COMMUNITY PERCEPTIONS

Exploring the practices of risk assessment, information sharing and safety planning among agencies working with survivors of intimate partner violence

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Acknowledgments

Thank you to the service providers and partners who participated in the focus groups and interviews.

About WomanACT

Woman Abuse Council of Toronto (WomanACT) envisions a world where all women are safe and have access to equal opportunities. We work collaboratively to eradicate violence against women through community mobilization, research, policy, and education.

The organization has been operating as a community-based coalition since 1991 and became a registered charity in 2010. Today, WomanACT has 30 members who represent key community providers and institutions working to provide a community response to violence against women.

Working closely with the violence against women sector, governments, industry leaders, communities and survivors, we strive to promote knowledge sharing, build capacity and generate public discussion in order to advance women's safety and gender equity.

Introduction

This report is part of WomanACT's project looking at multi-agency responses to high risk domestic violence. WomanACT is undertaking a four-year initiative that will adapt, test and evaluate the Multi-Agency Risk Assessment Conference (MARAC) model in three communities in Ontario.

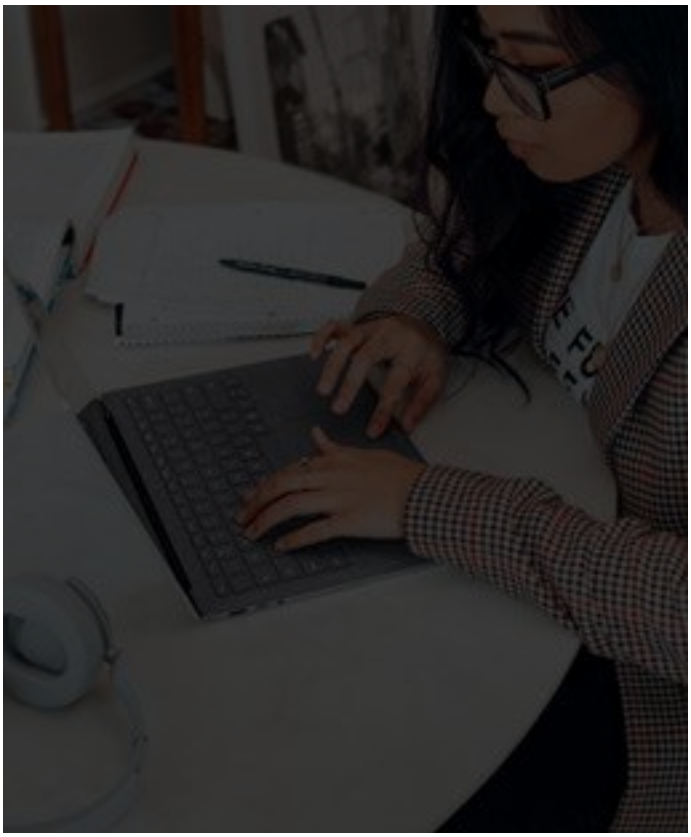
MARAC is a multi-agency meeting that brings together community agencies from across sectors to share case knowledge and professional expertise on high risk domestic violence cases. The role of MARAC is to facilitate effective information sharing in order to develop and implement immediate and effective safety plans with the aim of reducing high risk domestic violence. Developed in Wales in 2003, MARAC is now in place in over 270 communities across the United Kingdom.

The MARAC model has proven to reduce repeat victimization, increase victim safety and connect victims with the support and services they need to effectively flee domestic violence and establish safety. Within the scope of this project, WomanACT will aim to adapt the MARAC model to the Canadian context and test the model in two communities. In addition, the project will identify promising practices, develop protocols, and advocate for policy change that will support MARAC's function across Canada.

The purpose of this research is to better understand the risk assessment and information sharing practices among service providers in relation to intimate partner violence. Risk assessment and information sharing are critical components of the MARAC model and this research will help us better understand current practices, including opportunities and challenges.

Methodology

A total of 9 focus groups were conducted with 60 participants who work with survivors of intimate partner violence. The focus groups were conducted in the Toronto area between July 2019 and January 2020 and were on average two hours long. Service providers were contacted to participate based on their early engagement with WomanACT's MARAC project. Service providers included women's shelters, counselling services, and other community agencies. All participants met the specific research inclusion criteria of working in a front-line capacity with women experiencing intimate partner violence.



Participants of the focus groups were asked a variety of open-ended questions about their understanding and experiences of engaging with risk assessment tools and information sharing practices.

The following questions helped to guide the focus groups:

1. How do community providers serving women who are fleeing violence engage with risk assessment tools?
2. What do community providers consider are the benefits and limitations of risk assessment tools?
3. How do community providers serving women who are fleeing violence conduct safety planning?
4. What do community providers consider are the benefits and limitations to safety planning?
5. How do community providers share information related to risk with other community providers?
6. What are the barriers to information sharing between community providers?
7. What are community providers' knowledge of information sharing legislation and practices?

RISK ASSESSMENT

Assessing risk is a common practice in the violence against women sector to identify the likelihood of repeat or escalated violence (Dutton and Kropp, 2000; Campbell, Webster and Glass, 2009). Across literature, there are two common approaches to conducting a risk assessment. The first is through clinical judgement and the second is through actuarial tools. Clinical judgement is an informal method of assessing risk in which clients narrate their experience of intimate partner violence and practitioners use their expertise and specialist knowledge to inform a violence prevention strategy. The use of actuarial tools is a structured process in which practitioners ask clients a set of questions that have been developed through empirical research to identify a perpetrators risk of re-offending or to assess the client's risk of lethality (Campbell et al., 2016). Risk assessment tools have been developed to reduce the reliance on a practitioner's subjective perception of risk and to improve the accountability, transparency and consistency of decision making (Hart, 2010).

Use & Application of Risk Assessment Tools

Among the service providers who were engaged in the focus groups, 55% expressed that risk assessments are a mandatory component of their intake process for new clients as directed by their funding agreements. Many practitioners reported that they would begin the risk assessment process during the first interaction with a client and would continue to gather information over time as they establish a relationship with the client. In absence of a mandated practice, a second majority (33%) of service providers still adopted risk assessments as a promising practice for client safety. A majority of service providers conveyed that risk assessments were completed at multiple points in the client engagement process.

Focus group participants reported using a wide variety of tools to assess risk of lethality. The tools that were used by service providers included the Redwood Risk Assessment, Danger Assessment, Ontario Domestic Assault Risk Assessment, Family Safety Assessment and the Safety Assessment. One service provider reported not having a standardized process for risk assessment and the use of actuarial assessment tools were based on the discretion of individual practitioners. Two of the nine service providers had developed their own tool for assessing risk of repeat victimization. Amongst the risk assessment tools that were mentioned through the focus groups, the most commonly used tool by practitioners engaged was the Danger Assessment. Risk assessment tools were used within each community provider for varying lengths of time and services reported used their current tool of assessment for 2-16 years.

Benefits of Risk Assessments

Clients leading the development of their safety plans was a practice that arose from service providers noticing that actuarial "risk assessment tools create informal practices where the worker becomes the expert on a woman's experience". To alleviate the power dynamic, some practitioners encouraged their clients to lead the risk assessment process and found that clients could develop "better safety plans as they knew their experience best". Furthermore, service providers reported that during the risk assessment process some clients could accurately identify their risk of lethality. In recognition that clients conducted more effective risk assessments and safety plans, some service providers changed their practice of assessing risk and developing safety plans to enable women to "maintain their autonomy" throughout these processes. In scenarios where women could not understand their own risk, practitioners used risk assessment tools with clients to help them "understand their own level of risk of lethality".

Service providers reported that the Danger Assessment is a "strong tool to easily communicate risk of lethality as well as [urgency of case prioritization comparatively] to other tools they have used". Two service providers reported favouring the Redwood Risk Assessment tool for its thorough examination of risk that they believe was absent in other tools. For example, the service providers reported that the Redwood Risk Assessment accounted for social identities of marginalization, cultural understandings of violence against women and external spheres of influence such as family and support networks.

Participants also conveyed that the structured nature of risk assessments was useful but that tools that included additional space to add context was important as it allowed them to "illustrate the situation at hand" and provide context for other practitioners reviewing the case.

Limitations of Risk Assessments

Many service providers engaged reported that not all survivors are able to understand or communicate their level of risk and may minimize the severity of the situation.

Practitioners engaged explained that victims can have reservations about engaging in a risk assessment process due to fear of institutional scrutiny. As one participant voiced, "many clients expressed that accessing such services will draw negative, unwanted attention to themselves". Focus group participants added that this perspective was particularly relevant amongst newcomer populations when engaging with child protection services. Additionally, service providers described that when supporting newcomer populations, translation of risk assessments is a primary barrier. Practitioners described their experience as a "time consuming and daunting process [of translating] English documents into other languages". In some instances, practitioners described that much of a client's time would be spent waiting on a translator, translating documents into a client's language or translating client statements into English. In 50% of the focus group participants pointed out that the unique needs of newcomer women were not formally accounted for within risk assessment tools aforementioned.

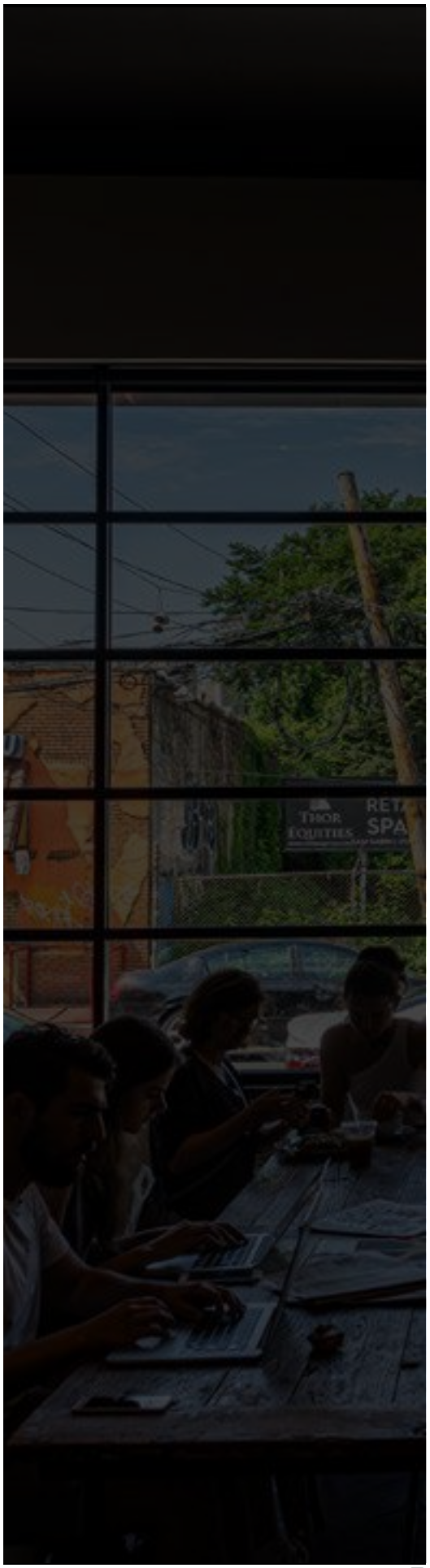
A majority of the participants reported that generic standardized tools do not work for everyone as they do not account for cultural considerations, cultural perceptions of abuse or same sex relationships. One of the service providers engaged reported that most risk assessment tools were missing factors which may signal risk. Examples of the missing risk factors include young parents or individuals and families unable to navigate systems or services, limited resources available especially for immigrants and no opportunity to incorporate practitioner judgement.

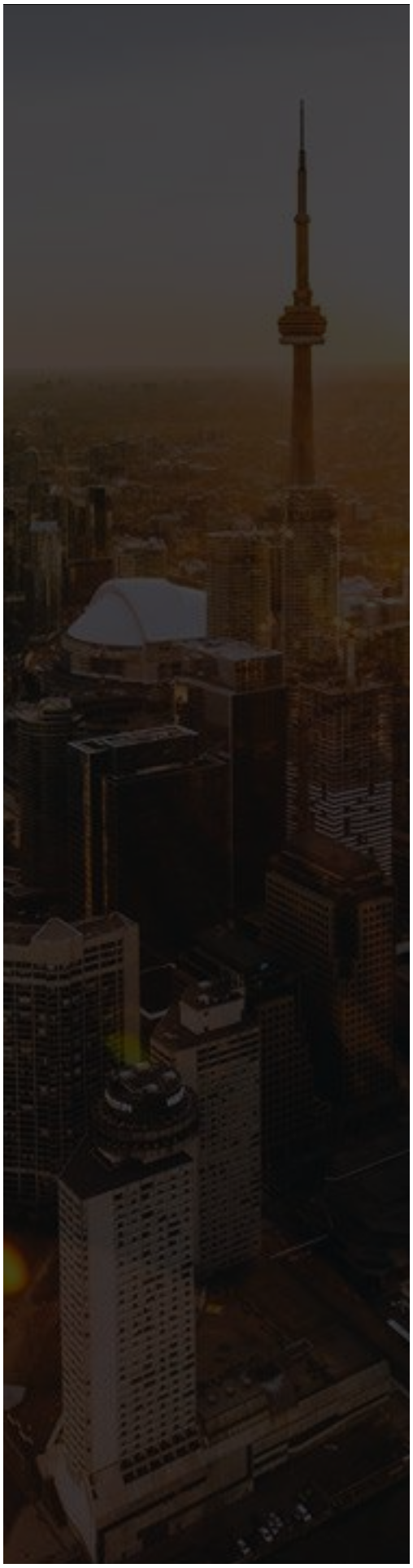
A majority (55%) of service providers indicated that factors such as language, access to social services and transportation were important to include in risk assessment tools. In circumstances where risk assessment tools did not account for particular risks, practitioners were able to use their professional judgement.

Perpetrator history of intimate partner violence with law enforcement is a common identification of high risk. However, practitioners report that “negative interactions or perceptions of police” results in lower rates of police involvement especially amongst marginalized communities. Lack of engagement with police in turn “lowers the score of a risk assessment if there has been no prior police involvement but does not necessarily lower the risk of lethality”. Additionally, one service provider expressed that “marginalized communities’ willingness to call police is significantly lower due to systemic racism and negative experiences with law enforcement”.

Many practitioners reported that the accuracy of the risk assessment is dependent on the amount of information that is provided by the client. If the client is unwilling to share their history of intimate partner violence, the risk assessment becomes less accurate. Almost one quarter of service providers reported that there is a need to include professional judgement above and beyond the scope of the tool.

Many participants stated that long risk assessments were difficult to complete with every client thoroughly due to a lack of time. One organization recommended that a short questionnaire could accompany a longer risk assessment as a means to effectively capture risk. Another organization found that long risk assessments provided “comprehensive assessments of risk [and] allowed practitioners to understand which clients required immediate intervention because of their high-risk status, and which clients did not need immediate intervention”.





Training on Risk Assessment

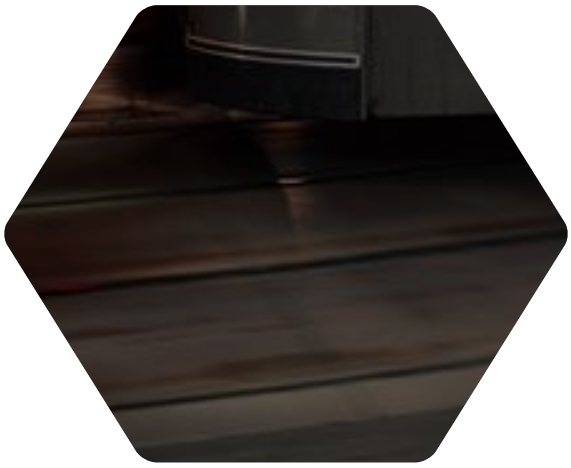
Service providers were asked about the training they received in relation to risk assessment, including the nature and frequency of training. Some service providers reported that they had received frequent training while others had received very little training. In addition, across all focus groups, practitioners within the same organizations had received different training on risk assessment. One service provider reported that they annually reviewed their risk assessment tools to ensure practice was aligned with current evidence. Following the review process, the organization provided training to practitioners. One organization engaged had developed a formalized online training that had become a mandatory part of their onboarding process for new practitioners. However, those engaged in focus groups from this organization questioned the training's ability to provide less experienced practitioners with a sufficient understanding of identifying risk factors and conducting risk assessments. Other practitioners engaged in focus groups described having either an insufficient level of risk assessment training or no training on risk assessment. Practitioners who expressed a need for supplementary training described feelings of unpreparedness in conducting risk assessments.

Risk Assessment: Discussion

Many of the service providers engaged practiced women-centered approaches to conducting risk assessments. This approach would allow women to have ownership and agency over how and when risk assessments are conducted. Practitioners engaged also explained that conducting risk assessments alongside their clients has allowed them to get a clearer understanding of their own risk.

Service providers reported that groups of women who may have unique barriers to safety such as racialized, immigrant, Indigenous or queer individuals were not accounted for within the majority of risk assessment tools used by service providers engaged. As a result of this absence, practitioners interpreted client stories, and identified high risk factors to produce a higher score or outcome to reflect their client's true risk of intimate partner homicide. In risk assessments that excluded the unique needs of vulnerable communities, the practice of interpretation enabled practitioners to identify and address unaccounted for risks.

Among service providers engaged in focus groups, 22% stated that there is a lack of consensus across the violence against women sector on a single actuarial tool to use for assessment of risk of lethality. The variety of tools used among service providers can result in different language and terminology which can make it difficult for service providers to convey the urgency of a case to other service providers. One service provider engaged noted that the use of different tools between service providers within the violence against women sector can produce different outcomes of risk as tools can focus on different areas to determine risk of lethality. Some service providers engaged stated that a standard tool would support collaboration between organizations with different mandates.



SAFETY PLANNING

Safety plans are guides to intervention for victims of intimate partner violence that are developed by service providers. Results from risk assessments inform the development of safety plans. A safety plan is unique to the individual experiencing violence and contains strategies to protect victims from further violence, harassment or stalking based on their risks (UNCG Department of Counseling and Educational Development, 2013). Often, safety planning is conducted with practitioners and women fleeing violence and is a living document that adapts as situations of violence evolve. After conducting risk assessments, practitioners supporting women fleeing violence should work collaboratively with external organizations to develop safety plans (Ending Violence Association of BC, 2013).

Process of Safety Planning

Among the service providers engaged, practitioners reported that the safety planning process was an opportunity to develop a relationship with a client. Some service providers reported that they allowed the client to decide when they are ready to disclose information. One practitioner stated that “trust and relationship building is key to safety planning and disclosures”. Many practitioners stated that it could be hard to get women to open up about the details of the most intimate part of their lives on the first meeting, and it will take time for a client to share their story of abuse.

Almost all service providers described the process of relationship building and the evolution of the safety plan as a process occurring over a period of weeks to months. Practitioners described the responsibility they hold to ensure safety plans adopt a holistic approach to risk management.

Many practitioners indicated that “safety planning should look at the entirety of a woman’s life, including support networks”. Most often, service providers dedicated a staff person to be the main point of contact with a client.

When the safety planning process begun, practitioners focused on generic questions at intake with clients. Examples of the questions included: What are your safety concerns? Are you safe? What brings you here? Are you comfortable here? What do you need right now? As trust develops between practitioners and clients, the level of detail and accuracy within a safety plan increases as further disclosures are made. Some practitioners (25%) reported that women are expected to sign off that they have received a safety plan and agreed to implement their safety strategies. Participants shared that safety plans are used as a method for survivors to become proactive in protecting themselves “in [a] way she see’s best fit”.

When asked about training on safety planning, one third of service providers indicated that there was no formalized training available on safety planning, another third had received formalized training as part of their onboarding process and another third had not received training as risk assessments and safety planning were not central to their role.

Benefits of Safety Planning

One service provider referred to the safety plan as a "living document, with responsive strategies that could adapt as the client's needs and lives progress or as a client moves from high risk, to low risk of lethality". The responsive nature of the safety plan ensures its relevance to the survivor's changing life circumstances and was described by a majority of participants as a positive method of intervention because such methodologies were not "set in stone".

One practitioner reported that "because the process is survivor lead, and only supported by [practitioners], the safety planning process is extremely engaging for women because they identified their needs, and developed their own plan to reduce their risk of further abuse or lethality". It becomes a means to "empower her to make decisions about her own safety" and establishes a means for her to respond to the situation "in her own way".

One quarter of the service providers described "utilizing legislation to obtain further information on high risk situations" in order to develop more accurate safety plans. One example of this was with a child protective service agency which would cite the interests and safety of children as the reason other service providers must share often confidential client information and non-compliance would mean service providers are breaking the law.

Practitioners noted that "risk assessments are only as strong as the information provided", and used legislation in the best interest of clients, with the intention of ensuring the most accurate safety plan and the appropriate referrals for resources and supports.

Limitations of Safety Planning

Most participants reported that their biggest limitation to safety planning is when safety planning strategies are not followed. Practitioners expressed that their "role in their life extends only so far, it is up to the client to follow the safety plan but there is no guarantee that the plan will be followed".

Practitioners reported that many mothers fleeing violent situations hesitate to include their children in safety planning strategies but reported that it is important to include children in the process. Practitioners further detailed the importance of including children because "perpetrators of violence will use their children as a mechanism to gain access to their intimate partners". Across several service providers, practitioners described the safety planning process as "one that should include the entire family", which may include: survivors, children and support systems. One participant stated that service providers should consider conducting safety plans ahead of clients leaving abusive relationships so victims can prepare themselves accordingly.

Safety Planning: Discussion

The safety plan is seen by community providers as an effective and practical tool for women fleeing violence to use. The safety plan can include important information such as passwords, documents and strategies for keeping women safe and away from further abuse. Ensuring safety plans are survivor centered was a strong theme shared across the focus groups. Many service providers described women as the experts of their own lives, and encouraged the development of self-led safety plans.

INFORMATION SHARING

For several decades, information sharing has been recognized as an international promising practice for the prevention of intimate partner violence (UN Women, 2012). In Canada, provincial death review committees recommended that the sharing of information will help community agencies obtain a greater understanding of a case and can help reduce homicide (Office of the Chief Coroner of Ontario, 2002). The sharing of information between providers is seen by researchers, international experts and service providers as an effective approach to reducing risk of serious harm or lethality.

Practices of Information Sharing

The focus group participants reported that the practice of information sharing is most commonly used during the process of developing safety plans. Many service providers reported creating safety plans based on information provided by their client more than third-party information. Focus group participants reported that if external information is received they are unable to use it in their client engagement techniques because clients have not shared this information directly with them. Service providers described that the inclusion of third party information could undermine the client's autonomy. Instead, practitioners will try to engage the client and build rapport in other ways to encourage the information to be willingly shared. All of the service providers engaged through focus groups reported that they had an organizational procedure which states that information is to be shared at the will and consent of a client.

Many focus group participants reported that the only time practitioners share information is when a child is or may be in need of protection, widely referred to as the "duty to report" practice. Many practitioners reported that referring agencies do not generally share the risk assessment or case file data upon referral to services. Some focus group participants expressed that they believe child protective services can be reluctant to share case information.

One of the service providers serving women engaged reported that they had a clear policy on information sharing between service providers which stated that "[information] is [seen as] confidential and does not get shared outside of the client-worker relationship unless there is imminent risk of that person or another person endangering a child, taking their own life or harming someone else or subpoena from the court. Otherwise, it is a consent-only protocol". Practitioners recounted instances in which clients asked service providers to send their information directly to third-party organizations on their behalf.

Some providers reported that they assign a single practitioner who leads the client-worker relationship and other service providers share client information amongst teams to reduce risk. One organization practiced internal information sharing through hierarchies, in which individuals who are working directly with clients in a case management setting (mostly managers and case practitioners) will be able to access this information.

A Hesistancy to Share Information

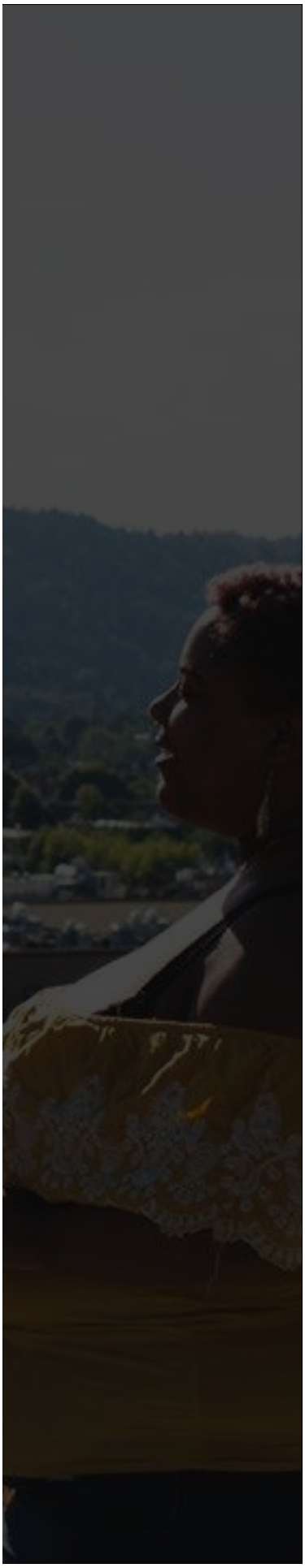
One quarter of the providers reported feeling hesitation in sharing information with other service providers, as practitioners fear "compromising their client's confidentiality". Service providers discussed the challenges they experienced in navigating interactions with other service providers when requesting information on clients. Practitioners from one service engaged described often being faced with reluctance from child protection service providers to share relevant case information.

Through a case example, one service provider described how the fear to share information can produce unsafe conditions for clients and practitioners. In this case, they described not having shared risks in relation to a client when transferring the client to another service provider.

One service provider stated that "it may not be helpful to risk management if you knew [too much] of the person's story ahead of their arrival" because "a person's story may not be accurately recorded, or may be contextualized in way which creates biases for those reading or working with such client". Some practitioners described their fear that if service providers shared information more openly and regularly it would create a practice amongst "clients to stop sharing information". Practitioners described that clients may develop fear on the inability to control who may have access to such information or that the information will be sent to a service organization the client may not want involved.

Practitioners described feeling that in scenarios involving information sharing, "the reason [to share] information would have to be "really good", and that the sharing of information will produce positive outcomes in their case management strategies. Practitioners reported that before the sharing of personal information they sought client consent on what information would be shared and to whom. In these situations, consent to share personal information is specific and is often dated to expire.

Practitioners described feeling that "[they] hold a lot of power and responsibility in terms of system navigation [and] there [are] a lot of people who trust the organization". To uphold community trust, service providers acted cautiously when sharing information. Practitioners described their fears of privacy infringements which could negatively damage the reputation of their organization.



Limitations to Sharing Information

One service provider engaged through focus groups stated that “partners also have their own set of [organizational] policies and procedures that limit their ability to share information”. When a practitioner wants to share information between providers, they have to ensure they are following organizational policies and procedures to do so, as well as legislation. Participants expressed that the number of hoops that people have to jump through makes information sharing an overwhelming process. This makes sharing information between service providers a time-consuming process.

A service provider described incomplete client files as a problem with information sharing between providers and stating that “not all service providers will always provide the relevant case file information and any missing information will be expected to be filled by the client retelling their story”. Files with a completed client history were described as helpful in assisting practitioners in providing informed and relevant service to clients. Practitioners have been in instances in which a client will withdraw the consent during the process of case management, creating new barriers for managing cases as collaborative information sharing will cease.

Privacy, Confidentiality & Information Sharing Legislation

All service providers stated that they were aware of their obligations to follow legislation from the Child and Family Services Act which stipulates that anyone with known knowledge of the physical, sexual, emotional abuse of a child or neglect must report to a legislated child protective service.

Providers engaged stated that practitioners are sharing information in inconsistent processes because “there were too many organizational and operational policies between different shelters and service providers within the sector, which made it difficult to work together and share information”. The service providers described how the different approaches limited the practice of information sharing as “everyone was off doing their own thing”.

Information Sharing: Discussion

Many service providers engaged explained the importance information sharing brings to case management. A majority of the service providers engaged expressed that sharing more information puts their clients in a safer situation faster. In another example, one service provider highlighted if a client has a working relationship with only one staff person, and that staff person is not available, this can cause serious risk of harm to client, practitioners and possibly the organization. Whereby, also emphasizing the need for organizational information sharing practices.

A few service providers engaged were aware of their responsibility to share information if they recognized a client is at risk of hurting themselves or others, or if they are at risk of serious harm or death.

The hesistency to share information can lead to service providers working in silos. One practitioner articulated that “systems are set up in a way where silo work can continue to happen and people can perpetuate silo work”.

In cases where consent could not be obtained, practitioners erred on the side of caution, and avoided sharing private and confidential client information. Service providers were hesitant to share information with one another because they expressed fear of infringing on the rights of their client’s privacy.

Navigating privacy and confidentiality legislation remains as a barrier for all practitioners.

Most practitioners agreed that information should only be shared with the consent of their client to respect their client’s autonomy. Practitioners reported the importance of sharing information to reducing the risk of repeat violence faced by clients. Further, some focus group participations described practices of information sharing as means to increase communication and partnership between different service providers.

Next Steps

As part of the MARAC project, WomanACT will take the community findings from this report to inform project activities. A few key areas of focus have been identified across the three broad themes this report explores.

Risk Assessment

- Evaluate the use of risk assessment tools and its use within the MARAC project to ensure the adherence to promising practices and evolving community and service providers need

Safety Planning

- WomanACT will continue to explore the need and interest by practitioners on safety planning by exploring promising practices across service providers.

Information Sharing

- WomanACT will provide support and build capacity on information sharing between service providers to reduce high risk intimate partner violence and homicide.

References

Campbell, M., Hilton, NZ., Kropp, PR., Dawson, M., Jaffe, P. (2016). Intimate partner violence risk assess ment: informing safety planning & risk management. Domestic Homicide Brief (2). Canadian Domestic Homicide Prevention Initiative.

Campbell, J.C., Webster, D.W., and Glass, N. (2009) The Danger Assessment: Validity of a lethality risk assessment instrument for intimate partner femicide, Journal of Interpersonal Violence, 24(04), 653 - 674.

Dutton, D.G., and Kropp, P.R. (2000) A review of intimate partner violence risk instruments, Trauma, Violence and Abuse, 1(02), 171 - 181.

Ending Violence Association of BC. (2013). Safety planning across culture and community: a guide for front line violence against women responders. Ending Violence Association of BC. Retrieved from: https://endingviolence.org/files/uploads/ure_and_Community_Manual_-_EVA_BC_Dec_9_2013.pdf

Hart, S.D. 2010. The critical roles of perpetrator risk, victim vulnerability, & community support factors. Paper presented at the Second Annual Canadian Domestic Homicide Prevention Conference.

Office of the Chief Coroner of Ontario. (2002). Ontario intimate partner violence death review committee annual report to the chief coroner: case reviews of intimate partner violence deaths.

UNCG Department of Counseling and Educational Development. (2013). Safety strategies safety planning for survivors of intimate partner violence and their children. Family Violence Research Group. Retrieved from: https:/files.nc.gov/ncdoa/documents/files/SafetyStrategiesBooklet.pdf

UN Women (2012). Handbook for National Action Plans on Violence Against Women. Retrieved from: http://www.un.org/womenwatch/daw/vaw/handbook-for-nap-on-vaw.pdf