Australian Domestic & Family Violence Clearinghouse

THINKING ABOUT HOMICIDE RISK: A PRACTICE FRAMEWORK FOR COUNSELLING

DR JAN BRECKENRIDGE
DR KERRIE JAMES
School of Social Science and International Studies, The University of New South Wales

KEY POINTS:

- Research tells us that many women experiencing domestic violence do not disclose their experience when seeking counselling but instead raise other related problems such as relationship conflict, depression or parenting issues. These women may 'fall under the radar' if counsellors are not able to identify domestic violence and homicide risk.
- Knowing how and when to assess for homicide risk is an essential skill for all counsellors who may work with women experiencing domestic violence, particularly those at non-specialist services.
- This paper proposes a multi-systemic practice framework to help counsellors assess for and respond to homicide risk. The framework outlines the four main system domains that counsellors may need to address: the client system; the therapeutic relationship; the organisational context; and the system of services.
- Organisations can use this framework to structure services and to evaluate their response to clients experiencing domestic violence, with the ultimate aim of preventing homicide.

INTRODUCTION

Recently, there have been a number of high profile cases reported in the Australian media where men have murdered their wives or partners, sometimes their children and/or other close family members, and then, in some instances, have themselves committed suicide.[1] These cases are often preceded by long histories of domestic violence and coercive control of the female partner (Cattaneo & Goodman 2003; Dobash & Dobash 2009; Mouzos & Rushforth 2003).

Research tells us that many victims of domestic violence do not seek formal help from counsellors (Block 2009; Regan et al. 2007) and some may not even identify their partner's controlling and violent behaviour as domestic violence (Campbell 2005). Moreover, frequently when women do seek help, they do so for other related problems such as relationship conflict, depression or parenting issues and may not in fact, disclose their experience of domestic violence. These women may 'fall under the radar' if counsellors fail to identify domestic violence or do not intervene to secure the safety of women, children and other family members (Breckenridge & Ralfs 2006; Lindhorst, Meyers & Casey 2008; Todahl et al. 2008).

Services that do not specialise only in domestic violence (such as relationship counselling services, child and adolescent mental health services, adult mental health services, and drug and alcohol services) may not routinely screen for domestic violence. Furthermore, their counselling staff may not be aware of the indicators of serious violence or know when and how to assess for potential lethality. However, we know that between 15 and 17% of Australian women have experienced domestic violence at some point in their lives (Australian Bureau of Statistics 2006, p. 11). Many of these women will seek assistance from a range of services for issues directly or indirectly related to the abuse.

Contexts such as these underscore the need to develop appropriate intervention strategies to ensure that counsellors and frontline workers are able to assess and intervene with a woman who is being abused by her partner and is at risk of serious injury or death. This paper aims to address these difficulties by providing a multi-systemic framework incorporating practice directions for counsellors and organisations who do not specialise in domestic violence but who may nevertheless encounter victims of domestic violence in their practice.[2] This work builds on and is informed by

an action research project undertaken in partnership with Relationships Australia, South Australia (RASA).

The rationale for developing such a framework is twofold. Firstly, organisations are accountable for their policies, processes and decisions made by the client's counsellor or other workers involved with a client, when that client of an organisation is killed as a result of domestic violence. We, therefore, propose this framework to be used to guide organisations to develop, implement and evaluate best practice in assessing and responding to domestic violence across a number of 'domains' of their operations. Secondly, this framework can be used by organisations to ensure that they are part of a comprehensive, multi-systemic response to domestic violence. In presenting this framework, the authors aim to provide directions for best practice, while recognising that domestic violence-related homicides cannot always be predicted or prevented.

Before presenting the framework and principles, this paper will provide a brief summary of the literature and research that specifically inform the definitions used in the paper and that provide the theoretical context for the development of the framework.

UNDERSTANDING AND DEFINING DOMESTIC VIOLENCE-RELATED HOMICIDE

A substantial problem in reviewing the research literature is the lack of clarity and consistency about the definitions used to describe different manifestations of domestic violence-related death. David (2007, p. 20) refers to 'domestic homicide' which she defines as 'involving a perpetrator who is or was at one time in an intimate relationship with the victim or victims [including children] such as a de facto or marriage partner'. This definition usefully identifies the past or present domestic relationship between victim and offender, although David (2007) and Johnson (2009) both note that definitions used to categorise a particular offender-victim relationship are not necessarily uniform between legal jurisdictions.

The term 'intimate partner homicide' (IPH) has been adapted from the concept of intimate partner violence (IPV) and is increasingly preferred to 'domestic homicide' in the literature. However, it can fail to accurately convey the contribution of ongoing domestic violence to the murder of a partner and does not sufficiently identify the retaliatory nature of women's acts of homicide against their male partners as a self-defence response and means of escape from domestic violence (Regan et al. 2007). The term 'domestic homicide' extends the definition of IPH by acknowledging the number of children and close family members that are also killed in the context of domestic violence. Both of these terms, though, exclude less direct manifestations of violence, such as suicide by either the victim or the perpetrator, which is not always calculated or recorded as domestic homicide or the means of escaping entrapment in IPV (Mouzos & Rushforth 2003).

Other researchers have attempted to better define domestic homicide by making reference to legal definitions. Regan et al. (2007) critique the use of 'domestic homicide' as being gender neutral and suggest instead the use of 'femicide' as a more accurate term when referring to the killing of women. Liem (2009) provides even more specific definitions such as: 'uxoricide' – the killing of an intimate female partner or wife; 'filicide' – killing one's children; and 'familicide' – killing multiple family members; all of which more precisely describe the homicide victim and their relationship to the offender.

This paper refers to 'domestic violence-related homicide' to acknowledge the range of contexts, relationships and lethal consequences of domestic violence, although alternative terms will be retained if they are specified in the original source. While acknowledging the range of contexts within which domestic violence-related homicides occur, this paper will not deal with women killing men in self-defence (pre-meditated or not) or family violence where children kill their parents or homicide between siblings or between other family members. The framework presented in this paper is designed to deal with the most usual manifestation of domestic violence-related homicide – men who murder their current or past intimate female partner, children and close family members.

ESTIMATING THE EXTENT OF THE PROBLEM

Estimating the incidence and prevalence of domestic violence-related homicides is obviously affected by definitional difficulties and choices about what will and will not be included in data sets. For example, a key finding of a recent NSW Bureau of Crime Statistics and Research study was that 43% of relevant homicide cases were not flagged as domestic violence-related on the NSW Police Force's Computerised Operational System (COPS) (Ringland & Rodwell 2009, p. 8, note 3). Websdale (2003) makes the point that it is hard to confirm the actual number of deaths as many suicides are domestic violence-related but are not counted as such, and that child deaths are often dealt with separately and recorded as child protection matters (Mouzos & Houliaris 2006).

Mouzos and Rushforth's (2003) Australian statistical review that compared and contrasted different types of family homicide, clearly demonstrated that it is a non-homogenous, gendered crime. Their study found that almost two in five homicides are perpetrated by family members, with an average of 129 family homicides committed each year. The majority, sixty percent, of family homicides occur between past and current intimate partners. Furthermore, three-quarters of all cases of reported IPH involved males killing their female partners. In a later study, Davies and Mouzos (2007) found that reported IPH accounted for one-fifth of all homicides and four out of five domestic violence-related murders involved a man killing his female partner, confirming the earlier finding that women are more likely to be killed by current or former partners than anyone else.

International studies, such as that by Campbell et al. (2007), report similar findings. In their analysis of US figures, these authors estimate that women are still the victims of domestic violence homicide four to five times more frequently than men and they are nine times more likely to be murdered by a current or former intimate partner than by someone else. Simmons and Dodd (2003) claim that in Britain domestic violence accounts for the murder of two women every week. While Australia's rate of homicide may be low in comparison with the rates recorded in other Western countries, the close association of domestic violence with the majority of intimate partner murders should be seen as cause for concern (Davies & Mouzos 2007).

COUNSELLORS' PERCEPTIONS OF SCREENING, RISK, LETHALITY AND BEST PRACTICE

Organisations frequently differ in how they define domestic violence, screening and risk assessment, and the degree to which they evaluate outcomes of intervention. An unintended consequence of this inconsistent implementation of screening, risk and lethality assessments, as well as infrequent evaluation, is that many counsellors and their organisations remain unclear about if, and how, these strategies may assist their practice. This is particularly the case in contexts where domestic violence is not the sole focus of intervention or is not a presenting problem. David (2007) and Barrett Meyering (2010) argue that domestic violence-related homicides are largely preventable deaths. However, before the likelihood of a domestic violence-related homicide can be assessed, a counsellor needs to be able to assess domestic violence in the first place. What then does the research tell us about counsellors in generic services and their capacities to assess for domestic violence initially and the potential risk of lethality?

In one of the earliest studies in this area, Hansen, Harway and Cervantes (1991, p. 229) examined 362 therapists' perceptions of severity of family violence. They found that the therapists surveyed failed to attend to the seriousness of the violence, if they attended to the violence at all. Two particular findings are relevant to the current discussion. Firstly, only eight out of 362 participant therapists foresaw the possibility of lethality in the examples given. Secondly, 23% of participating counsellors expected some type of pessimistic outcome if they intervened.

In a much later study, Todahl et al. (2008) obtained similar results. The therapists participating in their study varied widely in their most common practice patterns and attitudes. Some chose not to screen for domestic violence and other therapists chose to routinely screen. Some counsellors separated couples for screening; others believed this was rarely warranted, despite education programs and organisational guidelines recommending against screening with both partners present. Some participants held concerns commonly found in the literature that screening impairs the therapist-client relationship, while other participants argued that well-managed screening enhances the therapeutic relationship.

Lindhorst, Meyers and Casey (2008) attempted to identify factors that might increase opportunities for women to disclose domestic violence. Their analysis of 782 initial interviews found that only 9.3% of cases involved screening for domestic violence and that the majority of screening by counsellors was routinised or consisted of informing clients of the domestic violence policy without asking about abuse or considering on-going safety. Schacht et al. (2009) provide further evidence of counsellors' concerns about screening for domestic violence. They examined 620 couple therapists' strategies for assessing domestic violence and selecting a treatment modality when violence is discovered. They found that less than 4% of respondents indicated that they consistently followed key published guidelines for domestic violence screening. In addition, only a minority of therapists indicated that they considered the victim's safety as an important factor in treatment modality selection.

McCollum and Stith (2008) examined an especially complex issue for couple therapists – that of conjoint treatment for IPV. Despite other researchers expressing caution about attempting to intervene with couples jointly where there is violence – an approach they call 'one size fits all' – they attempt to develop typologies and strategies that support their belief in the usefulness of seeing both parties jointly, as well as

demonstrate that couple therapy can be used safely to end violence.

Braaf and Sneddon (2007) suggest that the major limitation of all screening and risk assessment tools is that they are only as good as the practitioners administering them and further contend that there is a dearth of professional standards to guide practice. Research and evaluation on screening and risk assessment instruments raise critical issues with respect to the skills of the practitioner, the potential danger of 'tick-box' assessment processes, the limited time available to screen and undertake assessments and the appropriateness of particular practice contexts in which to do so. Such specific issues inform overarching concerns about organisations' inconsistent response to domestic violence and their reluctance to intervene.

In reality, an adequate response should not fall on the shoulders of one practitioner or one organisation. This is clearly evident in fatality reviews, in which findings frequently reveal information deficiencies and lack of communication not only within but also between systems of service. Ver Steegh and Dalton (2008) highlight the potential for communication difficulties between organisations, often compounded by competing disciplinary perspectives, all of which affect ongoing collaboration.

THE POTENTIAL OF PRACTICE FRAMEWORKS

We know from a selection of recent studies that some women affected by domestic violence do seek help formally from professionals and informally from family, friends and their community (Regan et al. 2007). Block (2009) in a US study of eighty-seven IPHs, found that 90% of women homicide victims had previously sought help from informal networks, such as family and friends or formal help from professionals. Of this ninety percent, 52% had sought formal help in the preceding year. Seventy-nine percent of homicide victims in this study had tried to leave the relationship or had asked the offender to leave. These women clearly wanted help. Regan et al. (2007) argue that informal support networks are frequently women's first port of call for help and advice. However, they argue that researchers have not adequately studied their potential to contribute to a holistic response. From their analysis, they suggest that informal supports can act either as barriers to or facilitators of wider help, including referral to professional services.

Kropp (2008) points out that despite the burgeoning number of risk assessments and tools, there are no minimum qualifications for conducting or 'best practices' for applying these assessments. There is considerable emphasis in the literature on the importance of screening and risk assessment for identifying domestic violence, assessing seriousness and, therefore, potentially fatal outcomes. However, such an emphasis can tend to orient practitioners to an actuarial prediction of domestic violence-related homicide rather than prevention, which is based on a more holistic assessment.

Block (2009) somewhat controversially suggests that there is no such thing as 'domestic homicide'. Instead, she proposes that there are different types of violence, some of them ending in death. While a counsellor is focused on using instruments and indicators to predict the risk of severe or lethal violence accurately, they may miss elements that increase the complexity of the overall situation. Campbell (2005) similarly warns against an exclusive actuarial approach, suggesting that as important as the predictive ability of the assessment instrument or method, is the protocol or practice framework that goes with it.

Winkworth and McArthur (2009) argue that a 'practice framework' provides guidance or a frame of reference encompassing the domains, concepts and principles within which counsellors assess their client's needs. Moreover, such a framework should be underpinned by the notion that assessment is, in fact, ongoing and part of a cycle of planning, action and review (Laing 2004).

This paper aims to provide a practice framework, including a conceptual model to assist organisations and the counsellors they employ, to better provide the help sought by women living with domestic violence and reduce the risk of homicide. However, it is important to accept that certain situations may still end in a homicide regardless of the organisation's and counsellor's responsiveness or the use of any conceptual model or map.

THE MULTI-SYSTEMIC FRAMEWORK

As identified in the above research, the existence and availability of screening tools and risk assessments, domestic violence policies and best practice strategies does not guarantee that counsellors will be willing or able to implement effective interventions. Barriers that curtail effective implementation of policy and guidelines include: counsellors' lack of confidence, skill or familiarity with guidelines; allegiance to a particular approach or model; fear that they will not be able to maintain client engagement; fear that their actions in implementing policy would jeopardise their relationship with a client; and not feeling sufficiently supported within the organisation (Winkworth & McArthur 2009).

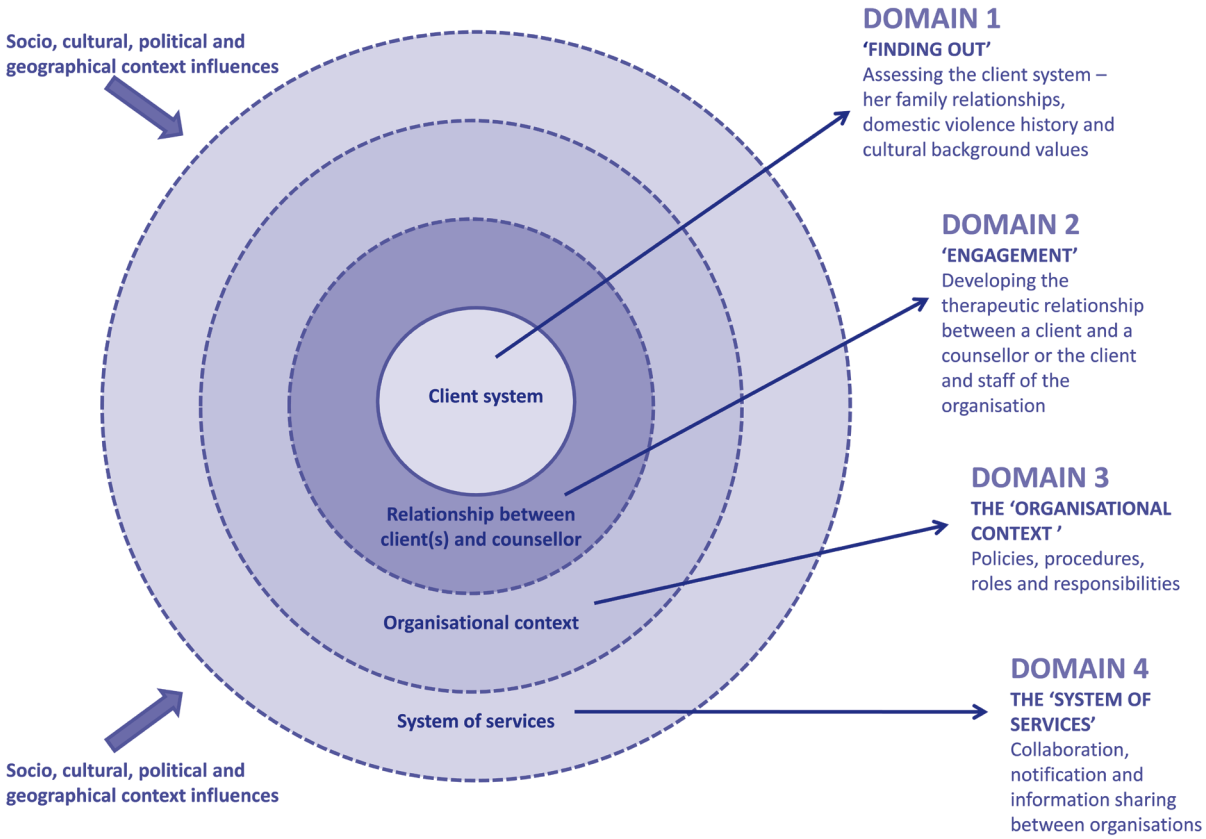
In the following section, we present a multi-systemic framework incorporating best practice directions derived from the research literature, to assist organisations and counsellors to work towards the prevention of domestic violence-related homicide. Staff at all levels of an organisation can use this framework to structure services and to review and evaluate the organisation's response to clients who are experiencing domestic violence and who may be at risk of further serious or lethal violence. In the event of a domestic violence-related homicide, if the organisation and counsellors have implemented the good practice directions or strategies in the various domains of this framework, they should be able to demonstrate and feel that everything possible was done to keep the client(s) safe and prevent the homicide.

A multi-systemic framework is crucial in conceptualising or mapping the different system domains that workers in and across organisations need to address, in order to identify and respond to domestic violence and potential lethality. The domains do not represent a linear progression of intervention tasks and strategies; rather, a counsellor may need to consider and/or address issues from more than one domain at the same time, or move across or revisit domains at different times according to the particular circumstances.

- **Domain 1:** 'Finding out' – assessing the client system. This includes gathering information about the woman, her partner, any children and other family members; extended relationships and the community and culture in which the family is embedded. Domestic violence may or may not be disclosed in this initial phase.
- **Domain 2:** 'Engagement' – developing the therapeutic relationship between a client and a counsellor or the client and staff of the organisation. Establishing safety is a primary therapeutic goal within this domain, for both the therapeutic relationship and in relation to the client's circumstances
- **Domain 3:** The 'organisational context of intervention' – the legislative context of practice; organisational policies, procedures, roles and responsibilities necessarily focusing on the relationship between counsellors, their supervisors and managers and the organisation as a whole.
- **Domain 4:** The 'system of services' – the organisation's interface with other services who may be used for referral or who may also have a role in ensuring the client's safety.

Within each domain, good practice directions and strategies are included to guide both counsellor and organisational responses to the client. These can be

FIGURE 1: CONCEPTUALISING A MULTI-SYSTEMIC APPROACH



relevant to more than one domain at a time. The four domains are visually depicted as a series of concentric circles and each domain provides the context for the next inner circle, which in turn provides the context for the next and so on (see Figure 1). This framework provides a conceptual map that counsellors and organisations who do not specialise in the area of domestic violence can use to plan and evaluate their contact with the client and the ensuing intervention. All four domains are of course influenced by the intersections of social, cultural and community values and attitudes about domestic violence generally.

Domain 1: 'Finding out' – assessing the client system

The 'client system' is the *raison-d'être* for services (and the existence of helping professions!). It encompasses the role of the counsellor in finding out information or assessing a client, her family, their shared history, socio-cultural dimensions, and current needs and problems, including the reason that the client is at this point seeking some kind of assistance. The organisation is ultimately responsible for ensuring that counsellors identify domestic violence when experienced by clients and assess for dangerousness in each situation. Before focusing on screening and risk assessment, it is important to consider the context within which these assessments occur. Counsellors may make different decisions as to whether or how they screen and assess risk depending on whether they are initially seeing the woman, the woman and her partner or the family including children.

SCREENING

The first step required to achieve identification of domestic violence is for organisations to have in place processes or protocols for identifying the presence of domestic violence and safety issues for clients at the point of initial contact. Screening involves asking all potential clients routine questions about domestic violence. This may occur over the phone at intake, via a questionnaire prior to their first meeting at the service, or in a face-to-face interview with an intake counsellor, a counsellor or other professional.

Research indicates that the implementation of screening, particularly organisational decisions to universally screen all clients, has met with, at best, an equivocal response from counsellors. Todahl et al. (2008) identified that therapists felt concerned about screening, in part because they often received negative responses from clients. However, other research into clients' experience of being screened indicates that women expressed overwhelming support for the process post-screening (Irwin & Waugh 2001; Spangaro, Zwi & Poulos 2009).

Screening is often the first step in the intervention process in that it provides an opportunity for the client to disclose domestic violence. Screening does not in itself identify the potential for domestic violence-related homicide but, as Block (2009) reminds us, any domestic violence situation could potentially end in homicide. If screening is based on limited definitions of domestic violence, such as physical assault, it may miss situations where a man dominates and coercively controls his partner but is not physically violent. Therefore, all clients, or all clients where domestic violence is identified in screening, should be assessed further. The use of both clinical interviews and actuarial assessment instruments produces the best outcomes (Williams & Houghton 2004).

RISK ASSESSMENT

While screening for domestic violence provides the first 'sieve' identifying clients who are in unsafe situations, risk assessment is a more in-depth enquiry that may be incorporated into a more comprehensive assessment of the client's situation, one that includes other aspects of the client's life relevant to the particular service. It is usually conducted as part of an assessment interview with a counsellor, who intends to provide ongoing counselling, and so it is often the case that this type of assessment occurs in the second domain. In many contexts, such as in adult mental health or alcohol and other drugs (AOD) services, a victim of domestic violence most usually will present by themselves. However, the situation may be more complex in relationship counselling and child and adolescent health services where it is conceivable that the perpetrator may present with his partner or family.

In accordance with organisational guidelines, counsellors need to assess how best to ensure client safety when undertaking this assessment. For instance, if a woman telephones a relationship counselling organisation requesting couple counselling and during initial screening reveals that her partner has been abusive in the past, she could be offered an individual session to discuss her situation in more detail. Further information about the nature of the violence, the degree of present risk and why she is requesting couple counselling needs to be obtained prior to deciding whether or not to offer conjoint sessions.

However, couples may also seek counselling together and/or with children where it becomes apparent that domestic violence is present. In situations such as this, counsellors will have to decide how they will assess for risk without putting the woman or children at any

greater risk. This is often best achieved by offering an individual session to the woman.[3, 4] Appendix B provides information about known risk markers and issues for the counsellor to consider in relation to the assessment for risk markers and potential lethality.

The section on Domain 3 will discuss in greater detail the organisation's responsibility to develop policies and procedures that counsellors can follow once domestic violence and risk markers for lethality have been identified.

DISCLOSURE

A woman may not necessarily disclose domestic violence in response to screening questions or risk assessments, even if the screening or assessment is detailed and specific. Some women do not identify their partner's behaviour as abusive or domestic violence. This is the case with some forms of psychological abuse such as when a perpetrator undermines his partner's competence or sense of reality (James & MacKinnon 2010). She may be afraid or ashamed, anticipating that service providers will minimise the violence or its impact, or that they might blame her (Hester 2006). A woman may worry that if she discloses domestic violence, a service will be denied to her, such as being excluded from couple therapy. She may worry that counsellors will over-react by pressuring her into leaving her partner or urging her to report her partner to the police. She may fear child protection intervention and loss of her children. Even if the woman does not directly disclose violence, by gaining an understanding of her life and circumstances, the counsellor should be able to ascertain whether or not the women is a victim of domestic violence and her level of risk.

An ongoing relationship between a counsellor and her client where trust is established may facilitate the woman's disclosure of domestic violence. This will be considered in Domain 2, which addresses the counsellor-client relationship.

THE CLIENT'S SUPPORT NETWORK AND COMMUNITY

In this domain of the client, her family and community, counsellors need to assess the quality of the client's relationships with others outside of her immediate family. Defining the 'community' for a particular client ensures that the counsellor and client know who could provide support, who can be trusted to assist and who should be avoided. A client's community might include key people within a recreational club, a religious organisation or neighbours. Identifying key people who could be part of a safety plan is a priority for women at risk of high levels of threat. How this is done will vary depending on the relationships, but in most instances the woman would discuss her situation with trusted others and ascertain their willingness to help in specific ways if called upon.

A client herself may be involved with other services. These other services then, from the client's point of view, are part of her network. The 'community', once defined, can play an important role in giving advice and support, and needs to be considered as part of an overall community response (Regan et al. 2007). The counsellor can facilitate the client's relationship with other services and/or link her to new services within or external to their own organisation.

Practice Direction 1: ***Organisations need to develop screening processes and risk protocols so that counsellors screen all new clients for domestic violence and immediate risk markers for lethality.***

Practice Direction 2: ***Counsellors need to understand and acknowledge the reasons why a woman might not disclose domestic violence while still being able to recognise signs of domestic violence in the absence of a direct disclosure.***

Practice Direction 3: ***As a woman's extended family and community can significantly contribute to her safety, counsellors should explore the nature of the woman's involvement with others in her extended family and community and involve them in safety plans where appropriate.***

Domain 2: 'Engagement' – developing the therapeutic relationship between a client and a counsellor or the client and staff of the organisation

In this domain, counsellors aim to establish effective therapeutic relationships with clients, so they continue in counselling until they are safe or their situation is resolved. In considering this domain, counsellors' trustworthiness is demonstrated by relationship skills, such as conveying warmth and communicating empathically. Gaining the woman's confidence involves the counsellor demonstrating knowledge and competence in responding to the client's presenting concerns, which may or may not be about her partner, let alone about his violence.

The relationship between a woman and her counsellor can determine the degree to which she is willing to disclose domestic violence. If domestic violence is disclosed, the counsellor must respond giving due weight to the importance of sustaining the trust that

has been established. Finding ways to intervene that do not further disempower clients has been a principle of effective clinical, social work and health practice but one that is often difficult to achieve. The limits to confidentiality need to be clearly explained to the client and, as much as possible, a woman in a violent relationship should be able to guide and control major interventions, such as informing the police, having the perpetrator removed from the home, deciding to leave the home, notifying child protection authorities or going to a refuge. It is important that counsellors are cognisant of the fact that a woman's disclosure of domestic violence and professional intervention might result in an increase in the perpetrator's violence and plan accordingly.

In the face of a woman not disclosing domestic violence, sometimes called a 'false negative' (Block 2009), it is nevertheless important that counsellors are aware of the signs of domestic violence, such as avoiding eye contact with her partner if present; not discussing certain topics; evident injury; displaying fear and mistrust; depression and lack of sense of self (James & MacKinnon 2010). Sometimes a child makes the disclosure to a therapist in an individual session. The therapist immediately needs to involve the mother and assess the situation with adult input.

ONGOING ASSESSMENT

As trust develops in an ongoing relationship and as counsellors get to know the woman and her relationship with her partner or ex-partner, it is important that they keep informed of changes in the couple's circumstance and their implications for the severity of domestic violence. To do so requires ongoing assessment of risk throughout the duration of the therapeutic relationship. The counsellor's ability to 'frame' assessment questions and why they are asking them, to acknowledge and validate the client's reactions and back off if necessary, may enhance the client's engagement. It often helps to frame questions as 'routine' and as 'compulsory' so a client does not feel singled out.

It is important that the counsellor, having assessed for risks of lethality, is able to clearly communicate to their clients the nature of these risks.[5] While it is important to listen to clients' own assessments of serious risk posed to them, good practice suggests that the counsellor should provide information about what is known about the assessed risks and help women develop safety strategies and plans appropriate to those risks. These risks could also provide a rationale for a counsellor to breach confidentiality and report serious risk to police or child protection authorities. Making such reports without a client's consent is very risky for the client's relationship with the counsellor (MacKinnon 1998). As such, sensitive and truthful discussion with the client should precede any actions by the counsellor to notify others of the danger a client might be facing.

In situations of high risk or extreme danger, it is important that case planning and management occur in consultation with key personnel in an organisation, such as supervisors or a manager, so that counsellors are not alone in the decisions that they make. The organisation's role in providing clear policies, procedures and supervisory support is further discussed in Domain 3.

Practice Direction 4: ***As a necessary step in enabling a woman to continue to seek intervention for domestic violence, counsellors need to understand the importance of, and be competent in establishing, a positive ongoing therapeutic engagement with clients.***

Practice Direction 5: ***Counsellors need to ensure they continue to monitor the client's safety and violent partner's current behaviour (usually indirectly) throughout interventions, assessing for increased dangerousness and lethality risk makers in an ongoing way.***

Practice Direction 6: ***As a better understanding of their lethality risk can inform women's decisions about their safety, it can be helpful for counsellors to inform clients about known risk markers for lethality and discuss their relevance to the client's own situation.***

Practice Direction 7: ***If it is not appropriate for a counsellor in a generic counselling organisation to offer an ongoing therapeutic intervention with a client identified as experiencing domestic violence, it is important to know how to refer a client safely and sensitively to a specialist worker or service.***

Domain 3: The 'organisational context of intervention' – policies, procedures, roles and responsibilities

It is in this domain that an organisation ensures that it has done all that it can to prevent a domestic violence-related homicide. This involves a number of practices that, if adhered to, can be used to demonstrate that the counsellor, supervisor and manager did all that they could reasonably be expected to do in the circumstances.

Policies need to articulate the organisation's position about domestic violence and offer guidance to all staff, including counsellors, supervisors and managers, about their roles and responsibilities. Policies should define and describe the nature of domestic violence; the screening and risk assessment requirements; procedures for supervision and consultation; guidelines for the reporting of serious matters to superiors; and guidelines for reporting to police or child protection authorities. Organisations have a responsibility to ensure that their protocols incorporate and clearly detail the use of professional tools (such as formal assessment instruments or key interventions) that can be supported through counsellor supervision and clinical consultation (Regan et al. 2007).

Ideally, policies should specify a timeframe within which counsellors must report situations of concern to their supervisor. In some organisations, a majority of the clients experience domestic violence or have done so in the past and it is not possible for every situation to be discussed in supervision. However the outcomes of all assessments should be in writing and reviewed by supervisors within a defined time. Where a counsellor's assessment provides evidence of a high risk of lethality, the next step is an urgent consultation within the organisation about the case to determine immediate actions. Each person's role in responding to a client's account of increasing dangerousness needs to be clear. In fact, we recommend that agencies have something akin to 'disaster response training' based on realistic case scenarios, to clarify responsibilities and motivate staff to adhere to policy and follow procedures. This would ensure that all staff can understand and implement policy. It would also give staff an opportunity to contribute to the review and development of policy and procedures.

DETAILED CASE NOTES, SAFETY PLANS AND NOTIFICATION

If a woman reports that her husband or partner has made homicidal or suicidal threats, such threats need to be carefully documented in the case file and an immediate dangerousness assessment undertaken. A safety plan needs to be developed based on the assumption that the worst scenario is possible. Notifying police, child protection or other services should be a component of a safety plan.

In the event of serious violence towards a client or a client being murdered by her husband or partner, there should be an investigation into the effectiveness of interventions and protocols. In the case of homicide, there should be a fatality review. It is in the organisation's and counsellors' interests, and a requirement of best practice, that counsellors keep detailed case notes of their risk assessments, safety plans and supervision consultations.

TRAINING, STAFF DEVELOPMENT, SUPERVISION AND CONSULTATION

Policies and procedures, while necessary, are not in themselves sufficient. Counsellors need to be trained in understanding and implementing policies as well as adapting procedures to specific situations (Hanson, Harway & Cervantes 1991; Regan et al. 2007). Training and professional development is a key component to an organisation's response to domestic violence. Training should not be 'one off' but ongoing even for experienced staff. This means that people who are absent from work when the training is given, should be identified and receive training at another point in time. Regan et al. (2007) emphasise the need for training and support to be ongoing because their study found that counsellors often only received one-off training or forgot the content of even recent training events. In the event of a domestic violence-related homicide, the organisation needs to be able to provide evidence that the counsellor and/or other staff had participated in recent training and were aware of risk factors and knew how they should respond. (See Appendix C for proposed content of training.)

An additional essential ingredient for management of domestic violence risk and identification of dangerousness is a system of staff support, such as regular supervision and opportunities for consultation. Therapists, counsellors and other workers, if worried about a client, need to consult with a more experienced person or someone who is 'meta' to the therapist-client work. Supervisors should also have knowledge of the range of cases being seen by their supervisees. To obtain such knowledge, supervisors and supervisees need to meet regularly to discuss all clinical issues pertaining to the supervisee's cases and not limit discussion to case management. Ideally, senior management should require supervisors to audit all cases periodically, especially when counsellors are able to decide themselves which cases they will discuss in supervision sessions.

Supervisors need to be experienced clinicians with training in supervision, extensive experience as counsellors in the field and experience in dealing with domestic violence. Supervision discussions should be focused on the first and second domains (the client-family system and the counsellor-client relationship) of this multi-systemic model, with sufficient time for counsellors to de-brief, develop interventions, reflect on their relationship with their client and identify assessment issues that need further exploration. Using his or her 'super-vision', sometimes a supervisor can

identify situations of dangerousness that a counsellor might not have noticed. Supervisors, guided by agency policy, need to be available outside of the usual supervision time to assist counsellors dealing with crisis situations or in this context, domestic violence 'alarms'. Supervisors, in order to have such flexibility, need to be supported by managers and senior managers.

The role of the supervisor in relation to domestic violence should be specified in the supervision policy. The supervisory context is also the venue for counsellors to consider the role of other service providers and organisations, either as part of the problem or, potentially, as part of a solution as described in Domain 4.

Practice Direction 8: ***Domestic violence policy and procedures need to be developed by generic counselling organisations to guide staff and managers in their roles and responsibilities in identifying domestic violence and preventing domestic violence-related homicide.***

Practice Direction 9: ***The organisation is responsible for ensuring that all staff members receive appropriate training in domestic violence (either externally or internally provided) and that all counsellors are aware of and adhere to their agency's policies and procedures and how these are implemented. Training should occur annually to include new staff members and ensure ongoing professional development of other staff.***

Practice Direction 10: ***In order to ensure essential support for workers to identify and manage the risk of domestic violence, counsellors need to participate in regular professional, clinical supervision. Supervisors need to ensure that they are available for immediate consultation.***

Practice Direction 11: ***Counsellors need to ensure that they keep detailed case notes, developing and recording safety plans with any clients identified as being at risk.***

Domain 4: The 'system of services'

This domain focuses on the wider system of services, the relationships between services, and clients' and their families' relationships with multiple service systems. Each organisation is embedded in a system of other services and organisations within a given locality. They may actually share the same client or work with similar client groups. Each organisation is a part of a 'whole of community' response within the relevant community.

The counsellors in the organisation, at all levels of the hierarchy, need to be familiar with the system of service provision that exists outside of their organisation. Given that domestic violence often coincides with child abuse, clients are often involved in a myriad of services such as: community services; police; specialist domestic violence services; and child protection counselling services. Clients involved in family law disputes or going through separation may also be involved in Family Court proceedings and attending Family Relationship Centres. Some clients may be involved in the criminal justice system through contact with probation and parole or juvenile justice agencies.

Homicide or suicide threats could be disclosed to any service provider and issues of privacy and confidentiality need to be balanced with the 'need to know' and negotiated carefully between agencies. Having protocols in place for sharing information between counsellors at different levels in organisations may provide a safety net for a client at risk of being fatally attacked by her partner. Fatality reviews of domestic violence-related homicides often identify gaps in service providers' responses and in the flow of communication between organisations and services (David 2007).

In relation to interagency guidelines and response protocols, it is important for organisations to have considered information that can and cannot be shared. An agreement between services on what constitutes high risk for lethality facilitates communication between services and ideally enables a more integrated response to client needs. Organisations use different definitions of domestic violence and may use different screening and risk assessment instruments. Clients may be involved in more than one service and unless this is identified, warnings of potential lethality cannot be passed from one organisation to another.

It is both desirable and important that services agree on definitions of what constitutes 'risk' and the markers of potential lethality. It may be the case that a particular service is not equipped to assist a woman with her situation and referral to a specialist domestic violence service is indicated. Having a good understanding about the range of services available and good links and referral protocols will assist women to gain support. If the system of services is fragmented, with limited or no communication between services, women at risk of increased dangerousness from their partners may not be identified and offered the protection that could otherwise be provided.

Practice Direction 12: ***Effective links with other services enables designated workers in the organisation to be aware of the roles of other workers and organisations for possible referral and/or collaboration.***

Practice Direction 13: ***A shared understanding of what constitutes high risk for lethality and a common professional language can facilitate communication between services, ensuring a more integrated response to client needs.***

Practice Direction 14: ***Agreed protocols for sharing information about domestic violence risk with other services and organisations is critical to managing client safety and furthering collaboration within the system of services.***

CONCLUSION

This paper concludes with an important caveat. No matter how effective the response of services and counsellors is to domestic violence, it will never be possible to prevent all domestic violence-related deaths. Some men's homicidal actions cannot be predicted or known in advance and many women do not present at or are unable to maintain ongoing contact with services. Nonetheless, we believe that appropriate counselling intervention can assist women to understand their level of risk and better ensure women's and children's immediate and ongoing safety.

The multi-systemic framework presented in this paper is intended to guide organisations and their counselling staff in the development, implementation and evaluation of best practice strategies in relation to domestic violence across a number of 'domains' of their operations. Responding to domestic violence in the first instance is essential and the framework provides counsellors and their organisations with a 'conceptual map' that assists with the initial identification of domestic violence and the ongoing assessment of risk, dangerousness and potential lethality. When used by both organisations and counsellors, this framework can contribute to a comprehensive, multi-systemic response to domestic violence. Further, services and organisations that share a coordinated and uniform framework for understanding and assessing domestic violence will enhance each other's effectiveness in identifying and responding to high risk situations and ultimately in preventing domestic violence-related homicide.

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ENDNOTES

1 See for example, the Poulson/Phithak Kongsom murders/suicide; the Glenys Heywood murder; the Bell/Poxton murders/suicide; and the Jodi Cunningham murder.

2 We use 'counsellor' to refer to those employed as counsellors, as well as therapists and other workers who have a counselling component in their role.

3 See Gottman (1999) for a framework for assessing partners separately in the context of couple counselling.

4 While this paper is not intended to detail working with men who are perpetrators of domestic violence, some organisations may offer perpetrator programs or may choose to work with men individually. An overarching consideration for offering such a service is that it doesn't compromise the immediate and ongoing safety of his partner and children.

5 This information and the accompanying practice skills should be provided to counsellors in staff training which is part of Domain 3, the organisation's role. Appendix B provides information about known risk markers and issues for the counsellor to consider in relation to the assessment for risk markers and potential lethality.

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APPENDIX A – SUMMARY OF PRACTICE DIRECTIONS WITHIN DOMAINS

Practice Direction 1: Organisations need to develop screening processes and risk protocols so that counsellors screen all new clients for domestic violence and immediate risk markers for lethality.

Practice Direction 2: Counsellors need to understand and acknowledge the reasons why a woman might not disclose domestic violence while still being able to recognise signs of domestic violence in the absence of a direct disclosure.

Practice Direction 3: As a woman's extended family and community can significantly contribute to her safety, counsellors should explore the nature of the woman's involvement with others in her extended family and community and involve them in safety plans where appropriate.

Practice Direction 4: As a necessary step in enabling a woman to continue to seek intervention for domestic violence, counsellors need to understand the importance of, and be competent in establishing, a positive ongoing therapeutic engagement with clients.

Practice Direction 5: Counsellors need to ensure they continue to monitor the client's safety and violent partner's current behaviour (usually indirectly) throughout interventions, assessing for increased dangerousness and lethality risk makers in an ongoing way.

Practice Direction 6: As a better understanding of their lethality risk can inform women's decisions about their safety, it can be helpful for counsellors to inform clients about known risk markers for lethality and discuss their relevance to the client's own situation.

Practice Direction 7: If it is not appropriate for a counsellor in a generic counselling organisation to offer an ongoing therapeutic intervention with a client identified as experiencing domestic violence, it is important to know how to refer a client safely and sensitively to a specialist worker or service.

Practice Direction 8: Domestic violence policy and procedures need to be developed by generic counselling organisations to guide staff and managers in their roles and responsibilities in identifying domestic violence and preventing domestic violence-related homicide.

Practice Direction 9: The organisation is responsible for ensuring that all staff members receive appropriate training in domestic violence (either externally or internally provided) and that all counsellors are aware of and adhere to their agency's policies and procedures and how these are implemented. Training should occur annually to include new staff members and ensure ongoing professional development of other staff.

Practice Direction 10: In order to ensure essential support for workers to identify and manage the risk of domestic violence, counsellors need to participate in regular professional, clinical supervision. Supervisors need to ensure that they are available for immediate consultation.

Practice Direction 11: Counsellors need to ensure that they keep detailed case notes, developing and recording safety plans with any clients identified as being at risk.

Practice Direction 12: Effective links with other services enables designated workers in the organisation to be aware of the roles of other workers and organisations for possible referral and/or collaboration.

Practice Direction 13: A shared understanding of what constitutes high risk for lethality and a common professional language can facilitate communication between services, ensuring a more integrated response to client needs.

Practice Direction 14: Agreed protocols for sharing information about domestic violence risk with other services and organisations is critical to managing client safety and furthering collaboration within the system of services.

APPENDIX B – ASSESSING FOR RISK MARKERS

Risk assessment should not take place only once. If the counsellor has ongoing contact with a client, periodic risk assessment is necessary because people's lives change and the risk of severe violence or lethality changes accordingly. The questions that a counsellor asks should address the known risk factors for increased dangerousness and lethality, such as: ongoing high levels of coercive control, jealousy and domination; actual or imminent separation from partner; and any changes in custody or family law matters. Other risk factors for homicide that should be assessed include sexual assault, strangulation and use of weapons. A man's dangerousness and potential lethality increases if he has access to guns, abuses drugs and/or alcohol, is depressed and suicidal, or has expressed homicidal ideas or intentions.

Counsellors need to be aware that men who murder their wives or family members may have no known history of criminality, abuse of alcohol and other drugs or of physical violence (Dobash & Dobash 2009). A profile of a woman who is leaving an extremely controlling partner who is making threats of self-harm should ring alarm bells. In a study by Koziol-McLain et al. (2006), the following risk factors for domestic violence homicide and suicide were identified:

- prior perpetrator suicide threats
- victims having ever been married to perpetrator
- perpetrator having major health problems but not having sought treatment
- older men not having sought treatment for depression or having been put on anti-anxiety drugs and not anti-depressants
- access to a gun
- use of illicit drugs (a separate risk factor of homicide but not suicide).

The study also found that perpetrators were more likely to be married, employed and not use illicit drugs, thus demonstrating a higher degree of conformity and appearing less dangerous.

In assessing for domestic violence and risk, counsellors need to inform women not only about behaviours that constitute domestic violence but also about the risk markers for increased lethality. While most of the research suggests that women are often good at assessing their levels of safety (Gondolf 2002; Laing 2004; Regan et al. 2007; Weisz, Tolman & Saunders 2000), one study has suggested the opposite: that women may think they are safe when they are not (Campbell 2005). Moreover, women may simply not be aware of the lethality risk of some violent behaviour, like strangulation (often mistakenly referred to as 'choking') and sexual assault. Informing a woman about known risk markers will assist her to re-assess her own safety if she is tending to minimise danger.

Additionally, a man's ongoing pattern of coercive control may become dangerous to the point of lethality in response to changes initiated by his partner, such as accessing counselling and making changes as a result of counselling. This should not dissuade women from accessing counselling or taking steps to end the violence but is something that counsellors need to cognisant of; for example, in discussing safety issues with clients and enacting safety measures, such as having a place to go, if she were to make changes.

APPENDIX C – TRAINING AND STAFF DEVELOPMENT

Training should aim to address developments in knowledge and changes in what constitutes best practice. In particular, training should address the following:

- definitions of domestic violence as a pattern of coercive control and all forms of physical and non-physical abuse
- purpose and practice of screening and assessment of domestic violence; screening and risk assessment questionnaires and structured interviews
- clinical assessment of signs and symptoms when abuse is not verbally revealed such as: expressions of fear; avoiding eye contact with her partner; unexplained injuries; and depression
- perpetrator profiles and risk markers for lethality
- policies and procedures in relation to domestic violence and their implementation
- formal protocols for working with other services and informal networking with other service providers
- best practice guidelines for working with emergency services and specialist domestic violence services, such as hospitals, police, counselling services and refuges
- managing confidentiality and its limits.

Professional development needs to ensure that counsellors are familiar with:

- the role of mental illness in domestic violence, homicide and suicide
- the signs and symptoms of mental illness especially depression and psychosis
- skills in working with women in relation to domestic violence (e.g. developing trust; attending to safety; and respecting women's self-determination)
- skills in working with men, where appropriate for the organisational context (e.g. engaging men; confronting men; providing emotional support; dealing with separation and attachment based trauma; supporting men during a crisis)
- theories of attachment, trauma, gender and power in relationships
- the dynamics of family relationships, including closeness, distance, warmth and control.

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Australian Domestic & Family Violence Clearinghouse
The University of New South Wales
NSW 2052
p: (02) 9385 2990
f: (02) 9385 2993
freecall: 1800 753 382
e: clearinghouse@unsw.edu.au
w: http://www.adfvc.unsw.edu.au

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