence as mothers.

Impacts of Domestic, Family and Sexual Violence



9. IMPACTS OF DFV ON CHILDREN AND YOUNG PEOPLE AS VICTIM SURVIVORS

What victim survivors say

"They saw him hit me and they said, 'Mum, I don't feel like staying with dad'. The kids don't want to see him. But he wants to take the kids back and me."

> *Children's 'witnessing' of or exposure to DFV has been increasingly recognised as a form of child abuse, both in Australia and internationally. The RAMF acknowledges that children's witnessing of or exposure to DFV is equivalent to experiencing DFV and makes them a victim survivor of DFV.*

Children's 'witnessing' of or exposure to DFV has been increasingly recognised as a form of child abuse, both in Australia and internationally. The RAMF acknowledges that children's witnessing of or exposure to DFV is equivalent to experiencing DFV and makes them a victim survivor of DFV.

Living in a home where DFV is part of family functioning causes serious, lasting harm to children. It impacts on attitudes to relationships and violence, as well as behavioural, cognitive and emotional functioning, social development, learning and job prospects.

Limiting our understanding of the impacts of DFV on children by labelling them as "witnesses" or "having been exposed to the violence" minimises the extent of the impact. Children are victim survivors in their own right, with needs, fears and loyalties independent of their parent who is experiencing the DFV.

Trauma experienced as a child or young person has been associated with negative cognitive changes, developmental problems, and problems regulating mood and behaviour that can follow the individual into adulthood, including impacts on physical health, mental health, substance use, and problems with social and economic participation.

Infants and babies are impacted by DFV and it can affect their brain development. The ongoing exposure to DFV means their fear reactions are over developed which can put the child on a lifelong hair trigger, where the brain is trained to react to even the slightest hint of perceived danger. In response to DFV, babies may withdraw into themselves, as they are unable to physically hide as older children can.

Exposure to DFV also increases the risk of a child or young person experiencing other forms of abuse or neglect. Aboriginal children and young people are over represented in the NT child protection and youth justice systems.

10. TRAUMA

Trauma is an impact of DFV. A worker may observe clients presenting with signs of trauma such as constant hypervigilance (being fearful and on alert, experiencing intrusive thoughts) or, at the other end of the spectrum, as hypo-arousal (appearing disconnected, avoidant, lethargic and flat).

Trauma impacts adults and children differently. It also impacts people differently depending on their life circumstances, and the circumstances of their families and community. The table below summarises different forms of trauma as it relates to DFV.

Type of trauma	Descriptions
Trauma	Trauma is an impact of DFV. It is a psychological wound that has occurred due to a person's experience of stressful events, and is a common impact of DFV. Trauma is an experience of real or perceived threat to life, bodily integrity and/or sense of self.
Complex Trauma	Complex trauma has been described as the persistent effects that exposure to repeated, cumulative, compounded or chronic trauma (such as a pattern of DFV) has over a period of time.
Intergenerational Trauma	Intergenerational trauma is a form of historical trauma transmitted across generations by survivors of the initial trauma experience who have not healed from it. For Aboriginal people and communities, intergenerational trauma can be communal, prolonged, cumulative, and compounded, with its origins stemming from colonisation.

11. RESISTANCE

What workers say

"Another woman got completely off because she had repeatedly called the police to implement the DVOs she had taken out the first time she was beaten; she had been taken to hospital so many times from injuries, so there were extensive police and hospital records. The lawyer subpoenaed all the records. The case was thrown out of court because she was clearly acting in self-defence over a long period of time. It educated the magistrate as well."

Many people believe victim survivors passively accept violence, and lack self-esteem, assertiveness, or boundaries. Unfortunately, this leads people to have an incorrect, stereotyped, or negative view of victim survivors, and blame them for the violence.

> *Victim survivors of DFV are far from passive recipients– they do not 'just go along with it' or 'let it happen'. Victim survivors try to reduce, prevent or stop the violence in many ways, and even the smallest act of resistance is significant.*

Victim survivors of DFV are far from passive recipients– they do not 'just go along with it' or 'let it happen'. Victim survivors try to reduce, prevent or stop the violence in many ways, and even the smallest act of resistance is significant. It is important for services to uncover the ways in which victim survivors creatively and strategically resist in an effort to escape the violence, retain their dignity and protect themselves and their children.

Victim survivors decide how to resist abuse based on what they know of the person committing DFV against them, and what they need to do to be safe and to keep their dignity. Because DFV can be very dangerous, usually victim survivors resist it in ways that are not obvious. This means that as workers we may not notice when acts of resistance have occurred. Victim survivors may show resistance and ways to keep themselves and their children safe by:

- not doing what the person committing DFV wants them to do;
- visiting the person when a DVO is in place because they know if they don't they will be assaulted;
- ringing the person and seeking them out because they know if they don't they will be assaulted;
- standing up against the person committing DFV; in the presence of police because they know they are safe there;
- fighting back physically and/or verbally in a public space; (which can often lead to assessments that the victim survivor is an equal partner in the violence);
- avoiding the person committing DFV;
- maintaining relationships with friends and family (sometimes secretly), when the person committing DFV is trying to isolate them;
- maintaining dignity and self-respect in the face of insults and abuse;
- quietly disregarding the controlling instructions of the person committing DFV;
- maintaining internal beliefs that they are not responsible for their DFV behaviour;
- asking for help from friends, family, police or other services;
- refusing to cover up injuries; and
- when the victim survivor knows from experience that the perpetrator will become abusive, the victim survivor purposely says things that they know will make the perpetrator angry so they have some control over when they get hit.

In some cases, the final act of victim survivor resistance results in the death of the person who committed the DFV. The 2018 Australian Death Review report, which studied 152 DFV related homicides in Australia between 1 July 2010 and 30 June 2014, found that 18% of cases involved a woman killing her male intimate partner and the majority of these women were primary DFV victim survivors who killed a male abuser.

12. DETERMINING THE PERPETRATOR

What victim survivors say

"The male judge who sentenced me spoke wrong way about me. He said I was really dangerous, not a responsible person, and not a responsible person for my children. He did not listen to my history and why I did things, I wouldn't just be violent for nothing. That judge should have listened to my story and given me help in prison—given me rehab and counselling. I am a young woman, and not a violent person until violence is done to me."

Without knowing the context and history, it may be difficult to establish whether a client is the person committing DFV or whether they are in need of safety and protection from DFV. For example, two adults in a relationship might claim to be experiencing violence from each other, or a man might claim to be a victim survivor of his female partner. Sometimes the victim survivor will fight back, and this can make it difficult to work out who is the person most in need of protection.

A phrase that is sometimes used to establish who is committing the DFV is determining the primary aggressor. This term seeks to identify the actual person committing DFV in the relationship, by distinguishing their history and pattern of coercion, power and controlling behaviour, from the history of a victim survivor who may have used self-defence or violent resistance in an incident or series of incidents. The person committing the DFV is the person who poses the most serious and ongoing threat to safety and wellbeing.

Part of determining who is committing the DFV is recognising that DFV is:

- coercive and controlling in nature;
- commonly characterised by a victim survivor who is fearful of the person committing DFV; and
- distinguished from other forms of violence such as family fighting, where coercive controlling violence is a less common factor.

This is an important issue in screening and assessing for DFV risk. More information is provided in Practice Guide 1: DFV Screening and Practice Tool 4: DFV Indicators.

13. DRIVERS AND CONTRIBUTING FACTORS OF DFV

Using violence and coercive control for the purposes of power and control is a choice. Responsibility for the use of violence rests solely with the person committing DFV, and victim survivors are not to be blamed or held responsible.

DFV is not an inevitable or intractable social problem. It is the product of complex yet modifiable social and environmental factors, including historically-entrenched beliefs and behaviours, and the social, political and economic structures, practices and systems that support them. While there is no single cause of DFV, with the exception of the behaviour of the person committing DFV, there are certain factors that consistently predict—or drive—it.

Gender inequality

Extensive international and national research into the drivers of DFV identifies gender inequality as a primary driver or cause.

The expressions of gender inequality most commonly linked with higher levels of violence against women are:

- condoning of violence against women;
- men's control of decision-making;
- limits on women's independence;
- rigid gender roles and identities; and
- male peer relations that emphasise aggression and disrespect towards women.

Systemic inequality, individual impacts

While gender inequality is a primary driver of DFV, the intersection of co-occurring structural inequalities can, in some cases, increase the frequency, severity and prevalence of violence against women.

Another way to understand how co-occurring structural inequalities can, in some cases, increase the frequency, severity and prevalence of violence against women, is through a theoretical approach called intersectionality.

Intersectionality refers to people's experiences of multiple and intersecting forms of discrimination and disadvantage. Intersectional approaches to policy and practice recognise that multiple forms of discrimination can overlap, leading to compounded disadvantage.

People who face social exclusion as a result of their particular experiences or identity are at an even greater risk of violence and abuse, and may have fundamentally different experiences of DFV. Those differences are often shaped by social attitudes, which in turn create structural barriers and long-term disadvantage and marginalisation including from the DFV service system. For example, Aboriginal women experience far higher rates and more severe forms of DFV than non-Aboriginal women.

Aboriginal women are 32 times more likely than non-Aboriginal women to be hospitalised and 10 times more likely to die from violent assault than non-Aboriginal women. DFV against Aboriginal women is perpetrated by both Aboriginal and non-Aboriginal men.

Contributing factors to DFV against Aboriginal women and children include inter-generational grief and trauma resulting from the ongoing impacts of colonisation, including social inequality, and the removal of children, as well as ongoing racism and discrimination.

Women and girls with disability are more likely to be subjected to forced interventions which infringe their reproductive rights (such as forced sterilisation and forced contraception) than women without disability and men with disability. Women with disability in institutional settings are more likely to be subject to guardianship proceedings for the formal removal of their legal capacity. Women and girls with disability may also be vulnerable to increased financial abuse.

Aboriginal women with disability are more likely to be subject to indefinite detention than non-Aboriginal women with disability and women without disability.

Victim survivors of DFV from multicultural communities, particularly refugees or migrants, can be affected by their own and their families' experiences of migration and settlement. Their concerns may include fears about reporting DFV due to reprisals and the impact on migration and residency status; and fears about police and child protection interventions. They may also be impacted by different cultural understandings about forms of DFV; and language and communication barriers.

LGBTQI people may have concerns and experiences that result in feeling unsafe to report DFV, or lacking trust in the service system, including discrimination, 'outing' or exclusion by services; and having their sexuality, gender, or intersex variation questioned or not recognised by services, or not having their needs understood. DFV also occurs in the context of same-sex intimate partner relationships.

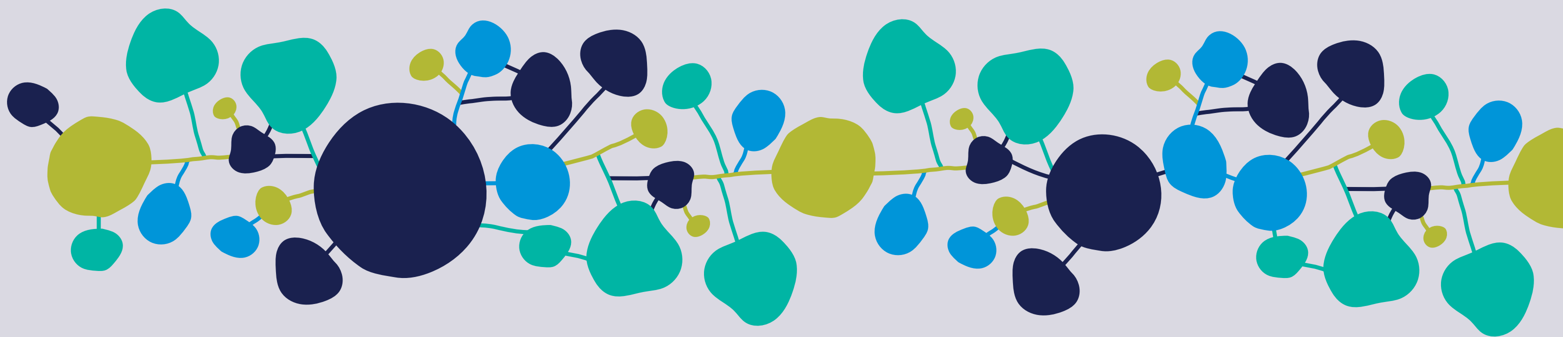
Alcohol and other drugs

Alcohol and other drug use is not sufficient in itself to predict DFV, and is not a 'cause' of DFV. Women consistently report that coercive and controlling violence occurs whether their partners are intoxicated or sober. However, alcohol and other drug use increases the probability, frequency and severity of DFV.

Per-capita, alcohol consumption in the NT is 1.5 times higher than the Australian average, with alcohol consumption rates higher than the national average in every age category.

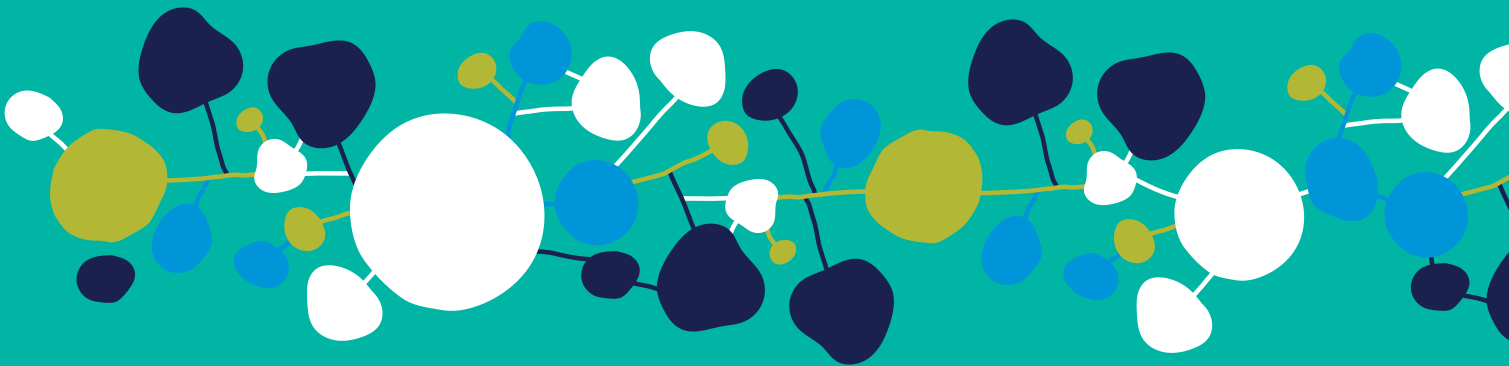
Alcohol is a feature in a large number of police call-outs for DFV, and is correlated with a higher number of, and more severe, incidents of violence against women.

The 2018 National Death Review report found that almost 50% of people who committed homicide against an intimate partner were using alcohol at the time of the fatal episode, and 31% were using other substances.



PART C

PRACTICE GUIDES



There are seven individual practice guides that support the implementation of the RAMF.

Responding to DFV risk does not occur in a straight line. Many steps overlap and can run parallel to others. To decide which practice guide to use, workers should consider:

1. the needs and safety requirements the client presents with at the time;
2. the time and skills available at the time; and
3. the policies, procedure, responsibilities and funded activities of the worker and service.

The practice guides, supported by practice tools, are aimed at promoting a common language and shared understanding of DFV and of DFV risk, to work towards an integrated service system.

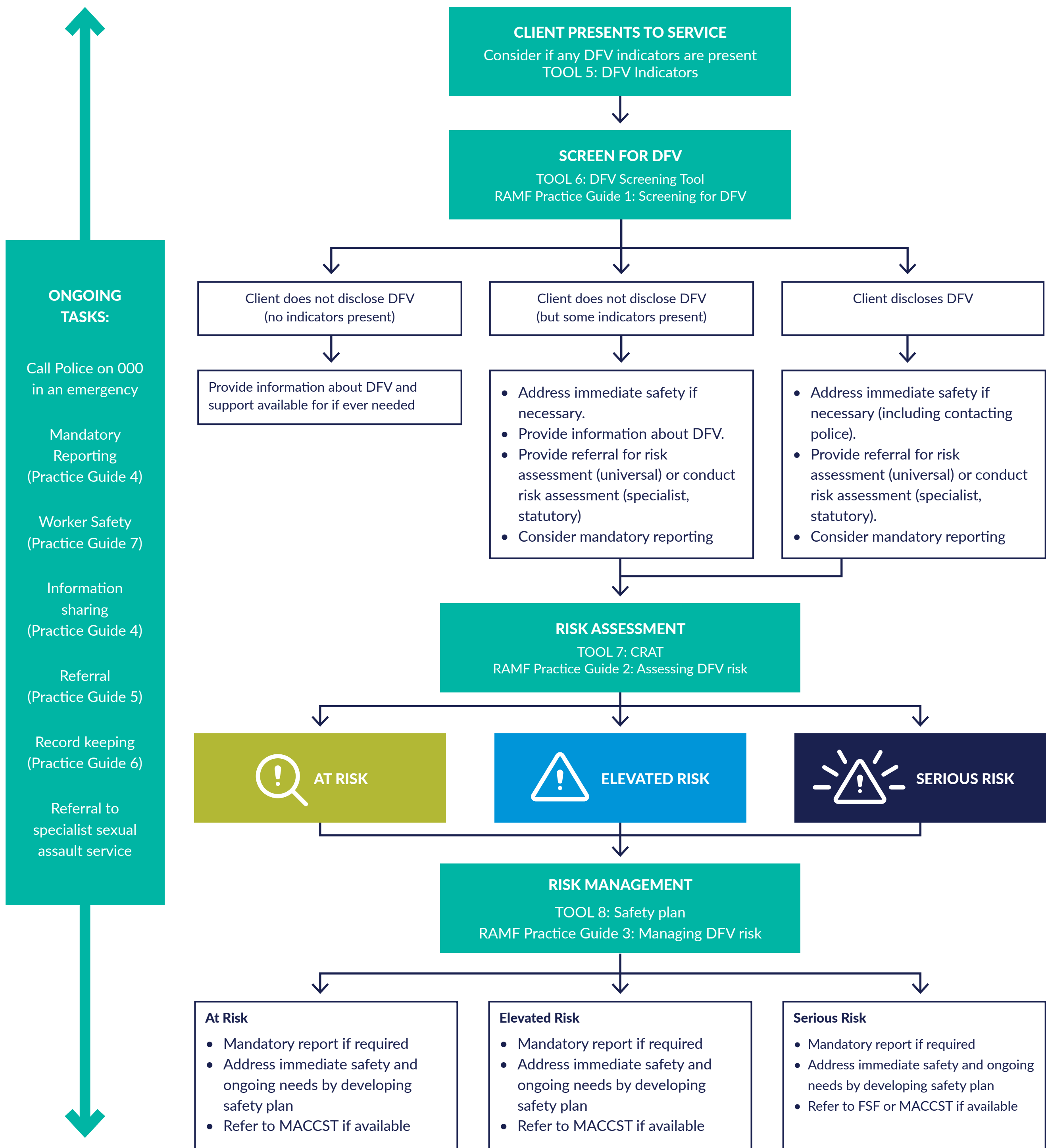
They can be used by a wide cross-section of services, including specialist DFV services, generalist or universal services, and those with statutory responsibilities. These services are defined in Part A section 2.

The flowchart on the following page demonstrates the steps for screening, assessing and responding to DFV risk. Throughout these steps, workers and services also need to understand their legal obligations (such as information sharing and mandatory reporting), how to make referrals and keep good records, and the importance of worker safety.

List of Practice Guides

1. Screening for DFV
2. Assessing DFV risk
3. Managing DFV risk
4. Shared legal responsibilities
5. Referrals
6. Record keeping
7. A safe, supported and capable workforce

PRACTICE TOOL 4: FLOWCHART OF RESPONSE PATHWAY FOR DFV SCREENING, RISK ASSESSMENT AND RISK MANAGEMENT



Mandatory Reporting Child Abuse / Neglect

Central Intake Team
(24 hours): 1800 700 250
(or report online for Government workers)

Mandatory Reporting DFV

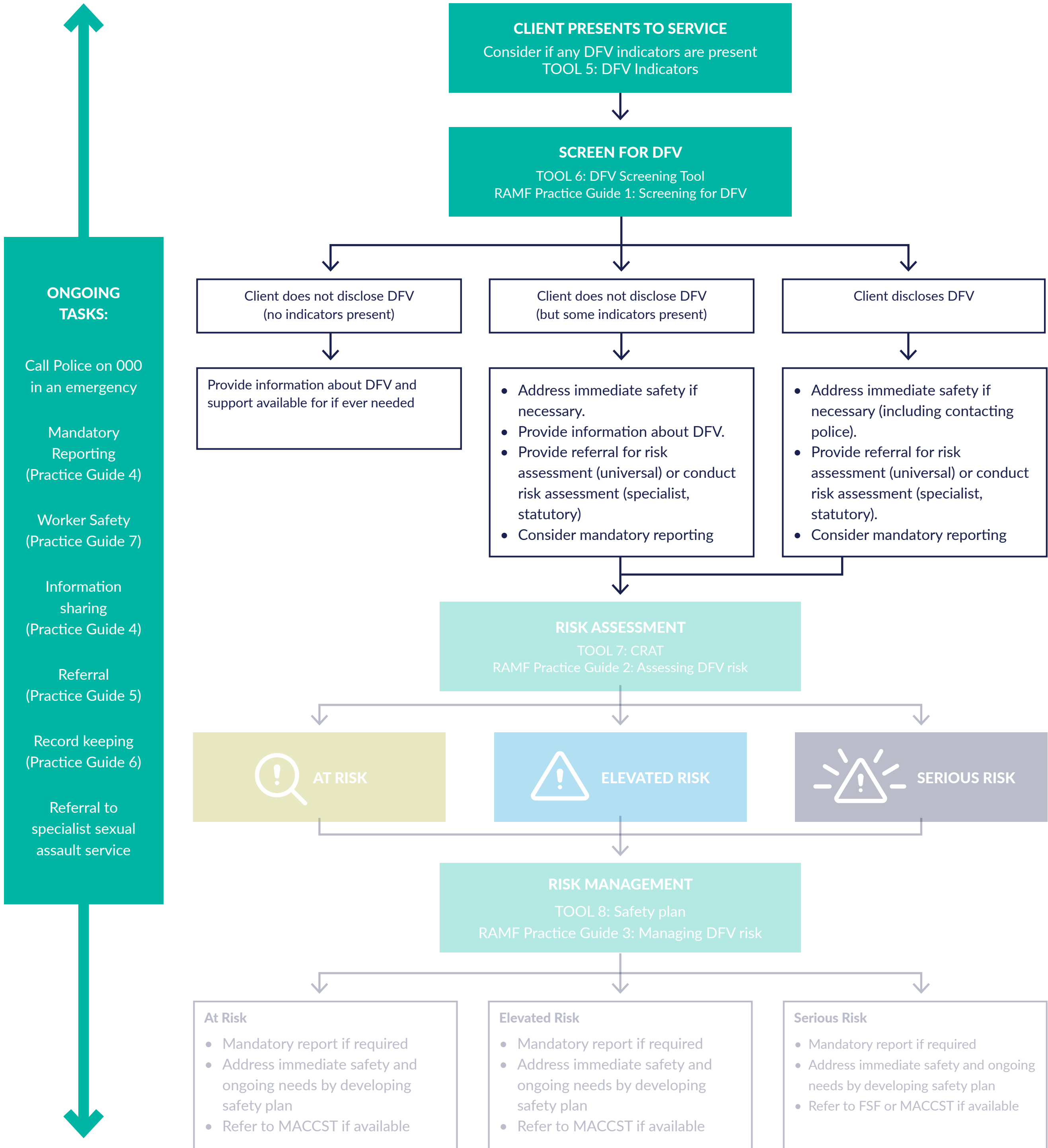
Police: 000 (emergency)
131 444 (non-emergency)

Sexual Assault Referral Centre (SARC)

Darwin: 8922 6472;
Katherine: 8973 8524;
Tennant Creek: 8962 4361;
Alice Springs: 8955 4500 (business hours)
or 0401 114 181 (after hours)

PRACTICE GUIDE 1: SCREENING FOR DFV

This practice guide provides information, resources, tools and practice tips about screening for DFV, including what it is, why it is required, when it should be used, who should do it and how it should be done safely and effectively.



PRACTICE GUIDE 1: SCREENING FOR DFV

Screening for DFV can be done by universal, statutory and specialist workers.

REMEMBER: All adults must comply with their existing legal obligations under mandatory reporting laws – see Practice Guide 4 Shared Legal Responsibilities.

It is best practice to inform the client of your responsibility to report DFV, and child abuse and neglect, as early as possible in the interaction, provided this does not compromise their safety.

NOTE: IF THE CLIENT (OR ANY OTHER PERSON) IS IN IMMEDIATE DANGER, CONTACT POLICE.

What is screening?	Screening is a conversational enquiry using a common set of questions to find out if someone is experiencing, or has experienced, DFV.
Why is screening important?	Victim survivors of DFV may enter the service system at a number of different points. It is often the case that victim survivors have had contact with a range of services, but the DFV has not been identified. Screening provides an opportunity for action to be taken to increase safety for victim survivors and accountability for people who commit DFV, regardless of where the victim survivor enters the service system. If DFV screening doesn't occur, services provided may not be as effective as they could be, and may inadvertently place the victim survivor at further risk.
Who should do DFV screening?	All services in the NT who come into contact with potential DFV victim survivors should be able to screen for DFV risk. This includes specialist DFV services, universal services, and statutory services.
When should DFV screening occur?	Where DFV is suspected, through the presence of indicators (see Practice Tool 5), DFV screening questions should be asked. Some services apply screening questions routinely; others only when indicators of DFV are identified. Screening is not a one-time event, but may be undertaken at any time where indicators of DFV are suspected or become apparent.
How should screening be done	If there are indicators of DFV (see Practice Tool 5), screening should occur by asking the screening questions (see Practice Tool 6). If a client has already disclosed DFV or it is clear that DFV is occurring, the screening steps do not need to be undertaken.

TIPS - Preparing for screening

Screening should not be undertaken if the person suspected of committing DFV is present. Make sure the screening for DFV is done away from the person suspected of committing DFV or by people who may inform the person who committed DFV.

- The client can have a support person with them if they feel more comfortable.
- If indicators of DFV are present, find a private and safe area to ask the screening questions. Some services including remote health clinics have women and men only spaces which can be private and safe enough to screen for DFV.
- It is ok to do DFV screening by phone, as long as you clarify that the client is alone, or is with a trusted person and that it is safe to speak.
- When working with people whose English is limited, it is important to use interpreters. You can access interpreters through the Aboriginal Interpreter Service or through the Interpreting and Translating Service NT.
- Check that you understand confidentiality and its limitations, including your mandatory reporting obligations.
- Prepare for any children/dependents accompanying the victim survivor so that they are looked after and not present during conversations that may be distressing for them.
- Remember that disclosing DFV always carries an element of risk for the victim survivor. This risk may be from the person who is committing the DFV, or from the service system, for example, how the worker or service responds to the disclosure or how the victim survivor perceives they may respond.

TIPS - Starting the conversation

- Discuss the purpose of screening with the client. Explain that you are asking for information because you are concerned for the client's safety. The following statements can be used to start the conversation.
- ***Many people/women have problems with their family, their husband or partner or someone they live with, so we ask questions about the safety of all our clients so that we can work out what kind of help you need to keep you (and your children) safe; or***
- ***I am worried because [list the DFV indicators that are present]. I would like to ask you some questions about how you feel about your safety so that we can work out what kind of help you need to keep you safe; or***
- ***Sometimes people can hurt other people. Can I ask you some questions about this?***
- Explain that participation is voluntary.
- Acknowledge that some of the questions may be confronting and difficult to answer. Be aware of the distress and fear that disclosing DFV may cause. A client is more likely to disclose if they are feeling safe and supported.
- Check that the client understands confidentiality and its limitations, such as your obligation to follow mandatory reporting procedures.
- If the client finds it hard to talk, you can start by telling a story about a fictional person's experiences of DFV and then ask if anything in that story sounds like what the client is experiencing.
- Always watch and listen closely to what is happening for the client during the conversation. If they appear upset, ask if they would like to stop or take a break. It is important that they go at their own pace and are not pushed to reveal information that they are not ready to.

TIPS - Starting the conversation (Continued)	• Only seek information that is necessary. Avoid asking unnecessary questions if the information has already been provided. • Don't be afraid to listen to a difficult answer. It is important that client stories are listened to and responded to appropriately. If you feel you do not have the skillset to sit with and respond to challenging information, identify this development need with your workplace. • This may be the first time the client has ever been asked about the DFV. How they are asked, and how they are supported if they disclose DFV, can have a profound effect on their next steps.
Screening questions	The following questions are examples to help you screen for DFV. They are part of a conversation and are not intended to be asked one by one in a survey style. • ***Has your partner/husband, ex-partner/husband or someone in your family hurt you or threatened to hurt you; yelled at you, talked down to you or called you bad names?*** • ***Has your partner/husband, ex-partner/husband or someone in your family become jealous and tried to control what you can or cannot do?*** • ***Are you worried about the safety of your children or someone else in your family or household?***
TIPS – if the client discloses DFV	When a client discloses DFV it is important to respond in a supportive way. Take care that the client does not feel blamed for the DFV or responsible for making it stop, and hears the message that all people have a right to be and feel safe. The following are examples of what you can say: • ***I am sorry that that has happened to you.*** • ***It is not your fault that this is happening.*** • ***I will do what I can to help you.*** • ***You have the right to feel and be safe and I'm working with you and the people that I know to try to keep you safe.***

Next steps after screening	There are several possible outcomes after screening for DFV: • **The client has not disclosed DFV and you are satisfied that DFV is not occurring:** acknowledge the client and provide them with any resources needed should they ever experience DFV. You should continue to provide your usual services. • **The client has disclosed DFV:** All disclosures of DFV require a risk assessment. If DFV is part of your core business, you should then do a risk assessment (see Practice Guide 2 – Assessing DFV Risk). If not, make a warm referral to a specialist or trained worker to do a risk assessment (see Practice Guide 5 - Referral). The referral should include the option to accompany the client or provide transport to get to the service safely if possible. • **You have a reasonable belief that DFV is occurring, even though the client has not disclosed it:** if the client is not yet ready or able to disclose or accept assistance, this must be respected. In this case: > It is important not to pressure the client to disclose; > Provide them with information about their options; > Acknowledge their response, and inform them of DFV services that are available, and encourage them to recontact at any time; > Focus your work on building your relationship with the client; > Consider whether you may need to make a mandatory report. The client may not disclose DFV for a number of reasons, including fear of escalating the violence, prior negative experiences with services, fear of having children removed, shame, embarrassment, or concern about the consequences for the person who is committing the DFV.
What else needs to happen after screening?	Screening is an ongoing process, not a one-off event. The risk and occurrence of DFV can change quickly and occur at different times Remember to fulfil your record keeping responsibilities. If the client has experienced sexual assault (recent or historical) AND they consent to support contact a specialist sexual assault service.
Related resources	Practice Tool 5: DFV Indicators Practice Tool 6: DFV Screening tool

PRACTICE TOOL 5: DFV INDICATORS

The list of possible indicators of DFV in adults are provided for the purpose of forming judgements about when to undertake DFV screening. It is essential that workers initiate a conversation about DFV if a number of indicators or a pattern of recurring indicators are present. This process should be guided by the screening tool or other similar prompting questions.

Area	Indicator
Physical	• Bruising, cuts and scars; • Fractures; • Terminations of pregnancy; • Complications during pregnancy; • Sexually transmitted infections; • Strangulation - neurological and physical signs such as visual changes, movement disorders, bruising around the neck; • Head, eye, jaw, neck and facial injuries; • Injuries to unexposed parts of the body; • Injuries that do not match explanations; • Delayed presentation between time of injury and treatment; and • Memory loss.
Behaviour	• Unconvincing explanations of any injuries; • Describe a partner as controlling or prone to anger; • Partner speaks for client and/or insists on remaining with client; • Anxiety in the presence of a partner; and • Needing to be back home by a certain time and becoming stressed about this.

Area	Indicator
Psychological and Emotional	• Ongoing emotional health issues, such as stress, anxiety, panic attacks, depression or Post Traumatic Stress Disorder (PTSD); • Self-harming behaviour and suicide thoughts, plans or attempts; • Phobias; • Sleep problems; • Impaired concentration; • Harmful alcohol and other drug use (including prescribed medications); • Physical exhaustion; • Eating disorders; • Withdrawal from physical contact; • Fear, shame or anger; • Feelings of worthlessness and hopelessness; and • Feeling disassociated and emotionally numb.
Social/ financial	• Homelessness; • Isolation from family and social supports; • Unemployment; • Financial debt; • Recent separation or divorce; and • Parenting difficulties.

PRACTICE TOOL 6: SCREENING FOR DFV

This tool should be used in conjunction with Practice Guide 1 – Screening for DFV.

Starting the conversation

The following are examples to help you start the conversation leading to screening for DFV.

- Many people/women have problems with their family, their husband or partner or someone they live with, so we ask questions about the safety of all our clients so that we can work out what kind of help you need to keep you (and your children) safe; or
- I am worried because [list the DFV indicators that are present]. I would like to ask you some questions about how you feel about your safety so that we can work out what kind of help you need to keep you safe; or
- Sometimes people can hurt other people. Can I ask you some questions about this?

Screening questions

The following questions are examples to help you screen for DFV. They are part of a conversation and are not intended to be asked one by one in a survey style.

- Has your partner/husband, ex-partner/husband or someone in your family hurt you or threatened to hurt you; yelled at you, talked down to you or called you bad names?
- Has your partner/husband, ex-partner/husband or someone in your family become jealous and tried to control what you can or cannot do?
- Are you worried about the safety of your children or someone else in your family or household?

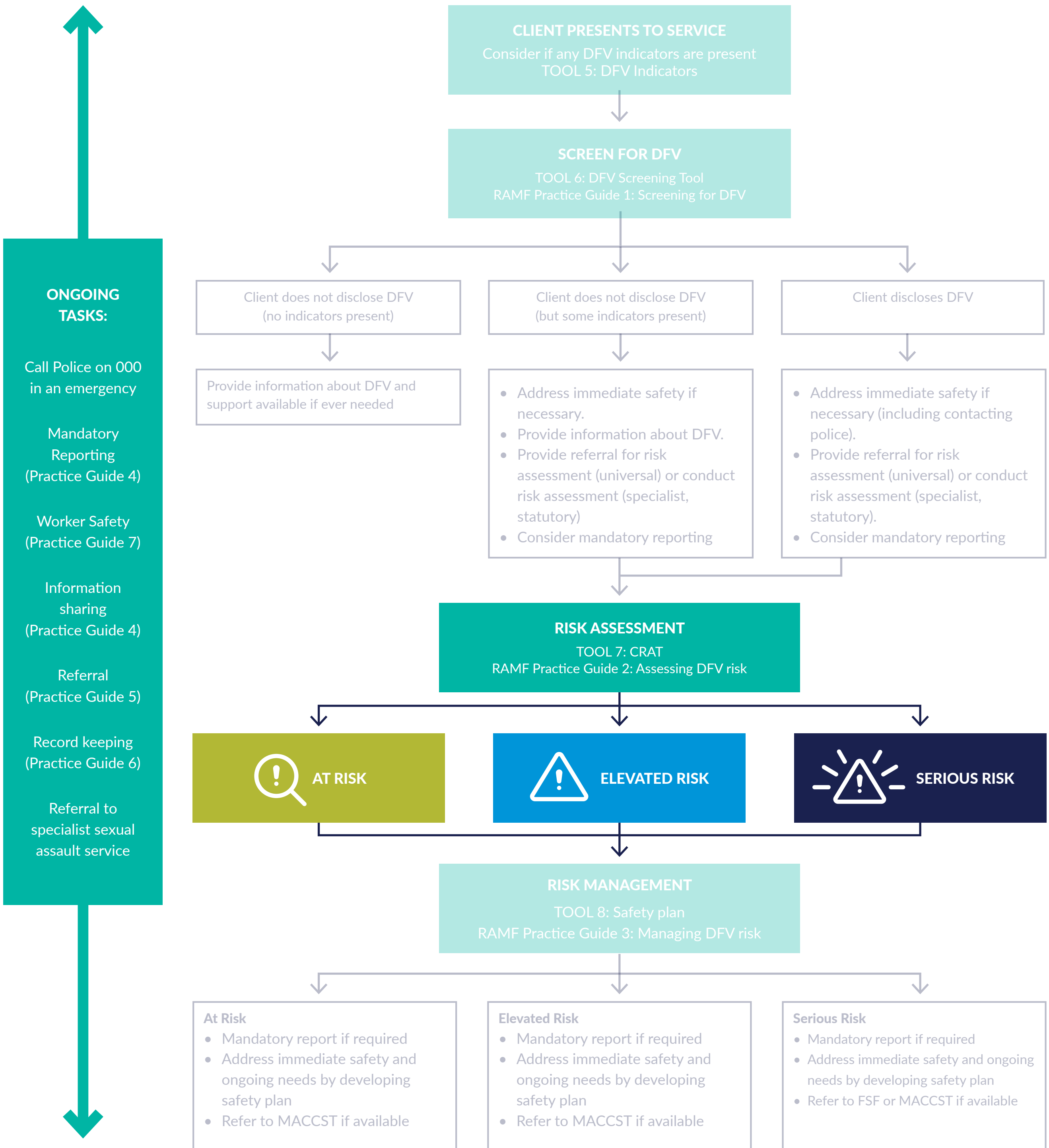
Responding to a disclosure

The following are examples to help you acknowledge a disclosure of DFV after screening.

- I am sorry that that has happened to you.
- It is not your fault that this is happening.
- I will do what I can to support you.
- You have the right to feel and to be safe and I'm working with you and the people that I know to try to keep you safe.

PRACTICE GUIDE 2: ASSESSING DFV RISK

This practice guide provides information, resources, tools and practice tips about assessing DFV risk, including what it is, why it is required, when it should be used, who should do it and how it should be done safely and effectively.



PRACTICE GUIDE 2: ASSESSING DFV RISK

Risk assessments are best done by specialist DFV services, and/or by workers with DFV skills and a sound understanding of DFV. This may include workers in statutory services.

REMEMBER: All adults must comply with their existing legal obligations under mandatory reporting laws – see Practice Guide 4 Shared Legal Responsibilities.

It is best practice to inform the client of your responsibility to report DFV, and child abuse and neglect, as early as possible in the interaction, provided this does not compromise their safety.

NOTE: IF THE CLIENT (OR ANY OTHER PERSON) IS IN IMMEDIATE DANGER, CONTACT POLICE.

What is DFV risk assessment?	Risk assessment is the process of gathering and analysing relevant, evidence-based information about a DFV situation to determine the level of risk and to guide the response. A tool may be used to assess risk, which is based on evidence about what factors have been found to be predictive of injury, serious injury or death. The DFV assessment tool used in the RAMF is the Common Risk Assessment Tool (CRAT).
Why is DFV risk assessment important?	Risk assessment is done to estimate the risk of injury, serious injury or homicide for a DFV victim survivor, in order to inform the risk management response. DFV risk assessment is central to effective response that keep victim survivors safe while keeping the person who is committing DFV visible and accountable.
Who should do DFV risk assessment?	Risk assessments are best done by specialist DFV services, and/or by workers with specialist DFV skills and a sound understanding of DFV, this may include workers in statutory services. Full assessment of risks should not be done by workers who are unable to provide the time and skill needed. Workers who do not have the skills or time should refer to a specialist or trained worker who can appropriately conduct a risk assessment.
When should DFV risk assessment occur?	Risk assessment must be undertaken when DFV has been identified in the screening process (see Practice Guide 1 – Screening for DFV). Risk must be reviewed and re-assessed continually. It is common for risk to fluctuate, including rapid escalation, as circumstances change. Evidence shows that there are particular circumstances where risk can escalate, including during and just after separation, during pregnancy, when there is an imminent release from custody, or during family court matters. At these times a new risk assessment should be completed.

How should DFV risk assessment be done?	Risk assessment involves: 1. a conversational assessment/s with the victim survivor, followed by 2. the completion of the CRAT. The CRAT uses structured professional judgement, which combines all three good practice and evidence-based elements: 1. **The client's own assessment of their risk, needs and safety:** Evidence shows that in many cases the victim survivor is the best judge of their level of risk, because they are most familiar with the patterns of behaviour of the person committing DFV against them. 2. **The presence of risk factors that, based on the evidence, indicate an increased likelihood of serious injury or death:** Findings from academic and practice-based literature, and reports produced by international and Australian DFV death review committees and Coroners' Courts, indicate that some risk factors are associated with a higher likelihood of violence re-occurring, serious injury, or death, in the context of intimate partner violence committed by men against women. 3. **The worker's professional judgement of the risk:** A worker's professional judgement of the level of risk to a victim survivor may override the level of risk indicated by the victim survivor's own responses, or by the evidence based factors. In addition, information held by other services may need to be accessed using client consent and/or information sharing legislation to complete a risk assessment.
TIPS – Preparing for risk assessment	**Risk assessment should not be undertaken if the person suspected of committing DFV is present.** Make sure the assessment is done away from the person suspected of committing DFV or by people who may inform the person who committed DFV. If DFV has been identified through a screening process or otherwise, the following steps are to be undertaken: • Prepare yourself to discuss the purpose of DFV risk assessment with the client. • The client can have a support person with them if they feel more comfortable. • When working with people whose English is limited, it is important to use interpreters. You can access interpreters through the Aboriginal Interpreter Service or through the Interpreting and Translating Service NT. • Check that you understand confidentiality and its limitations, including your mandatory reporting obligations. • Prepare for any children/dependents accompanying the victim survivor so that they are looked after and not present during conversations that may be distressing for them. • Remember that disclosing DFV always carries an element of risk for the victim survivor. This risk may be from the person who is committing the DFV, or from the service system, for example, how the worker or service responds to the disclosure or how the victim survivor perceives they may respond. • Before conducting a risk assessment, consider what effective responses are actually available to support the client, especially in areas where services are limited. You should do everything possible to improve the situation of safety for the client, but also be careful not to promise more than you are capable of within available resources. This can act to further erode trust with an already vulnerable client.

TIPS – Starting the conversation

One of the most effective ways to assess DFV risk is to have a conversation with the client. This provides a less formal atmosphere than filling in forms, reveals a more detailed picture of the situation, and develops rapport.

During an effective conversational assessment you should:

- build rapport by demonstrating care for the client and recognising their strengths;
- provide information about DFV;
- seek to understand the situation and risk the client is facing;
- seek to understand what assistance would be helpful from the client's perspective;
- understand what DFV responses are mandated by law.

Conducting a full conversational assessment with a client experiencing DFV takes time and requires a reasonable understanding of DFV. Proper assessment of risk is best done by specialist or trained workers who are able to provide the time and skill needed.

The CRAT can be used to guide the conversation but should not be done as a survey. The questions in the CRAT should be woven into a conversation that explores the client's experience and level of fear. The CRAT is designed to be completed by the worker when the client is not present, following one or more conversational DFV assessments.

It is important to inform the client if you will be completing the CRAT, and if possible gain their consent to do this. While consent should always be sought, the victim survivor's safety is the priority.

Explain that you are asking for information because you are concerned for their safety. For example:

Many people/women have problems with their family, their husband or partner or someone they live with, so we ask more questions about the safety of all our clients so that we can work out what kind of help is needed to keep you (and your children) safe.

I am a bit worried about you because [list the DFV indicators that are present]. I would like to ask you some questions about how you feel about your safety so that we can work out what kind of help you need to keep you safe.

We are doing this assessment to see how we can help you, I can fill in this form to work out the best way to help you.

I would like to talk to you to find out more so that I can understand, and so together we can work out any risk to you (and your children). Once we have done that, we can work out a plan to help keep you (and your children) as safe as possible. Are you OK to do this now?

Explain that participation is voluntary.

Acknowledge that some of the questions may be confronting and difficult to answer. Be aware of the distress and fear that disclosing DFV may cause.

Check that the client understands confidentiality and its limitations, such as your obligation to follow mandatory reporting procedures.

Always watch and listen closely to what is happening for the client during the conversation. If they appear upset, ask if they would like to stop or take a break. It is important that they go at their own pace and are not pushed to reveal information that they are not ready to.

TIPS – Guiding the conversation	***Ask questions to help you understand who is around the client, for example:*** *'Tell me about who lives in your house?'* *'Are there people in the house or community who you can't trust? '* *'Is there anybody that you worry about or anybody who is not safe or not OK?'* ***Ask questions to help you understand the behaviour of the person committing DFV, for example:*** *'Is anybody hurting you, treating you badly, acting the wrong way or doing bad things?'* *'Are the kids safe and if they are not safe who is making them unsafe? or do bad things happen to them? '* ***When asking the client to assess their own level of risk and safety, the following questions may be helpful:*** *How scared do you feel (eg, not at all scared, sometimes scared, really scared that I (and/or my children) will be seriously injured or killed)?* *What are you afraid might happen?* *Is the violence happening more often or getting worse?*
TIPS - Acknowledging disclosures	When a client discloses experiences of DFV, and talks about it in depth such as during an assessment, it is very important to respond in a supportive way. Take care that the client does not feel blamed for the DFV or responsible for making it stop, and hears the message that all people have a right to be and feel safe. It is important to recognise the client's strengths. Many will have strategies in place to keep them and their child/ren safe which may not be evident without further exploration. *I am sorry that that has happened to you.* *It is not your fault that this is happening.* *I will do what I can to support you.* *You have the right to feel and to be safe and I'm working with you and the people that I know to try to keep you safe.*
TIPS – Completing the CRAT	The CRAT is an evidence based tool which can be used to assess risk, particularly the risk factors which are predictive of harm or death for a DFV victim survivor. The CRAT can be used to guide the conversation but should not be done as a survey. The questions in the CRAT should be woven into a conversation that explores the client's experience and level of fear. The CRAT is designed to be completed by the worker when the client is not present, following one or more conversational DFV assessments. The CRAT combines evidence based risk factors (SECTION A), with the victim survivor's self-assessment of their risk (SECTION B) and the worker's professional judgement (SECTION C). Once completed, the CRAT provides an assessed level of risk and recommended actions to be taken to respond. For clients assessed as being at serious risk, the CRAT can also be used to refer a client to a Family Safety Framework meeting. This is discussed further in Practice Guide 3 – Managing DFV Risk. Clients can also be referred to MACCST.

TIPS – Completing the CRAT (Continued)

Workers need to discuss their risk assessments with their Team Leader or Supervisor for the accountability and safety of both the worker and the client.

A risk assessment using the CRAT may result in the following risk levels which can change and escalate at different points in time.

Risk level	CRAT scoring	Meaning
At risk	14	• While there is evidence of risk to a victim survivor's safety and wellbeing, high risk factors that are linked to an increased likelihood of serious injury or death are not present. • Other DFV risk factors are present. • The victim survivor's self-assessed level of fear and risk is not high and risk management and protective strategies such as safety plans are in place.
Elevated risk	15 – 27	• A number of risk factors including high risk factors are present. • Risk is likely to continue and increase if risk management is not initiated in response • The victim survivor's self-assessed level of fear and risk is elevated and safety is moderate due to activation of risk management strategies.
Serious risk	28+	• There are high risk factors present which indicate serious risk of harm or death. • Urgent action is necessary to prevent or lessen the risk. • The victim survivor's self-assessed level of fear and risk is high to extremely high and safety is low due to no or low activation of risk management strategies. • In the worker's professional judgement the victim survivor (including children and young people) is likely to be in serious and imminent danger if immediate action is not taken.

What needs to happen after a DFV risk assessment?	**All levels of risk require a risk management response.** After a risk assessment is made, the worker then manages the risk according to the risk level. For further details, see Practice Guide 3 – Managing DFV. DFV risk can change quickly so must be reviewed and responded to continually. Risk assessment is an ongoing process, not a one-off event. Remember to fulfil your record keeping responsibilities. If the client has experienced sexual assault (recent or historical) AND they consent to support contact a specialist sexual assault service.
Related resources	Practice Tool 7: Common Risk Assessment Tool **Story cards** are cards that can be used with a client to help identify and talk about forms of DFV, as well as aid in a risk assessment and management process. They can be useful to encourage discussion, and to assist clients whose english is limited to talk about DFV. The cards have pictures which depict different forms of DFV on one side, with plain English explanations on the other. NT Legal Aid and Tangentyere Council have both produced story cards that may be useful in DFV risk assessment and management. Story cards do not replace the CRAT, but can be used to start or assist the conversational assessment.

PRACTICE TOOL 7: NORTHERN TERRITORY DOMESTIC AND FAMILY VIOLENCE COMMON RISK ASSESSMENT TOOL (CRAT)

The CRAT is an evidence based tool which is used to assess and respond to DVF risk, particularly the risk factors which are predictive of harm or death for a DFV victim survivor.

For more information, see the RAMF Practice Guide 3: Managing DFV Risk.

Details of person completing this form			
Date form completed		**Worker name**	
		Organisation name	
Email		**Phone**	
Victim survivor details			
Name (and any other names victim survivor is known by)		**Date of birth**	
Gender	☐ Female ☐ Trans, gender diverse, non-binary ☐ Male	**Language/s spoken**	☐ Interpreter needed
Ethnicity		**Visa status**	
Aboriginal	☐ YES ☐ NO	**Home community**	
Primary address		**Contact number**	
Other locations the victim survivor has connections to			
Relationship to the perpetrator			
Has victim survivor previously been on FSF in relation to same perpetrator?			☐ YES ☐ NO ☐ UNKNOWN
Comments			

Children, young people accompanying victim survivors

	Child 1	Child 2	Child 3
Name			
Date of birth			
Gender			
Language/s spoken			
Ethnicity			
Aboriginal			
Home community			
Primary address			
Current location			
Primary carer			
Relationship to victim			
Relationship to perpetrator			

Perpetrator details

Name (and any other names perpetrator is known by)		Date of birth	
Gender	☐ Female ☐ Trans, gender diverse, non-binary ☐ Male	Language/s spoken	
Ethnicity		Visa status	
Aboriginal	☐ YES ☐ NO	Home community	
Primary address		Contact number	
Other locations the perpetrator has connections to			
Relationship to the victim survivor			
Is currently incarcerated (including on remand)		☐ YES ☐ NO	Date of release (if known): / /20
Comments			

SECTION A – EVIDENCE-BASED RISK FACTORS

Instructions:

- For each factor that is relevant, write the score for that factor in the right hand column.
- If the factor is not relevant, leave it blank.
- Do not put a partial score in. For example if the risk score for a factor is 3, put 3 in the right hand column (not 2 or 1.5).

Perpetrator's high risk behaviours towards victim survivor

If this risk factor applies, write the total risk score in the risk score column		Risk score
Has physically harmed the victim survivor	**3**	
Has used a weapon(s) or object(s) in violence towards the victim survivor	**3**	
Is intoxicated while being violent towards the victim survivor	**3**	
Started using DFV early in the relationship	**3**	
Has a history of violence against the victim survivor	**3**	
DFV (including physical and sexual violence, and coercive control) is becoming worse and/or more frequent	**3**	
Has tried to kill the victim survivor	**3**	
Has sexually assaulted the victim survivor or coerced them into unwanted sexual practices	**3**	
Has choked, strangled or suffocated the victim survivor or attempted to do so	**3**	
Has assaulted the victim survivor in a public place or outside the home	**3**	
Has stalked or monitored the victim survivor	**3**	
Has used highly coercive and or controlling behaviours	**3**	
Has threatened or attempted suicide and/or self-harm	**3**	
Has harmed or threatened to harm pets	**3**	
Has threatened to physically or sexually harm, or to kill, the victim survivor	**2**	
Has a reported or unreported history of violence against a previous partner (or previous partner is a missing person)	**2**	
Has breached court orders such as a DVO, bail or parole	**2**	
Has a history of other violent behaviour	**2**	
Has attitudes and/or cultural beliefs which support violence towards women / children / elderly	**2**	
Comments		

Child victim(s) (accompanying adult victim survivor, and aged under 18)

If this risk factor applies, write the total risk score in the risk score column		Risk score
Perpetrator has threatened to harm or kill the child/ren	2	
Child/ren has been in the adult victim survivor's arms or physically in between the victim survivor and the perpetrator when the victim survivor was attacked	2	
Perpetrator has physically harmed the child/ren	2	
Perpetrator has sexually harmed the child/ren	2	
Child/ren has tried to stop the perpetrator from being violent towards victim survivor	2	
Perpetrator unreasonably controls the child and disrupts the non-offending parent's relationship with the child/ren	2	
Perpetrator has emotionally harmed the child/ren	2	
Child/ren from a previous relationship is in the victim survivor's care	1	
Child/ren expresses / indicates through action that they are afraid of the perpetrator including saying that they don't want to have contact with the perpetrator	1	
Child/ren named on victim survivor's DVO and or has own DVO	1	
Comments		

Situational risk factors

If this risk factor applies, write the total risk score in this column		Risk score
Victim survivor is isolated (including isolated from family, friends, culture, services or supports)	3	
Perpetrator is due to be released from prison and or is currently on bail, remand and or parole in relation to violent offences	3	
There has been a recent separation or a planned separation in the near future	3	
Perpetrator is aged under 25 years	3	
Perpetrator has access to firearm(s) or prohibited weapon(s)	3	
Perpetrator has recently been denied or restricted access to the children	3	
Perpetrator misuses alcohol and/or other drugs	2	
Victim survivor is pregnant or has a new baby (within the last 12 months)	2	
Victim survivor is reliant on the perpetrator for their immigration status	2	
Perpetrator is involved in pending child protection matters	2	
Perpetrator's family actively support the perpetrator's use of violence and/or blames the victim survivor for the violence	2	
Perpetrator and or victim survivor's / perpetrator's family puts pressure on the victim survivor	2	

Perpetrator and/or victim survivor has recently experienced extreme social, economic, and/or environmental disruptions	2	
Perpetrator is experiencing employment or financial difficulties (including gambling)	1	
There is an actual or perceived new partner in the victim survivor's life	1	
Comments		
		TOTAL
TOTAL SCORE (add up the numbers in the Risk Score column and use the Total to identify the risk level by ticking the corresponding box below): ☐ AT RISK (0-14) ☐ ELEVATED RISK (15-27) ☐ SERIOUS RISK (28+)		

SECTION B: Victim survivor's assessment of risk for themselves and their child/ren
Instructions: Fill in the victim survivor's answers to these questions in their own words

How frightened is the victim survivor of what the perpetrator may do to them in the immediate future (eg, not at all scared, scared, terrified that I (and/or my children) will be seriously injured or killed)?	
Has the frequency and severity of the DFV violence (including physical, sexual and controlling violence) increased?	
Would the victim survivor ring police or someone they trust if they feel unsafe? And do they have the means to actually do this?	
Does the victim survivor think workers or the service is at risk from the perpetrator?	
What level of risk does the victim survivor believe they are at?	☐ AT RISK ☐ ELEVATED RISK ☐ SERIOUS RISK
Comments	

SECTION C: Worker's professional judgement and assessment of victim survivor's situation

Instructions: Tick and fill out the sections below if you are aware of any of these additional factors which make you believe there is an increased risk to the safety of the victim survivor, child/ren and/or others?

- [ ] **The victim survivor is 18 years of age or under. Comments:**

- [ ] **You believe the victim survivor's injuries are not consistent with explanations they have given. Comments:**

- [ ] **The victim survivor is homeless or in unsafe or insecure housing and or highly mobile. Comments:**

- [ ] **The victim survivor has a disability and/or is dependent on the perpetrator for day to day care. Comments:**

- [ ] **You believe children in the household are at risk of harm. Comments:**

- [ ] **The victim survivor is legally compromised (they have a warrant/DVO/are named on the Banned Drinker Register (BDR) / they have been imprisoned for violence against the perpetrator). Comments:**

- [ ] **The victim survivor is unlikely to disclose the violence to police or services due to their fear of increased risk, or of being blamed or losing children. Comments:**

- [ ] **The victim survivor describes using violence as a form of protection or resistance against the perpetrator's violence, and their use of violence is becoming more serious and frequent. Comments:**

- [ ] **The victim survivor misuses alcohol and/or other drugs. Comments:**

- [ ] **The victim survivor has diagnosed mental health issues and/or expresses wanting to end their life. Comments:**

- [ ] **The victim survivor is financially dependent on the perpetrator. Comments:**

- [ ] **There are other critical or imminent safety concerns including cultural / religious practices and customs, conventions, beliefs that may increase the victim survivor's risk. Comments:**

Indicate the level of risk the you believe the victim is at: NOTE: If in doubt, you should revise the risk level up.	☐ AT RISK ☐ ELEVATED RISK ☐ SERIOUS RISK

Comments

SECTION D: Overall risk assessment

Instructions: Record the level of risk from sections A, B and C and select an overall level of risk

AT RISK 0 – 14 | ELEVATED RISK 15 – 27 | SERIOUS RISK 28+

A	What was the risk level assessed in Section A: Evidence Based Risk Factors?	☐ AT RISK ☐ ELEVATED RISK ☐ SERIOUS RISK
B	What was the victim survivor's self-assessment of risk in Section B?	☐ AT RISK ☐ ELEVATED RISK ☐ SERIOUS RISK
C	What was your professional assessment of the victim survivor's level of risk in Section C?	☐ AT RISK ☐ ELEVATED RISK ☐ SERIOUS RISK
Based on this, tick the overall level of risk? NOTE: If in doubt, you should revise the risk level up.		☐ AT RISK ☐ ELEVATED RISK ☐ SERIOUS RISK

Tick how imminent the risk is (imminent means that you believe that death or serious physical harm could occur within a short time)

☐ NOT IMMINENT ☐ IMMINENT

SECTION E: Positive actions for workers to respond to the assessed level of risk

Instructions: Take positive action appropriate to the assessed level of risk. A referral to the FSF can be made if the risk is assessed as serious.

LEVEL OF RISK	POSITIVE ACTIONS FOR WORKERS TO TAKE	TOOLS
AT RISK	• Discuss and explain that client, child/ren or both are at risk of being harmed by the perpetrator • Make mandatory report if required (with the client if possible) • If client has experienced sexual assault (recent or historical) AND they consent to support contact specialist sexual assault service. • Address IMMEDIATE safety by calling police on 000 or 131 444 if there are immediate concerns for the safety of the client and or their child/ren • Address safety by developing a SAFETY PLAN • Consider referral to specialist DFV service • Consider referral to MACCST	• Practice Guide 3: Managing DFV Risk • Practice Tool 8: Safety Plan
ELEVATED RISK	• Discuss and explain that client, child/ren or both are at elevated risk of being harmed by the perpetrator • Make mandatory report if required (with the client if possible) • If client has experienced sexual assault (recent or historical) AND they consent to support contact specialist sexual assault service. • Address IMMEDIATE safety by calling police on 000 or 131 444 if there are immediate concerns for the safety of the client and or their child/ren • Address safety by developing a SAFETY PLAN • Consider referral to specialist DFV service • Consider referral to MACCST	• Practice Guide 3: Managing DFV Risk • Practice Tool 8: Safety Plan

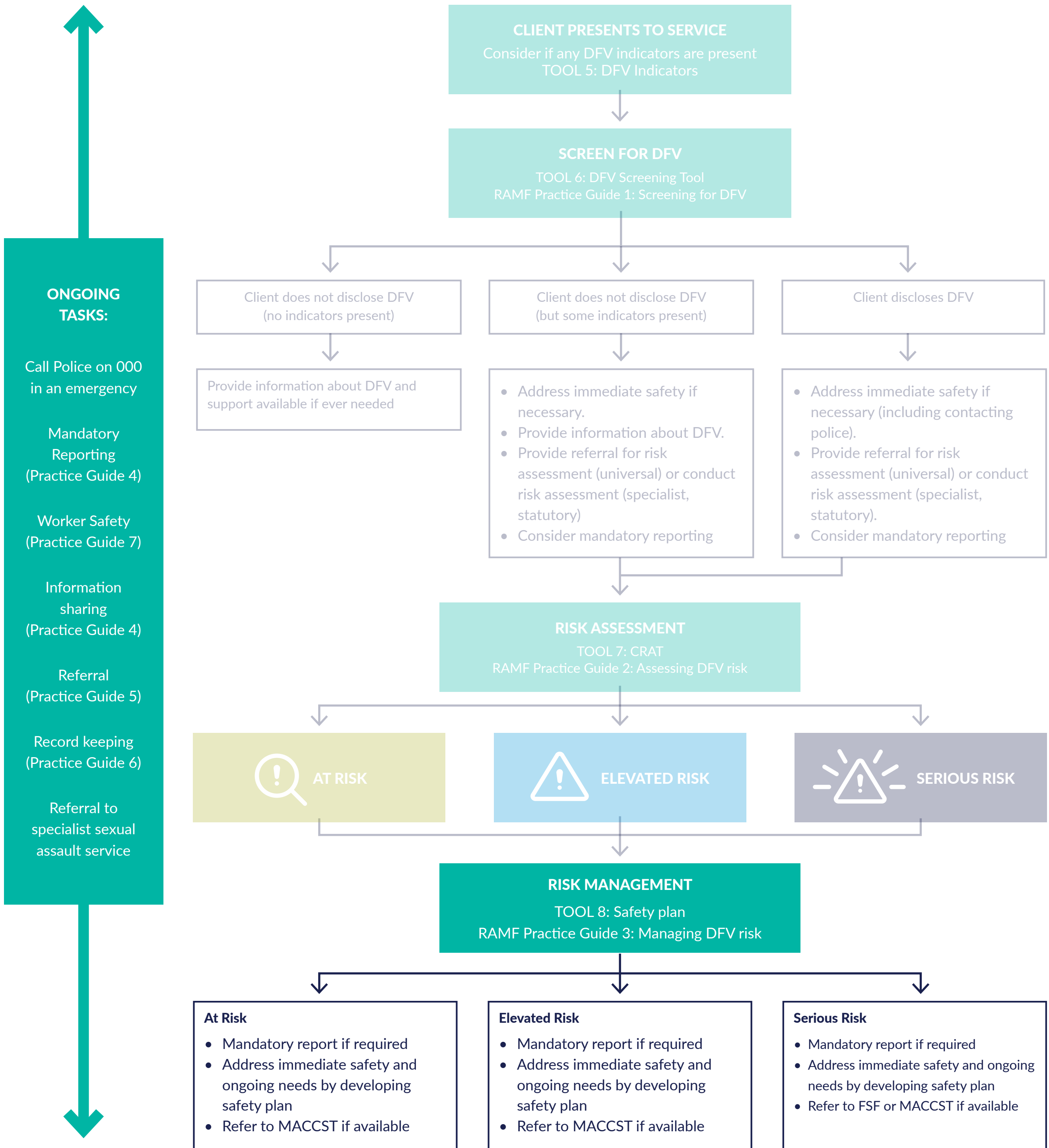
SERIOUS RISK	• Discuss and explain that client, child/ren or both are at risk of being seriously harmed or killed by the perpetrator • Make mandatory report if required (with the client if possible) • Refer the client to the nearest Family Safety Framework if one operates in your region (Alice Springs, Darwin, Katherine, Nhulunbuy, Tennant Creek, Yuendumu) • If client has experienced sexual assault (recent or historical) AND they consent to support contact specialist sexual assault service. • Address IMMEDIATE safety by calling police on 000 or 131 444 if there are immediate concerns for the safety of the client and or their child/ren • Address safety by developing a SAFETY PLAN • Consider referral to specialist DFV service • Consider referral to MACCST	• Practice Guide 3: Managing DFV Risk • Practice Tool 8: Safety Plan

SECTION F: Reporting record

Mandatory report of child abuse and neglect			
Time Sent	AM ☐ PM ☐	Date:	
Reported by:			
Reported to:			
REF/PROMIS#:			
Comments			
Mandatory report of DFV			
Time Sent:	AM ☐ PM ☐	Date:	
Reported by:			
Reported to:			
Comments			
REF/PROMIS#:			
Referred to FSF			
Time Sent:	AM ☐ PM ☐	Date:	
Referral by (Worker name, agency, contact details):			
Referral to:	☐ Alice Springs FSF (FSFAliceSprings@pfes.nt.gov.au) ☐ Katherine FSF(FSFKatherine@pfes.nt.gov.au) ☐ Tennant Creek FSF(FSFTennant@pfes.nt.gov.au)	☐ Darwin FSF (FSFDarwin@pfes.nt.gov.au) ☐ Nhulunbuy FSF (FSFNhulunbuy@pfes.nt.gov.au) ☐ Yuendumu FSF (FSFYuendumu@pfes.nt.gov.au	
Total Score: (Enter total CRAT score in this box)	Has the victim survivor given consent to the FSF referral? Yes ☐ No ☐ If no, why not? Please always consult your Team Leader/Manager or your FSF delegate in preparing a referral or notification.		
Please keep this form in your records.			

PRACTICE GUIDE 3: MANAGING DFV RISK

This practice guide provides information, resources, tools and practice tips about DFV risk management, including what it is, why it is required, when it should be used, who should do it and how it should be done safely and effectively.



PRACTICE GUIDE 3: MANAGING DFV RISK

Everyone in the service system has a role to play in risk management. Comprehensive DFV risk management is best done by trained or specialist workers. However, responding to immediate risk, including emergency risk management responses, is the responsibility of all workers.

REMEMBER: All adults must comply with their existing legal obligations under mandatory reporting laws – see Practice Guide 4 Shared Legal Responsibilities.

It is best practice to inform the client of your responsibility to report DFV, and child abuse and neglect, as early as possible in the interaction, provided this does not compromise their safety.

NOTE: IF THE CLIENT (OR ANY OTHER PERSON) IS IN IMMEDIATE DANGER, CONTACT POLICE.

Emergency risk management

If a client's safety or life is in immediate danger, your first responsibility is to take whatever steps are necessary to keep the client safe, while also maintaining your own safety. In these situations, waiting for any other risk management response may be too late.

An emergency or crisis risk management response may include:

- contacting police on 000
- assisting the injured client to access emergency medical care, by calling an ambulance, or assisting them to go to the nearest clinic, health centre, doctor or sexual assault service;
- assisting the client to identify a place they can go to be safe from immediate violence and assist them to get there (by booking a taxi or accessing public transport);
- calling night patrol if available;
- contacting a person who can help the client to be safe (with the person's permission) this may be a safe family or community member, or a service;
- contacting police to help the client collect belongings from their home;
- helping the client to get to a place where they believe they will be safe; and
- helping the client get to a safe house or refuge.

What is DFV risk management?	Risk management is a series of actions (often contained in a safety plan) that may be done by workers in order to remove, reduce or mitigate the risk factors identified through a DFV risk assessment, in particular those that increase the risk of the victim survivor being killed or seriously harmed. Risk management responses and actions will include any one or a combination of the following: • responding to immediate risk; • mandatory reporting; • engaging the Family Safety Framework or other interagency responses;

What is DFV risk management? (Continued)	• safety planning (immediate and ongoing); • information sharing; • secondary consultation; • referrals; • ongoing risk assessment and management monitoring through case planning; and • ongoing case management.
Why is DFV risk management important?	The fundamental aim of risk management is to increase the safety of victim survivors. If risk is not managed, or not managed adequately, the safety of victim survivors may be compromised. This could result in serious injury and death.
Who should do DFV risk management?	Everyone in the service system has a role to play in risk management. Comprehensive DFV risk management (such as safety planning, FSF referrals, and coordinated case management) is best done by trained or specialist workers. However, emergency risk management responses (such as an initial referral to a specialist service, a mandatory report, or calling the police in an emergency) are the responsibility of all workers. Risk management can include actions taken by a service as a first responder or be delivered by a group of services. DFV risk management is most successful when there is a service or agency which is identified as the lead or case coordinator. Ideally, managing the risks to a victim survivor should be coordinated with the risk management of the person committing DFV against them.
When should DFV risk management occur?	Risk management is required for all people who have been identified as experiencing DFV, regardless of their level of risk. Risk management occurs after a risk assessment has been completed and DFV risk has been assessed as present. Risk management can be short term to minimise or mitigate the risk of a DFV incident occurring, or minimise or mitigate the severity of that incident. It also includes increasing safety and reducing the likelihood of continued violence in the medium to long term. Risk management is required whether the victim survivor has decided to stay in, or leave, the violent or controlling relationship. When the victim survivor has decided to stay in the relationship the risk continues and must be managed in an ongoing way. Risk management may occur numerous times over the life of a relationship. When the victim survivor is planning to separate, or has recently separated or moved away from the person who commits DFV, the risk of serious harm or death from DFV increases.

How should DFV risk management be done	Risk management is a dynamic, active and collaborative process. Risk management should respect the agency and dignity of victim survivors by partnering with them as active decision makers, where this does not compromise safety. Where DFV risk has been identified through the CRAT or other risk assessment process, there are a range of risk management strategies that workers can use. See below for more details.
TIPS - Preparing for risk management	Risk management conversations should not be undertaken if the person suspected of committing the DFV is present, or if other people are present who may inform the person who committed the DFV. The client can have a support person with them if they feel more comfortable. Find a private and safe area. Some services including remote health clinics have women and men only spaces which can be private and safe enough to discuss DFV. Ask the client about the best and safest way to communicate. It is ok to have a DFV risk management conversation by phone, as long as you clarify that the client is alone or with a trusted person and that it is safe to speak. When working with people whose English is limited, it is important to use interpreters. You can access interpreters through the Aboriginal Interpreter Service or through the Interpreting and Translating Service NT. Check that you understand confidentiality and its limitations, including your mandatory reporting obligations. Prepare for any children/dependents accompanying the victim survivor so that they are looked after and not present during conversations that may be distressing for them. You should maintain the principle that the non-offending parent is not responsible for any harm caused to the children. Remember that disclosing DFV always carries an element of risk for the victim survivor. This risk may be from the person who is committing the DFV, or from the service system, for example, how the worker or service responds to the disclosure or how the victim survivor perceives they may respond. You should always seek to provide choices and options to the client. It is important that the client is in charge of what happens in response to their experience and that responses they are not comfortable with are not actioned (unless it is to protect a child or young person at risk of harm, manage mandatory reporting requirements or effectively manage the risk of imminent serious injury or death). Remember that making a decision or beginning to plan to leave a relationship with a person committing DFV is a high risk period for an escalation of, and/or change in violence, including increased risk of being killed or seriously harmed.

Starting the conversation with the client	Check that the client understands confidentiality and its limitations, such as your obligation to follow mandatory reporting procedures. You could start a conversation about risk management by discussing the risk assessment outcome with the client. Explain that the client and/or their child/ren are at risk of being harmed by the perpetrator. Explain that, based on the outcome of the risk assessment you've undertaken, you need to work together to develop actions to support their safety. For example: ***"I'd like to talk to you about how we can help to keep you (and your children, if applicable) safe."*** Continue to keep the client's wishes and needs central to your planned risk management actions, while maintaining safety as the first priority. Recognise that the client has often been taking their own actions to manage the risk of DFV, including to children, and may have been doing so for a long period of time. Identify those actions that continue to work and which ones are no longer helpful or need to be changed. ***"You have demonstrated strength and resilience in managing your own (and your family's) safety — how have you done this in the past and how can we best support you with this?"*** ***"It is must be very difficult for you at times to keep yourself and the kids safe, and I know there are lot of things you have done in the past to keep them safe. I would really like to hear about the times when you think your plans have worked."*** ***"It must be really hard to get help. I would really like to hear how you have got help before."*** ***"Who helps you when you need help?"*** ***"Who do you trust?"*** ***"Where do you go when you need help?"*** ***"Now that I understand a little bit about what is happening, I'm wondering what is most important to you?"*** ***"There are many things we could focus on trying to change but I really would like to know which one you think we should choose first?'*** ***"Where do you go when you need help?"***

Risk management actions	Risk management actions may include:
	- making a mandatory report if required (with the client if possible); - addressing IMMEDIATE safety concerns by calling police on 000 or 131 444; - working with the victim survivor, their supports, and other services to develop an immediate and ongoing safety plan (see more information about safety planning below); - seek secondary consultation or referral to a specialist DFV service for comprehensive risk management; - making a referral to a specialist DFV service or to other relevant services such as legal services, court advocacy and support, safe accommodation, transport to a safe place. - for a list of services see https://nt.gov.au/law/crime/domestic-family-and-sexual-violence/get-help-for-domestic-family-and-sexual-violence and Practice Guide 5 – Referrals; - sharing information relevant to the risk and the client's safety with other services, and also share information to keep the person committing DFV's location and tactics in view (see Practice Guide 4 – Shared legal responsibilities); - needs assessment, case management and case coordination to address ongoing needs such as mental health concerns, social and emotional wellbeing, homelessness, and financial needs; - if the client has been assessed as at serious risk in the CRAT, and a FSF is operating in the region, making a referral to the Family Safety Framework (see more information about the Family Safety Framework below); - consider referral to MACCST; - making a referral to a specialist sexual assault service, if the client has experienced sexual assault (recent or historical) AND they consent to support; and - working together with other services to collaborate to meet the needs of the client.

What is safety planning?	Safety planning is a part of risk management. All DFV victim survivors should be supported to have a safety plan, regardless of the level of assessed risk. Safety planning involves discussing with a client what practical actions you can take or coordinate with other services to manage risk from the person committing DFV and meet the client's immediate safety needs. Safety planning can also include practical actions the client can take to reduce harm or remove themselves from harm, including assisting the client to identify their existing supports and strengths. Most victim survivors have developed a number of strategic and creative ways to keep themselves and their children safe, but may not have developed a formalised or written plan. It is dangerous for services to assume that they know what will keep victim survivors safe in situations of DFV. Safety planning starts with an understanding and assessment of what the client needs. Immediate safety is the first priority, and there will be times when the safety plan is only able to address this immediate need. While safety needs are the first priority, where there is time to do an ongoing safety plan, this should be prioritised according to the client's preferences and availability of services. These may include housing, legal help, financial support, physical and mental health, counselling, sexual violence responses, education and employment needs, children's needs, help with pets and transport needs.
Developing a safety plan	Safety plans are developed in partnership with the client. Responsibilities for actions are shared between the client, the worker(s), and a range of other relevant services. It is crucial to recognise that a client is not responsible for developing their own safety plan – this is the responsibility of the service(s) and worker(s). Safety plans can also include the client's family and friends. You should guide the client through a safety planning process that respects their knowledge of the behaviour by the person who is committing DFV and their understanding of what will keep them and their children safe. For some workers, safety planning is part of case management and case coordination processes. Some clients will already have a safety plan in place, and you can ask the client if they have a safety plan - whether it is written or not, and the details of this plan, and whether it needs reviewing. A safety plan builds on what the client is already doing to keep safe and what works for their circumstances, as well as how the worker can support them. A safety plan should: • be done collaboratively with the client; • be relevant to the client and their family's own circumstances, for example, consider safety at home, at work, going to and from work, in public places, at places frequented, such as school, childcare centre, safety online and on devices; • be documented and kept by the client and worker(s). If it is unsafe for the client to keep a copy at home, consider an alternative place to keep it; • identify actions, individuals and services responsible, and timelines;

Developing a safety plan (Continued)	• be tailored to the client's situation, including whether they are living with the person who commits DFV, considering leaving the person who commits DFV, or have left the person who commits DFV; • clearly outline the responsibilities of the worker and what the client and worker agree that they will each do; • clearly outline what other services or people can do to assist the client; • be regularly reviewed and updated based on ongoing risk assessment. Most of the time victim survivors will have multiple different needs and it will be impossible for one person or service to respond to them all. Collaboration with others is necessary to effectively respond to DFV needs. It is important to ask the victim survivor about their experiences in engaging with services, and what organisations/types of services have been involved (police, health, housing, immigration, legal organisations, schools). Finding the right response to each need can be challenging. Workers will often have to: • listen closely to find possible solutions that might work for the client; • think creatively to come up with ideas that other people haven't already thought of; • use their networks to provide access to support when there are few services available locally; and • most importantly, build a trusting and respectful relationship with the client. This will maximise the client's willingness to try different ideas and ensure that the client is participating in finding responses and bringing their knowledge and expertise about their own situation to the safety planning process.
Tips for safety planning	These are some of the questions to consider in creating a safety plan: **Where are safe places for the client?** *Where can you go to be safe when the violence/control is likely to happen or starts to happen? (If possible, find several options).* *How would you get to a safe place when you need to? (Identify possible barriers to easily access to a safe place and problem solve these together).* *What practical assistance do you need, such as emergency relief that can help pay for transport, a prepaid telephone, and immediate safe accommodation?* *What practical support do you need to relocate (if this is a safe and chosen option)?* *What potential social supports are there in the new place?* **Who can support the client?** Offer to contact them together, such as: • Domestic Violence Legal Services, Women's Legal Services, Family Violence Legal Services, Aboriginal Legal Services - to apply for or vary a DVO, family law, child protection and other legal support and advice. • police to apply for a DVO and/or report DFV offence(s) • police to request a job PROMIS number and officer name for a recent DFV event that police attended

Tips for safety planning (Continued)	• the probation/parole officer who is monitoring the person committing DFV and report any breaches of their obligations. • the Victims Register (when the person who committed DFV has been sentenced) or the Witness Assistance Service (when the person who committed DFV has not been sentenced) to gain information about the person's movements, for example parole or release from jail • specialist counselling support (where available) to resolve trauma impacts and disrupt the cycle of violence. • trusted family members, friends, healthcare providers, employers, education staff, or childcare providers – help the client provide information about the DFV so that these supports can assist to keep people (including children/dependants) safe. (Sometimes it can be helpful to provide these people with a copy of the DVO and a recent photograph of the person perpetrating DFV.) • the Victims of Crime 'Safe at Home' Assistance scheme may be able to provide reimbursement for improving security around the home. *Who is there in your community who can positively influence the person perpetrating violence and/or control so that they cease the unsafe behaviours?* Support children who feel able to call police to practice what they would say if they need to call police e.g., 'My name is, my mum / dad / parent is being hurt by ...., and my address is...................'
Using the safety planning template (Practice Tool 8)	The safety planning template allows for immediate safety needs to be considered as the first priority, as well as broader and longer term safety needs. It may be that the broader and longer term safety needs are not able to be considered until after the client's immediate safety needs are addressed.
Making a referral to the Family Safety Framework	The FSF operates in six locations in the NT – Darwin, Nhulunbuy, Katherine, Tennant Creek, Alice Springs and Yuendumu. The FSF is an action-based, integrated service response to people experiencing DFV who are at high risk of imminent and serious injury or death. A victim survivor that has been assessed as being at serious risk using the CRAT can be recommended for referral to the FSF. The worker completing the CRAT should discuss this recommendation with their team leader/supervisor, or the FSF delegate in their organisation. The referral consists of the CRAT being sent to the relevant FSF Chair. There is no additional referral form that needs to be completed. The client will then be discussed at a Family Safety Meeting (FSM) which is a fortnightly meeting chaired by the local Officer in Charge of the NT Police Domestic Violence Unit, and includes government and non-government agencies. Government agencies include Northern Territory Government Department of Attorney General and Justice, NT Corrections, Department of Education, Department of Health, and Territory Families, Housing and Communities. Non-government agencies include specialist DFV services in the region. At the FSM, members receive referrals, share information, agree on actions to improve safety for the person referred, and monitor and review how those actions have improved safety. Do not stop working with the client because you have referred them to the FSF. You should continue responding to any immediate safety concerns and ongoing needs as well as making this referral.

What if there is no Family Safety Framework in my area?	The FSF is just one part of managing DFV risk. If there is no Family Safety Framework meeting operating in the region, you can still take other relevant risk management actions as outlined above. You can also work together with other relevant services to collaborate to respond to the safety needs of the client. You may also be able to refer to MACCST.
What needs to happen after risk management?	DFV risk and needs can change quickly and so risk management responses in relation to those risks must be reviewed and responded to continually. Managing DFV risk is an ongoing process, not a one-off event.
Related resources	Practice Tool 8: Safety Plan Practice Tool 9: E-Safety

PRACTICE TOOL 8: SAFETY PLAN

All victim survivors of DFV require a safety plan, regardless of the level of assessed risk. The safety plan clearly outlines the responsibilities of the worker and what the victim survivor and worker agree that they will each do. It is developed with the victim survivor and should begin by asking her what she already does to keep herself and her children safe. The plan should be documented and kept by the victim survivor (if safe) and worker(s), and should be regularly reviewed and updated based on ongoing risk assessment.

For more guidance see RAMF Practice Guide 3: Managing DFV Risk

	Worker safety planning checklist
☐	Assist with access to a mobile phone and /or free call for help and support.
☐	Help the person connect to workplace supports including DFV Leave, workplace safety planning tools, emergency contacts and identify trusted workplace colleague(s).
☐	Help the person create signals and/or code words and share them with neighbours, friends or family members so that they will know when it is necessary to call for help or to visit if safe. Examples of signals are a turned-on front light, a closed curtain, or a sentence such as 'I can't come over on Thursday after all' spoken over the telephone.
☐	Assist with arrangements for someone to care for pets if this is needed.
☐	Help the person prepare to quickly access to information they might need in a DFV emergency e.g. keeping the telephone number of the local police station and a note of the street address and nearest cross street easily accessible.
☐	Help the person download the Emergency+ app which provides emergency services location information via coordinates. This app can work also in places where there is no phone reception.
☐	If the person experiencing DFV wishes to leave the person committing DFV, talk with the person about the safest ways and times to leave e.g. think about leaving when the person perpetrating DFV is away from the house or away from the community, and think about who can help you make a safe and strong plan to leave.
☐	Help the person who is experiencing DFV to identify who would be able to assist them to pack up and leave if they chooses to exit the home quickly.
☐	Help the person who is experiencing DFV create a list of emergency help contacts (including police) on paper or on a mobile device. Alternatively, help them download the shelterme app which is free and contains all the local and national crisis services in their area.
☐	Assist the person who is experiencing DFV to check in regularly with someone they trust and create a plan for what the trusted person should do if they don't hear from them. For example, a trusted person may be someone who works at the community store, the local health clinic or the children's school.

Worker safety planning checklist

- ☐ Assist the person to develop and rehearse (either physically or mentally) an escape plan to use when violence or control is happening or is likely to happen. It is recommended to develop and rehearse a second (back-up) plan also so that if the first plan doesn't work, the back-up plan can be used.
- ☐ Assist the person to identify ways it might be possible to keep a small amount of money aside for use in a DFV emergency.
- ☐ Help the person to save or document evidence of abuse e.g. abusive texts, phone messages, emails and screenshots of social media.
- ☐ If there has been physical violence, assist the person to take photographs of injuries or take photographs of injuries for their own records (only with their consent). This evidence can be used to assist with obtaining a DVO or providing evidence of a breach of a DVO.
- ☐ Assist the person to check if their online presence is being monitoried or mirrored including through shared passwords on phones, shared social media accounts and other electronic devices.

When victim survivors leave violent partners it is important to take certain items with them.

Help the person experiencing DFV to prepare a safe escape bag and place the safe escape bag where she will be able to access it in an emergency e.g. at a friend's house.
Consider the following contents for the safe escape bag below

- ☐ Spare keys
- ☐ Important documents such as DVO, birth certificates, passports and visas, bank records, bank cards and driver's licence
- ☐ Medications, prescriptions e.g. asthma puffer
- ☐ First Aid kit
- ☐ Clothes
- ☐ Cash
- ☐ Toiletries
- ☐ Torch
- ☐ Batteries
- ☐ Wet wipes
- ☐ Glasses, contacts, hearing aids and any other medical devices
- ☐ Sleeping bag or blanket
- ☐ Dummy, nappies
- ☐ A telephone and charger (preferably one that the person perpetrating DFV cannot track)
- ☐ Children's favourite toy or book
- ☐ Pet bowl, lead and pet food if needed
- ☐ Any items that are very important to the person experiencing DFV and irreplaceable e.g. photograph of a deceased relative.

SAFETY PLAN TEMPLATE

Instructions: After reviewing the safety planning information in the RAMF Practice Guide 3: Managing DFV Risk, complete the safety plan template below. All DFV risk requires a safety plan.

Part One below responds to the immediate safety needs of the client, and should be filled out using the checklist provided above.

Part Two responds to ongoing safety needs. It may be that it is only possible to complete Part One of the safety plan with the client until their immediate safety is established, at which time Part Two can be completed.

Every safety plan will be unique and based on the needs of the client– you should be guided by them on what is important and safe for them in their safety plan.

Worker Name		**Organisation name**	
Client Name		**Date form completed**	
Other workers/ services engaged in responding to DFV needs:			
Comments			

PART ONE: Immediate safety planning action table		
Who	**What**	**By When**
Trained or specialist worker		
Other organisations working with the client		
The client and their support network		

PART TWO: Ongoing safety planning action table				
Needs identified by victim survivor	How will these needs be met?	Service or agency which can best respond to this need	Actions taken to meet this need	Date that actions were taken
Monitoring perpetrator eg bail and parole supervision				
Safe accommodation e.g. home security / replace locks, safe place with family, refuge accommodation, access to safe house when needed or transport to safety				
Medical care e.g. injury management, access to medication, assistance to attend for dialysis, STI testing and response				
Response to trauma e.g. access to health, legal and other systems through multiple pathways, flexible services that provide predictable and continuity of care				
Responses to sexual violence including child sexual assault e.g. Access to forensic testing, sexual assault counselling, medical management that give privacy and protection from blame and safe accommodation				
Help for the children e.g. childcare, play therapy, counselling, transport to and from school, school holiday and after school activities, positive role modelling				
Safety for pets e.g. transport, safe relocation				
Education about DFV e.g Information about responsibility for violence, sharing experience of and resistance to violence				
Empowerment e.g. building confidence by learning a new skill like learning to drive or swim; learning and improving literacy, learning English; employment and training, helping other victim survivors				
Financial assistance e.g. assistance to open a bank account, redirect Centrelink benefits, access to emergency funds; manage internet banking				
Legal Assistance e.g. assistance to make changes to a DVO, advice about charges and court processes, family law assistance, visa assistance, court support and advocacy				
Access to belongings and essentials e.g. police assistance to access belongings from the home; emergency supplies of food, nappies, clothing, bedding				
Transport e.g. transport to a safer community, transport to work, medical and legal appointments, transport to safe accommodation, finding ways to pick up children from school				

PART TWO: Ongoing safety planning action table

Needs identified by victim survivor	How will these needs be met?	Service or agency which can best respond to this need	Actions taken to meet this need	Date that actions were taken
Assistance with e-safety e.g Help with changing settings on devices, information about privacy settings				
Social support e.g. help identifying people including family who can support in everyday life				
Language solutions e.g. interpreter services for legal appointment and other case management actions				
Maintenance of cultural/religious practices e.g. returning to country or home community, regular contact with safe and supportive family and elders, or attending religious services				
Workplace safety e.g. assessment of victim survivor safety in the workplace, access to paid leave or flexible work				
Any other needs identified by victim survivor				

PRACTICE TOOL 9: E SAFETY

Mobile phone, tablets, computers, smart watches and other devices hold personal information like photos, calendar appointments, call histories, emails and social media posts. Technology assisted stalking and abuse is more than likely to be used by the person committing DFV to monitor and control their partner during the relationship as well as after separation, so it is important to be aware of the risks.

Actions to increase e-safety

- Make sure the victim survivor is aware that hidden cameras may be installed in their home or may be accessed remotely on their phone or computer's camera (through spyware).
- Talk with the victim survivor about trusting their instincts. If they suspect that the person committing DFV is harassing, stalking or monitoring them with technology, it is possible and likely.
- Talk with the victim survivor and people close to them, including children, to understand the safety risks of posting on social media such as photos that identify where they are.
- Make sure 'location' is turned off on mobile devices.
- Make sure the victim survivor's devices can't save passwords, sign-in to accounts automatically, and that the victim survivor can keep log-in details to all of their accounts safe.
- Help the victim survivor learn how to delete their history in the Internet browser they use.
- Help the victim survivor open new private email and social media accounts without information about themselves in the settings e.g. profile picture or location.
- Help the victim survivor to set privacy settings to block others.
- Help the victim survivor to know how to sign out completely.
- Help the victim survivor change passwords and PIN numbers (on a safe computer).
- Help the victim survivor to activate 2 step logins. This is an extra security measure that asks for a security code that is sent via email or mobile e.g. mygov website.
- Encourage the victim survivor to use the **SmartSafe+** App to collect evidence of DFV safely. https://www.dvrcv.org.au/file/smartsafe-mobile-app
- Encourage the victim survivor to consider their own (prepaid, private) mobile phone and not use their old SIM card. Tell them to handwrite important numbers and manually enter them into the private safe phone.
- Help the victim survivor to check for unusual apps on theirs/their child's phone and to delete them if they think it is safe to do so.
- The victim survivor can turn their device to 'airplane mode' to avoid being tracked.
- Finally, make sure they auto-lock their mobile device with a PIN.

GPS tracking devices are easily available and can be hard to see. They are mostly the size of a postage stamp. Computer spyware is also easy to purchase and install on home computers, devices, smartphones and watches. This allows the person committing DFV to track and access what the victim survivor is doing and seeing. A device or smart watch can also be turned into a GPS tracking tool and a listening or recording device.

Often, the victim survivor wants to stop the stalking behaviour by getting rid of the technology. However, this could escalate the controlling and dangerous behaviour if the person committing DFV feels they are no longer in control. Workers should think about what might happen if the victim survivor removes the device. Another option could be for the victim survivor to use a safer computer and/or device whilst keeping the one being monitored.

SIGNS SOMEONE IS BEING MONITORED

Does the person committing DFV seem to know the victim survivor's location?

Has the victim survivor noticed any strange activity on their phone?

Does the person committing DFV have access to the victim survivor's mobile phone, social media accounts, bills or passwords?

Does the person committing DFV know what the victim survivor is doing when they are home alone?

Does the person committing DFV seem to know where the victim survivor goes even when they don't have their mobile? It might not be their mobile, it could be a GPS tracker or other technology.

Does the victim survivor experience a quick battery drain or a spike in data usage? This can indicate that spyware is running on their mobile phone.

PRACTICE GUIDE 4: SHARED LEGAL RESPONSIBILITIES

This practice guide provides information, resources, tools and practice tips about information sharing and mandatory reporting of domestic and family violence, and child abuse and neglect, including what it is, why it is required, when it should be used, who should do it and how it should be done safely and effectively.

Shared legal responsibilities apply to universal, and specialist or trained workers.

What is information sharing?	**Information sharing** refers to workers and services sharing relevant information about a victim survivor's DFV risk factors and management strategies, and about the whereabouts and behaviour of the person committing the DFV. Relevant information can be shared with the informed consent of the client. Information sharing without consent may be authorised (or required) under a range of legal frameworks, such as mandatory reporting, the DFV Information Sharing Scheme, Part 5.1A of the Care and Protection of Children Act 2007, and the Information Privacy Principles. Under the *Domestic and Family Violence Act*, information sharing entities must align their policies, procedures and practice guidance with the RAMF.
What is mandatory reporting?	**Mandatory reporting** refers to the obligation to report DFV and child abuse, harm or exploitation to police under NT laws. A failure to report to police (or to NT Government in relation to children) can be considered an offence. The following mandatory reporting obligations in relation to DFV apply to all adults in the NT: • all adults must report DFV to police as soon as practical, if they reasonably believe that serious DFV related physical harm has or is likely to occur, or if someone's life or safety is under serious or imminent threat from DFV (Section 124A of the *Domestic and Family Violence Act*); • physical harm can be temporary or permanent and it can include unconsciousness, pain, disfigurement, infection with a disease, any physical contact that a person might object to (whether or not they are aware of it at the time). 'Serious physical harm' is any physical harm that endangers or is likely to endanger a person's life or where the effects are longstanding; • all adults must report their concerns if they reasonably believe a child is at risk of harm, abuse or exploitation. Harm to a child includes a child witnessing violence (Sections 15 and 26 of the *Care and Protection of Children Act*). The responsibility to mandatorily report lies with the individual. In the workplace, line managers can provide advice but cannot direct staff not to make a report.

Why are information sharing and mandatory reporting important?	The benefits of timely and appropriate **information sharing** in assessing and managing DFV risk can include: • a more comprehensive picture of the DFV situation which can save lives and prevent serious harm, as well as hold to account people who commit DFV; • multiple types of safety needs responded to simultaneously and more efficiently; • a consistent approach that is better understood by the client and better implemented by multiple services; and • victim survivors not having to repeat their story to each new service they come into contact with. Many different services such as police, specialist DFV services, child protection, youth justice, and health services can become involved in an individual case, and each service may hold different information about the relevant risks. Effective sharing of this information brings together information that would otherwise be unknown, to gain a more comprehensive picture of the DFV situation, the risk, and the risk management needed. Sharing information also enables effective, coordinated responses and collaborative practice between services, in order to manage DFV risk. **Mandatory reporting** of DFV and child abuse, harm or exploitation is a legal obligation that acknowledges the prevalence, seriousness and often hidden nature of DFV, child abuse and neglect, and enables early detection of cases that otherwise may not come to the attention of agencies. Mandatory reporting requirements reinforce the moral responsibility of all adult community members to report, and help to create a culture of shared responsibility.
Who should do information sharing and mandatory reporting?	All services are responsible for safely sharing relevant information about DFV risk assessment and management. Information may be shared with the consent of the client, or under legislation. Under the DFV Information Sharing Scheme, certain agencies are designated as Information Sharing Entities (ISEs). ISEs can share information with other ISEs, without the consent of the client, in order to assess, lessen or prevent a serious threat to a person's life, health, safety or welfare because of DFV. All relevant government agencies and non-government schools are prescribed as ISEs. Other government and non-government organisations may apply to become ISEs in order to participate in the scheme. The application form as well as a full list of ISEs is provided on the NT Government DFV Information Sharing website. Under Part 5.1A of the *Care and Protection of Children Act 2007*, information about children may be shared by authorised information sharers. Mandatory reporting obligations in relation to DFV and child harm, abuse or exploitation, apply to all adults in the NT. Certain professionals (such as health practitioners) have additional reporting obligations. Services covered by the Information Privacy Principles (under the *NT Information Act* 2002) may share information if they reasonably believe that the use or disclosure is necessary to lessen or prevent a serious or imminent threat to an individual's life, health or safety, or of harm to, or exploitation of a child.

When should information sharing and mandatory reporting occur?	Relevant information may need to be shared at any point in the risk assessment and management process, including during screening, risk assessment, and risk management (including when safety planning and referring to the FSF). A mandatory report for DFV should be made as soon as possible. If you are involved in providing an immediate response with the client, reporting may be delayed until it is practical or safe to do so.
How does serious risk in the CRAT relate to serious threat in DFV information sharing?	The determination of 'serious risk' correlates to the 'serious threat' threshold for sharing information under the DFV Information Sharing Scheme. If a serious risk has been identified through assessment using the CRAT, this is considered akin to a determination of 'serious threat' for the purposes of sharing information without consent to lessen or prevent a serious threat under this Scheme. (Note that an ISE may give information to another ISE if it may help lessen or prevent a **serious threat** to a person's life, health, safety or welfare because of DFV, including by providing or arranging a DFV related service to or for a person).
How should information sharing be done?	• Information sharing, where safe, possible and practical, should be done with the informed consent and participation of the client. • Sharing information without consent is permitted in certain circumstances under DFV Information Sharing Scheme and other laws. **Consider information sharing without consent in situations where the risk of not sharing information outweighs the risk of sharing information.** • Due to the complex nature of this decision, consultation with a colleague, senior staff member or where the client resides in a small community, a staff member with strong local knowledge, is advised when considering information sharing. • Professional judgement and service policies should be used to determine whether it is safe, possible and practical to obtain the consent of the client. • If you are an ISE you must follow the DFV Information Sharing guidelines. • In some situations information sharing can increase risk, and consideration should be given to where the information will go once it has been shared, and whether there may be a chance of the information becoming available to people who will use it to increase violence or control. Particular consideration should be given to this occurring in smaller communities.
Information sharing about person who has committed DFV	In relation to the person who commits DFV, it is unlikely to be safe to obtain their consent to share information. This is because asking their consent to share information may increase the risk of further violence and harassment to the victim survivor, other partners, or other family members, including children.

How to make a mandatory report	**It is best practice to inform the client of your responsibility to report DFV, and child abuse and neglect, as early as possible in the interaction, where possible and where this does not compromise safety.** **It is best practice to involve the client in the mandatory report (if this is safe), including supporting them to make the report themselves.** • Emergency reporting of DFV can be made directly to police on 000. • If it is not an emergency, call police on 131 444 or contact your local police station. • Emergency reporting of child abuse and neglect can be made directly to police on 000, reported to the child abuse hotline on 1800 700 250 or Crime Stoppers on 1800 333 000. • If you are an NT Government worker, you can submit a report online. • You are not civilly or criminally liable or in breach of any professional code of conduct for making a mandatory report. • Make sure mandatory reporting is done away from the person who has committed the DFV or people who may inform that person.
What needs to happen after information sharing and mandatory reporting?	• Keep accurate and secure records – see Practice Guide 6 – Record Keeping. Include why decisions were made to share or not share information. • Communicate with the client about any actions, decisions or outcomes in response to the information shared and or mandatory report.
Related resources	Information and resources about the DFV Information Sharing Scheme are available on the NT Government website, including templates for information sharing requests and disclosures and record keeping forms. There is also online training available. Information and resources about Information Sharing in relation to children are available on the NT Government website, including templates for information sharing requests and disclosures and record keeping forms. There is also online training available.

PRACTICE GUIDE 5: REFERRALS

This practice guide provides information, resources, tools and practice tips about referrals, including what they are, why they are required, who should do them and how they should be done safely and effectively.

Conducting referrals applies to universal and specialist workers.

REMEMBER: All adults must comply with their existing legal obligations under mandatory reporting laws – see Practice Guide 4- Shared Legal Responsibilities.

It is best practice to inform the client of your responsibility to report DFV, and child abuse and neglect, as early as possible in the interaction, provided this does not compromise their safety.

NOTE: IF THE CLIENT (OR ANY OTHER PERSON) IS IN IMMEDIATE DANGER, CONTACT POLICE.

What is referral?	Referral is the process of connecting clients to other information or services. There are different types of referrals, including information, warm and facilitated referrals. A secondary consultation is where a worker discusses a client with a worker from the same or another service, to gain advice, perspective or information about the client. Usually the client is not present, and the confidential details of the client are not shared.
Why is DFV referral important?	Referral to specialist DFV and broader support services is an essential part of the risk management process, as clients often have multiple needs that require multiple service responses. Secondary consultation can take place for a range of reasons, including using the skills and knowledge of specialist DFV services to help a worker in risk assessment, risk management and possible referral options. Secondary consultation can also occur with mainstream and other specialist services that have expertise to address wide-ranging needs such as providing practical or therapeutic support; working with Aboriginal people or people who identify as belonging to diverse communities; working with children, young people or older people. Using secondary consultation can help workers to build their own knowledge, establish working relationships across organisations, and to assist in providing support that is culturally safe.
Who should do DFV referrals?	Workers from all services should make referrals depending on the needs identified by the client. Workers from universal services that do not have the time available or the skills necessary to conduct a comprehensive risk assessment and management response should refer the client to a specialist DFV service or a trained worker where available. Services should have a good understanding of the programs provided by other services, including their eligibility and intake processes.
When should DFV referrals occur?	Referrals may be needed at any stage in the risk assessment and management process – during or after screening, risk assessment, or risk management.

How should referrals be made?	

How should referrals be made?

- All referrals should be made in consultation with the client, and, where safe, possible and practical, with their informed consent. Referrals are likely to be more effective when the client is involved in deciding which service is most appropriate for them. You can provide information about a range of options and let the client decide which services they want to use.
- An informal referral or information provision, is providing the client with verbal or written information about other services. If this type of referral is made, you should check at a later time if they have made contact and, if not, explore the reasons why. Do not assume that the person will follow up on the information and make contact. There may be various reasons for not making contact, and a warm or facilitated referral may help overcome any barriers.
- A warm referral involves contacting a service for or with the client, rather than just providing contact information and recommending that they contact the service directly. For example, the worker and client could make the phone call to the service together to make introductions and share information. Warm referral also involves a certain amount of follow up, in which the worker checks to make sure that the referral has been successful and that the client is receiving the required support from the service to which they were referred.
- A facilitated referral is where the worker provides relevant information to another service (verbally or in writing), makes arrangements for the client to attend, and/or goes with them to the service to assist in building rapport with a new service. This includes sharing information that prevents a client from having to repeat their story.
- Referrals can occur by telephone, face-to-face, or in writing (including e-mail), or a combination of these.
- Services may have referral protocols, agreed pathways or MOUs with other relevant services, to enable smooth referrals for their clients.
- Services can develop referral forms that include agreed information, minimising the need to ask the same questions of the client many times.
- Before making a referral, a worker should contact the service receiving the referral to make sure it is appropriate to refer, find out about waiting times and costs, advocate for the client to receive the service, and share relevant information (see Practice Guide 4).
- Consider what other support the client may need to assist them to access the service (for example interpreters, transport, childcare, speaking to a new worker while you are present).
- A referral, when made, should also include the option to accompany the client if required or if necessary. If possible provide the client with transport to get to the referral agency safely.
- The worker should explain to the client the purpose of the referral/s, the possible outcomes of the referral/s and any responses or actions that may be taken after referral. They should also be told of any risks associated with referral, the processes for referral and what information will be shared to facilitate the referral. Complete referral forms together with the client where appropriate.

How should referrals be made? (Continued)	• Clients should be offered choices where possible in being referred to a service that specialises in working with their community. Aboriginal clients, or people who have family members who are Aboriginal, may choose to use an Aboriginal or mainstream organisation. People from culturally, linguistically and faith diverse communities and LGBTIQ communities may also choose to access a specialist organisation. If there is no specialist service in your local area, you can support a receiving service to connect with a specialist service by secondary consultation to continue to facilitate safe engagement and service delivery. • Where a client declines, is unwilling or unable to accept a referral to support services, this decision must be respected. Clients of DFV may decline offers of assistance and support for a number of complex reasons, including (but not limited to) concerns related to culture, religious beliefs, fear, finances, previous experience with support agencies, concern about losing children or a combination of any of these and other factors. • If a client indicates that they do not want assistance, you can still provide them with written information and contact details for support services (where this is safe); discuss safety planning; and attempt to remain in contact with the client, perhaps by scheduling other appointments or telephone contact times. • You may also consider asking the client if they would like you to prepare a letter or other communication for them to take to other services that provides foundational information to enable safe engagement, such as about medical or mental health issues, medication, communication assistance needs, identity characteristics and pronouns.
What needs to happen after referrals?	In most situations, referral does not mean you stop working with a client. Depending on your role, you will likely need to maintain engagement or continue to 'check in' with the client to support connection to a receiving service and respond to any issues that arise. In most cases, it will also be necessary for you to work with the client to develop a safety plan to ensure their immediate safety. Referrals also need follow up. If a referral is made, you should check at a later appointment if the client has made contact and, if not, explore the reasons why.
Referrals and people who commit DFV	People who commit DFV often present with issues that intersect with their use of violence, for example, alcohol and drug misuse, mental health concerns and intergenerational trauma. These intersecting issues are not to be blamed for the violence, but they may exacerbate the violence or be used as an excuse for the violence and potentially act as a barrier to accessing the service system or making behavioural change. It is important that the person who has committed DFV is referred to appropriate services. When making a referral, indicate the forms of DFV used by the perpetrator as identified by the victim survivor, for example sexual violence, financially controlling behaviour, stalking. For more information see Practice Tool 2: Different forms of DFV. An inappropriate referral may result in continued, and in some situations, escalated risk for the adult victim survivors and children. Appropriate referrals for people who have committed DFV include: men's behaviour change programs; men's DFV helplines; and individual violence focused counselling. Inappropriate referrals for people who have committed DFV include: anger management; couples counselling, mediation, family counselling; and individual counselling that does not focus on the violence.
Related resources	For a Territory wide list of specialist domestic and family violence services see the NT Government website, or for NT social services see the NTCOSS Service Directory.

PRACTICE GUIDE 6: RECORD KEEPING

This practice guide provides information, resources, tools and practice tips about record keeping, including what it is, why it is required, who should do it and how it should be done safely and effectively. Workers must comply with their own agency's requirements for record keeping.

Record keeping applies to universal and specialist workers.

REMEMBER: All adults must comply with their existing legal obligations under mandatory reporting laws – see Practice Guide 4 - Shared Legal Responsibilities.

It is best practice to inform the client of your responsibility to report DFV, and child abuse and neglect, as early as possible in the interaction, provided this does not compromise their safety.

NOTE: IF THE CLIENT (OR ANY OTHER PERSON) IS IN IMMEDIATE DANGER, CONTACT POLICE.

What is record keeping?	Record keeping includes creating case notes, referral forms, safety plans, risk management plans and completed risk assessment tools that are relevant to the worker's engagement with their client. It should be noted on all documents that the information is of sensitive nature and sharing that information needs to be considered in the context of the victim survivor's safety. Record keeping also refers to the secure management and storage of all confidential information.
Why is DFV record keeping important?	Keeping accurate records, and keeping that information safe and secure is a critical part of managing risks to people's safety. Records that workers keep as part of their work practices, such as case notes and emails, are important in keeping the person who commits DFV in view by documenting clearly their patterns of behaviour and how it is impacting on the client and family. This is especially important with DFV, as ongoing records can provide a record of the pattern of behaviour over time. Good record keeping also helps with collaborative interagency work and referrals and is an important way to support applications for intervention orders and breaches or other legal processes. Safe storage of confidential information is essential in DFV situations, because unauthorised or inappropriate disclosures of information could have extremely harmful consequences for a victim survivor's safety and the safety of others.

Who should do DFV record keeping?	All workers have responsibilities to make and securely keep records. Victim survivors may also keep their own documentation. However, documenting could increase risk if discovered by the person committing DFV. If the victim survivor is in the home with this person, you may explore keeping the evidence in a safe place outside of the home. If safe to do so, you can guide the client on documenting their experience of DFV. This might include: • Photographing injuries. • Medical evidence (including of sexual assault by specialist services). • Evidence of financial abuse. • Recording or writing down what was said or done, including details on time, location and specific details including any witnesses. • Noting breaches of orders, such as communication or exclusion orders. • Evidence of stalking, including through apps and technology, telephone or in-person (or from a third party on behalf of the person committing DFV). • Recording evidence of behaviours that led to harm of children or impact of that harm on children. • Clients may want to keep copies of their own safety plans – (See Practice Tool 8: Safety Plan).
When should DFV record keeping occur?	Documenting of DFV screening, risk assessment and management plans can be done with the client or after the conversation with the client has finished. Ideally, documenting should not be allowed to disrupt the flow of conversation and relationship building with the client. A reliable and trusting relationship with a worker can be an important factor in supporting positive outcomes relating to DFV.

How should record keeping be done?	• All services should have a secure client record management systems and appropriate policies and procedures in place which are compliant with legislative and professional body requirements such as for the Australian Association of Social Workers. A client's confidential information must be stored securely and safeguarded against privacy breaches. • You should follow your service's record keeping policies and procedures. • This includes reasonable safeguards against loss or unauthorised access, use, modification or disclosure of information. Information should be requested and provided in a secure way so that it is seen only by those who need to be aware of it. Records kept in relation to DFV risk assessment and management should include: • DFV related reports to police or statutory authorities you have made. • Referral and secondary consultation actions you undertake. • Information you share with other services or workers. • Risk management actions assigned to you or other workers. • Copies of any assessments you have done (e.g. completed CRAT) and risk management plans (e.g. completed safety plans). • Case notes and any other relevant information about the victim survivor or the person committing DFV's circumstances. ISEs under the NT DFV Information Sharing Scheme have particular record keeping requirements that can be found in the Information Sharing Guidelines. Example record keeping forms have been developed to assist ISEs and are available on the Northern Territory Government website. The use of these forms is not mandated, and ISEs may use their own existing or adapted forms for this purpose.
Keeping client information private and safe	Breaches of privacy can cause harm to the person whose privacy has been breached and may have serious implications for a victim survivor's safety. For example, information that discloses a victim survivor's location can put them at risk from the person committing DFV. Services must ensure that the person committing DFV cannot access information about a victim survivor or that workers with access to client information do not have a conflict of interest (e.g. the worker has a personal or familial relationship with a victim survivor or person who commits DFV). This is especially important for people from smaller or interconnected communities, when the staff at a services may be known to the victim survivor and/or person committing DFV.

Case notes	Many services have their own case note protocols. Case notes can be recorded manually or electronically and should at a minimum: • include on each page the name and DOB or other identifying information of the client. This can be handwritten, typed or constitute an electronic tag where an electronic case recording program is utilised • be dated • be recorded as soon as possible after an interaction or event • be typed or clearly readable if handwritten • include the name, signature and profession/role of the author • include the time of contact, particularly where there are a high volume of interactions in a day. • Include documents such as CRAT, a safety plan, information about referrals. • Include the types of DFV disclosed, any high risk factors identified, and any actions including any referrals made with the client (internal or external). Information recorded about a client should be impartial, accurate and completed with care so that: • only details relevant to the provision of support or service are recorded • notes are free from derogatory or emotive language • subjective opinions are qualified with relevant background information, theory or research • there is a focus on the facts • direct quotes from the client are used where possible • Any observations and opinion are supported by assessment tools • Do not record opinions (unless they are founded in evidence), value judgements, unfounded speculations/assumptions, hearsay or misleading information • describe the pattern
Client access to their records	A client may ask for access to their client records. In this case: • You should consult your organisation's polices. • Even where a client has the right to access records, there are some circumstances where it may be appropriate or necessary to refuse access. • A request by a client for access to their client records may have to be dealt with under the relevant privacy and health records legislation. • Where the client records are held by government agencies a Freedom of Information (FOI) Application or a Government Information Access Application may be required. • If you make a decision not to provide a client with access to their record, you should ensure that the client is advised of the right to request a review of this decision through organisational or legal channels.
Related resources	DFV Information Sharing Guidelines and record keeping forms

PRACTICE GUIDE 7: A SAFE, SUPPORTED AND CAPABLE WORKFORCE

This practice guide provides information, resources, tools and practice tips about worker capability and safety, including what it is, why it is required, who is responsible and how it should be managed safely and effectively.

A safe, supported and capable workforce applies to universal and specialist workers and services.

REMEMBER: All adults must comply with their existing legal obligations under mandatory reporting laws – see Practice Guide 4- Shared Legal Responsibilities.

It is best practice to inform the client of your responsibility to report DFV, and child abuse and neglect, as early as possible in the interaction, provided this does not compromise their safety.

NOTE: IF THE CLIENT (OR ANY OTHER PERSON) IS IN IMMEDIATE DANGER, CONTACT POLICE.

What is worker capability and safety?

Worker capability and safety refers to processes, systems, policies and resources aimed at enhancing workers' skills in the area of DFV risk assessment and management, and protecting workers' health, safety and well-being. Appropriate supports include:

- professional development and mentoring to accurately understand DFV and trauma, the causes and consequences of DFV, assessment of and the appropriate responses to risk, relevant legislation, the evidence base, effectively building rapport, networking and providing culturally safe services;
- clinical supervision that assists workers to develop their skills in assessing and responding to DFV risk;
- vicarious trauma identification and management;
- worker risk assessment processes, and safe home visiting and outreach policies and practices.

Why is worker safety important?

Undertaking DFV risk assessment and management is not easy. Finding the right responses for people requires skill, determination, creativity and patience, especially in remote and very remote areas. Hearing traumatic stories is often difficult and can have long term effects on workers.

Appropriate supports for DFV workers enhance effective assessment and responses to DFV, as well as worker safety.

Vicarious trauma management	An important component of trauma-informed practice is acknowledging the risk of vicarious traumatisation. Vicarious trauma includes detrimental impacts to workers' emotions, energy, memory and cognitions as a result of exposure to traumatic materials. When workers are exposed to traumatic material e.g. a client's story of DFV, vicarious trauma should be conceptualised as a work, health and safety hazard. Effective systemic processes to support the early identification and resolution of vicarious trauma impacts are key to ensuring worker wellbeing. The strategies recommended for effective vicarious trauma management include: • Providing education to workers about vicarious trauma: this should enable workers to accurately identify vicarious trauma impacts, differentiating them from other workplace-based and more generalised stressors, and assist workers to identify useful mitigation strategies to implement when vicarious trauma impacts are present. • Risk reduction: The development of organisational strategies to reduce the risks associated with vicarious trauma impacts is an important component of effective vicarious trauma management. Assisting workers to effectively leave work at work and find refuge from exposure to traumatic information (both within the workplace and in their communities) can reduce the risk of serious impairment from vicarious trauma. Providing access to specialist support (such as debriefing and counselling) is also part of organisational responsibilities. • Risk reduction can be challenging in small communities where workers live alongside others whose traumatic experiences they know. • Monitoring vicarious trauma impacts: Systems that assist workers and their managers assess and identify the type and severity of vicarious trauma impacts present at any time may be formal or informal. Formal measurement will include the implementation of valid and reliable psychometric measurement. Informal measurement can be enacted using self-assessment worksheets or conversations with supervisors.
Related resources	1800 RESPECT (freecall: 1800 737 732) offers information, as well as telephone and online counselling for workers experiencing work related stress and trauma as a result of their work in the DFV area.

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