Country Reports and Cross-National Comparison on the Risk Assessment Tools and Case Documentation used by Frontline Responders

Deliverable 2.3

Deliverable report for

IMPRODOVA

Grant Agreement Number 787054

This project has received funding from the European Union's Horizon 2020 research and innovation programme under grant agreement No 787054. This report reflects only the authors' views and the European Commission is not responsible for any use that may be made of the information it contains.

Published by the IMPRODOVA Consortium, Deutsche Hochschule der Polizei, Münster (Germany), March 2020

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1 Risk Assessment

Police

Risk Assessment procedures and response strategies

Risk assessment protocols for domestic violence (DV) cases vary on a large scale concerning their methodological background in the participating countries – whether they have been individually and locally, as well as developed by scientists, or whether they are the implementations of standardized, national-level or internationally used tools. **In one third of the countries participating in the IMPRODOVA project, no formalized risk assessment protocols exist.** In some countries where formalized tools are used, such as some parts of Austria (Vorarlberg)and Hungary, risk assessment tools are rather static, meaning that risk is examined and evaluated at a certain stage of the procedure and the timing of the risk assessment imposes certain limitations towards the procedure. In three countries, **Finland, Portugal and Scotland, and the city of Berlin (Germany[1]), the risk assessment is dynamic and is processed on an on-going basis as new information is received or incidents occur.**

In **Austria** a risk assessment tool, 'SALFAG[2]' has been developed **within the framework of a pilot project** by the Ministry of Interior**. Its mandatory use was restricted on a trial basis** mainly to the state Vorarlberg between 2013 and 2014. Since then it has continued to see discretionary use in this location. It was designed primarily **for the use by prosecutors, and is therefore not specifically adapted to the needs of the police.** In practice, it is predominantly employed only after the police officer has left the location at which a case of DV occurred. Mainly due to issues in practical on-site applicability and lacking procedural refinement, the tool is rarely employed or able to provide guidance on decision making, especially when filing charges or to issue a restraining order.

In **Berlin**, it is mandatory to classify domestic violence according to its threatening potential if further incidents of domestic violence are suspected. This risk assessment includes all relevant information about the affected parties and all observations of the police officers classified as relevant and thus depict essential police expertise. A checklist integrated into POLIKS[3] also provides additional information. The final classification is made on an eight-point scale, which can be updated at any time. The information on the case is also written continuously. In **Münster** (federal state North-Rhine Westphalia), **Hannover** (federal state Lower-Saxony)**,** in **Mannheim** and **Freiburg** (federal state Baden-Württemberg), **there are no standardized tools** to measure/indicate risk. As risk assessment is part of handling a DV incident, police officers do risk assessment as part of the documentation procedure without any specific, standardized guidelines or set of criteria.

[1] Statements regarding the situation in Germany are made on a general level. As Germany is divided into 16 federal states, the states differ in how police deal with DV cases.

[2] *Situational Analysis Tool for violence in families and/or violence in relationships*. The Austrian police apply the SALFAG to assess the likelihood of escalation of a dangerous attack including the assessment of a future risk. The SALFAG is an automatized online tool, which takes maximum 15 minutes to fill in. The analysis recommends opportunities for the next steps and a classification of danger through a number of red boxes that show the increase of endangerment.)

[3] Police data base

In **Finland**, **crime investigation units use risk assessment tools discretionally.** Response operations units (patrol units who work with DV cases on the sight) do not use any formal, standardized risk assessment; police, however, use **different risk assessment tools in the different locations**. In one of the locations MARAC[4] is applied, a dynamic risk assessment process, used with the participation of the different agencies and monitoring the victim's situation on a regular base. Concerning MARAC, it is important to mention that it focuses on violence between intimate partners, excluding all other types of DV. Therefore, a large amount of violence within families and other close relationships falls outside the scope of MARAC risk assessment. At another location a modified tool developed by The National Bureau of Investigation is used for screening and predicting serious and targeted violence (e.g. mass shooting), which is sometimes also used when investigating domestic violence cases. It is based on a checklist, considering risk factors such as changes in life situation, previously known violent behaviour, how persistently the suspect has tried to approach a person previously, if the suspect has damaged the victim's property, if the suspect has done something concrete for preparing violent acts or hurting the victim.

In **Portugal** there is a **DV risk assessment checklist**, created as part of a project led by the Ministry of Interior and **based on the review and implementation of the most frequent items of several risk assessment instruments, including DASH[5]**. The implementation process involved reliability tests, pilot applications and an experimental test phase. Since the tool's implementation in 2013, **its use has been mandatory.**

In **Scotland** police use the DAQ[6] questionnaire mandatorily. This is a standardised risk assessment tool based on the 24 DASH RIC questions, extending the DASH RIC with additional three questions relating to children and dependents, totalling 27 questions.

In **France, in Slovenia and in Hungary there are no formal, standardized risk assessment procedures designed for cases of DV in use by the police.**

In Slovenia the police are a member of a multidisciplinary team, managed by the Centre for Social Work that has its own risk assessment tool, and the police receives the results of the Centre's risk assessment. Some interviewees explicitly stated that there is no need for a second assessment by the police. In Hungary, there is a semi-formal risk assessment procedure related to the ordering of restraining orders. The police officer who is in charge of ordering a temporary (72 hour) restraining order (it can be a patrol or an investigation officer) has a checklist (regularity, time of the incident, physical injuries, residence of the perpetrator, emotional status of the victim, previous measures taken by the police, etc.) based on risk assessment tools used in the IMPRODOVA countries.
In France, there is a generic procedure of risk assessment which is applied for all crimes, and not just DV cases under the terms of "Personalized evaluation of the needs of the victim"[7]. This procedure is imposed by the code of penal procedure. The idea is that law enforcement

[4] MARAC – Multi Agency Risk Assessment Conference is an internationally used, victim focused information sharing and risk assessment meeting attended by all FLR's of high risk DV.
[5] DASH – Domestic Abuse, Stalking and Honour Bsed Violence is a Risk Identification and Management Model, implemented in the UK.
[6] DAQ – Domestic Abuse Questionnaire
[7] See document D1.3.

pay attention not only to identifying and arresting suspects, but also to protect and accompany victims. Once the criminal complaint report is transmitted to the prosecutor's office, the prosecutor can decide to further examine the victim's situation, having recourse to a specialized NGO (funded by the Ministry of Justice) which has developed acknowledged expertise in conducting "social investigations" (that is examining the psychological and social aspects of the DV situation with emphasis on victim security). In addition, all the French gendarmerie and some police units use DV pre-hearing questionnaires. Nevertheless, these tools are not specifically designed for risk assessment. They are interview guides including details necessary to assess the risks and to define protection measures; to make sure that investigators don't forget to ask important questions during the hearing of the DV victim. The use of DV pre-hearing questionnaires are components of the case management software, their use is mandatory in the gendarmerie and discretional in the police.

Type and scope of use of risk assessment tools in the IMPRODOVA countries

	Category	**Type of tool**	mandatory	discretional
AT	individual	locally developed risk assessment protocol	X (Only during Trial Period)	X
Berlin	individual	formalized local procedure	X	
FI	standardized / in some locations no formalized tool	diverse: MARAC and in some units no formalized tool		X
FR		no formalized tool, but generic assessment procedures and DV pre-hearing questionnaires that contribute to a better assessment of the risks	X (gendarmerie)	X (police)
GER	individual	- in some locations no formalized tool - in other locations locally developed risk assessment protocols		X
HU		no formalized tool		
PT	individual	locally developed risk assessment tool	X	
SCT	standardized	DAQ tool	X	
SLO	-	no formalized tool		

Shortcomings

Austria

A crucial challenge faced by the officers is that the application of the Risk Assessment tool is not integrated in the routine knowledge and practice of frontline responders. Additionally, it takes on considerable amount of time. A further shortcoming mentioned is the timing of the risk assessment: As it is filled in after the decision to issue a restraining order, it is not providing any guidance during police actions for the patrol officers; thus they do not consider it as useful and rather use it as a “formality” to execute than a real tool for risk assessment. Moreover, on one hand the validation of the outcomes seems lacking in comparison to international best practices; on the other hand the tool does not include the perspective of frontline responders (FLRs) on the case as part of the risk assessment.

Finland

Lack of regular, systematic use of the risk assessment tool is the main shortcoming mentioned by the interviewees. A further problem mentioned was that as the power of MARAC lies in the multidisciplinary team, when using the MARAC method, the participation of the police is not mandatory. Even if there is no police officer present, the MARAC team meets and does the risk assessment without the involvement of the police.

France

The risk assessment and the choice of protection measures are performed by the prosecutor, while information necessary to take appropriate decision is gathered by the police. As a consequence, failures, distortions or misunderstandings in information sharing between investigators and prosecutors may affect the victim’s security.

Germany

In parts of Germany where no specific risk assessment tools are used, the police do not mention any shortcomings about the risk assessment procedure. Those units are satisfied with the fact that they do not have to use any checklist of indicators / measurements to gauge the risk; they have no restrictions when assessing and documenting the risk, and reflecting the specifics of a DV incident. In Berlin, however, where a formalized risk assessment is applied, officers see the value of a structured procedure.

Portugal

Portuguese interviewees consider the risk assessment checklist very useful compared to the situation before 2013, which was characterized by strong subjectivity and lack of a unified approach towards risk assessment. The only shortcoming mentioned was the nature of the risk assessment model, which is strongly contingent and is necessarily oriented to the present moment, meaning that it captures only a snapshot of the DV situation and this circumstance restricts its validity.

Scotland

Using the DAQ tool, some Police officers mentioned that answers to the DAQ are context dependant on a range of factors, including some features of the enquiring officer (gender, age, attitude); timing of DAQ questioning in relation to the incident; and the willingness of the victim to engage (some may be too fearful to make a disclosure). The DAQ is considered to be a valuable tool, but not one that can be used independent from other information and professional experience drawn upon by FLRs in their assessment of risk.

Suggested improvements

As part of the interviews, questions regarding possible improvements of risk assessment procedures were asked. In most participating countries, such as **France, Germany, Finland, Slovenia and Hungary** police officers do not recommend any specific aspects of a possible improvement of risk assessment procedures. Surprisingly, **in those countries where formalized risk assessment protocols are missing, police officers typically do not express the need for such tools.** In **Scotland**, officers highlight **the lack of internal and external (further agencies) feedback about the pathway of cases after filing a DAQ risk assessment report**, and recommend improvements on that field. In **Portugal**, although the responders do not present any specific suggestions, the team made the conclusion that improvement is needed concerning the risk assessment tool due to the currently high number of homicides in cases already signalled to the police, and because the risk assessment tool has not been updated since the beginning of its application in 2013. In **Austria,** it is suggested as an outcome of the interviews that a multidisciplinary crisis team would be useful, which shares the responsibility of the risk assessment procedure and placing of the restraining order. A further improvement of the procedure would be when the restraining orders were issued after the risk assessment procedure and took into consideration the outcomes of the risk assessment. Right now, the speed at which restraining orders are issued do not allow for an elaborated risk assessment procedure in every case.

Collaboration and information sharing in DV risk assessment

In most of the participating countries where formalized risk assessment procedures are used, further statutory agencies also benefit from the results of risk assessment. The following table lists such information sharing and also shows those cases where the different agencies cooperate in the risk assessment procedure:

Type and scope of use of risk assessment tools in the participating countries

	Further agencies who cooperate in the risk assessment process	**Further beneficiaries of police risk assessment (those agencies with whom the police possibly shares the results of risk assessment)**
AT	District Administration	District administration[8] (DA) - a statutory body, which is making a decision to uphold or reject the restraining order and to take further measures based on the risk assessment results (when this tool is employed) and the police report. The DA decides on involving other actors
Berlin	Victim support services, institutions, authorities and persons who are helpful in the respective case	Victim support services etc. (see left side), but only in cases when 1) law enforcement or danger prevention is concerned, *and* 2) the bodies to be informed are necessary for the fulfilment of this task (according to the General Safety and Order Act). The passing on of information must always be documented (in the case file).
FI	Social workers, victim support services, child welfare services, health services	Social workers, victim support services, child welfare services, health services
FR		no formalized tool, but the generic risk assessment process benefits the public prosecutor and victim support services
GER	-	Only police
HU	-	no formalized tool
PT	-	Public Prosecutor's Office(always, eventually to make accusations), Social Work and NGO's (in cases where victim support is necessary)
SCT		social workers and other statutory bodies, such as health and education and also voluntary sector victim support agencies
SLO	-	no formalized tool

[8] The district administration or district captaincy (Bezirkshauptmannschaft) is the representative organ of the state administration on district level. Relevant to the networked response to DV, the district administration also houses the position of *Security Administrator* on district level, tasked with the post-facto verification of all restraining orders issued by law enforcement. If the decision to issue a restraining order is seen to not fulfil the condition of proportionality, the *Security Administrator* is able to order a withdrawal a restraining order. *Security Administrators* also produce reports on cases of DV, intended to inform prosecution.

Perception of risk assessment procedures

In **Austria**, interviewees complained about procedural challenges in the use of the piloted risk assessment tool in the daily work of the police. In **Finland,** police officers consider the MARAC tool as an effective means to bring experts together and use information to piece together an overall picture of the victim's life situation. The main advantage of MARAC compared to other methods by the respondents was captured in the wide, multi-agency level cooperation and the dynamic nature of the risk assessment. In **Scotland**, the aspect, which was highlighted as useful in relation to the DAQ tool was the tool's ability to disclose abuse in cases where a victim would not report DV due to their fear of repercussions. In **Portugal,** according to the case studies, the police interpreted the tool as useful, and reasoned that its strengths lies in the tailor-made nature of the tool according to the needs of each agency. Although, in one location they mentioned that the checklist makes risk assessment procedures more mechanical and less comprehensive. The chosen procedure is sufficient for the Berlin police and is currently not questioned in any way.

Special focus on vulnerable groups in risk assessments

Regarding vulnerable groups only children are mentioned by the majority of IMPRODOVA countries as a specific group of vulnerable victims who are taken into consideration in the risk assessment tools and targeted with specific questions, and sometimes even with a peculiar way of questioning methods. Most interviewees do not reflect on other vulnerabilities regarding the DV-related risk assessment. **Finland** covers a specific type of DV-related crime, and its target group: honour-related violence suffered by immigrant women. As they report, there is a wide expertise and a multi-agency partnership using special risk assessment protocols (similar to PATRIARCH tool that is used in Sweden) regarding the handling of these types of cases, including the Targeted Threat Investigation Team, Preventative Policing Unit, and victim support services. Honor-based violence is also given special consideration in the Berlin police (**Germany**). **French** risk assessment processes pay special attention to disabled people. **Portugal** has mentioned a growing concern about the elders as a social group at risk, and those who are isolated in their homes being the most vulnerable.

Health Sector

Risk Assessment procedures and response strategies

We do not have comprehensive information about a standardized risk assessment tool in **Scotland,** though NHS Health Scotland is promoting the use of the DASH RIC amongst Health Visitors. With regard to other groups of health workers in Scotland, training on the use of the DASH RIC varies across health board areas. Some have done training with mental health and sexual health staff, but this is not consistent across the country. In most of the participating countries, including **France, Germany, Slovenia and Hungary are there are no formalized DV risk assessment processes in the health sector**. A prevalent opinion within the medical professionals of these countries is that **they do not see DV-related risk assessment as part of their job.** According to their understanding the health sector's responsibility is restricted to document the incident and the injuries. According to our understanding this attitude is not very beneficial, since health care is an entry point for many DV cases, which might remain in latency in case of an insufficient risk assessment.

In **Austria**, Child- and Victims Protection Groups are discretionally used as part of risk assessment in hospitals, developed by national authorities and professionals (based on Campbell's Danger Assessment[9]) and adapted during the initiative "Living FREE of violence". The tool in this form is solely used by medical professionals, but includes indicators compatible with others based on the Danger Assessment (Campbell, 19xx). The assessment consists of questions seeking to reconstruct past incidents of violence in the relationship and a checklist to guide possible steps to increase the security of the victim. The medical sector further employs a standardized forensic documentation procedure in cases physical injury. This also includes indicators relevant to risk-assessments in cases of DV.

The tool is used by internal experts on DV within hospitals, but physicians and other medical professionals are trained by them to use the tool and to cooperate in the risk assessment procedure.

In **Finland**, some emergency units use PAKE Abuse and Body Map form, which is a tool used in assault and abuse cases (not just DV cases). Medical professionals, doctors and nurses are trained to use this tool. The purpose of the PAKE form is to improve the comprehensive treatment of the victim, including psychological condition and legal representation. It also intends to facilitate cooperation between health care, social work, the police and judicial authorities, and to advice the victim about available services. PAKE involves a detailed map of injuries. It covers the cause of the injury, the violent action, consequences of the action, further threats, pain, victims' psychological condition, the involvement of children, and the follow-up treatment. PAKE is mandatory in those emergency rooms where it has been implemented. A doctor writes a medical report based on the PAKE form and sends it to the police if the victim gives his or her consent. However, health care professionals can only encourage the victim to report an offence to the police and can send information to the police only if the victim gives his or her consent.

[9] DANGER ASSESSMENT. Jacquelyn C. Campbell. Copyright 2004 Johns Hopkins University, School of Nursing

In **Portugal**, there are two different sectors of the health system that face DV victims: hospitals and health centres. The first ones deal predominantly with emergencies, often quite close after a DV incident; the second ones deal with situations known within regular medical appointments (indoor approach) and during community medical work (outdoor approach). Both sectors mandatorily use standardized, locally invented risk assessment tools, owned by the Ministry of Health[10]. An interdisciplinary team, including medical doctors, nurses, psychologists, social workers and even the police, if necessary, ensures that the risk assessment procedure is participatory and multidisciplinary. The tool includes a set of various steps to consider: (1) screening, (2) detecting/assessing, (3) diagnostic evaluation (hypothesis), (4) registering, (5) acting, and (6) signalling. Risk indicators cover different forms of threats, injuries; severity, intensity and frequency of violence; involvement of alcohol or other substances; and crime history. The risk assessment tool also contains items related with the risk perception of the victim. Imminent danger is diagnosed when there is the possibility of experiencing an imminent episode of violence, life-threatening for the victim (and/or her/his significant persons). It is based on information from the interview, the victim's perception, a bio psychosocial assessment, and a physical exam.

Shortcomings

In **Austria**, main shortcomings described are not related to the tools employed, but to the environment they are used in. Time constraints are mentioned and in some hospitals the lack of mandatory sensitivity trainings for medical stuff to gain expertise in using the tool. The Child- and Victims Protection Groups are not yet implemented in all hospitals in Austria, since roll out is going on. Implementation is seen predominantly in hospitals that were involved in the project "Gewaltfreileben" (Living Free of Violence) in Vienna. The risk assessment process and the groups are not regulated on a policy level. This seems to be an important gap in response to the high importance of hospitals for the identification and treatment of victims of DV.

In **Finland** a shortcoming mentioned in relation to the PAKE form is the paper form. In case of an electronic form it would be much easier to share information among the agencies. It might also vary how systematically PAKE is used in other areas in Finland.

In **Portugal**, two shortcomings are mentioned in relation to the risk assessment tool used at health care services. First, the time consuming nature of the procedure, second, that frontline responders were not involved in the design of the risk assessment policy, despite the fact that they have proper knowledge.

Suggested improvements

Interviewees of all countries that use DV risk assessment tools in health care emphasized the importance of continuous, mandatory training of the FLR's for the use of the risk assessment tool, and the lack of sufficient trainings and properly trained staff as a problem.

[10] I*interpersonal violence: Approach, diagnosis, and intervention in the health services* (Violência, interpessoal: Abordagem, diagnóstico e intervenção nos serviços de saúde, 2016

Collaboration and information sharing in DV risk assessment

In **Austria**, although the Child and Victim's Protection Groups as tools are implemented and **used only by the internal experts of the groups and medical professionals, the same** tool is frequently used in the social sector. That often results in collaboration between the sectors, since they have a shared understanding of indicators relevant for assessing risk in DV cases.

In **Finland**, PAKE tool used by emergency departments is sent to the police in case an investigation is ordered based on a victim's report. Health care professionals can send information to the police only if the victim gives consent. Health care professionals do not have an obligation to report DV cases, they can only encourage the victim to report an offence to the police.

In **Portugal**, at the case locations, risk assessment is carried out by a multidisciplinary team. Medical doctors, nurses, psychologists, social workers (police officers, when necessary) constitute the team that carries out the risk assessment process.

Special focus on vulnerable groups in risk assessment

Within the networked response to DV **in Austria**, the health sector appears to be a central entry point for a number of vulnerable groups. Particularly **elderly people and children or young adults** may seek aid from hospitals in case of DV incidents rather than calling law enforcement or approaching a social sector organisation. The barrier to entry might be lower in this sector, as the stigma experienced by victims of DV may be temporarily overcome when seeking help for a medical ailment. Notably, victims of neglect (usually the elderly and children) or persons exhibiting psychosomatic symptoms (e.g. victims of sustained violence or with trauma) may sooner approach the health sector than others. Finally, **immigrant women** may sooner seek medical attention than other forms of help, as interactions with law enforcement frequently have negative connotations (or they may have had bad experiences in the past) and they may not know many social sector services. In these cases, the language barrier is frequently a problem; medical staff often relies on family members for translation, which is highly problematic.

In one of the cases studied in **Portugal**, the interviewees mention elders as the main vulnerable group who suffer from DV, in this case the difficulty of detection is considered a great problem. It is difficult to make a differential diagnose between (for instance) a fall and an assault.

Social Work and NGOs

Risk Assessment procedures and response strategies

The social work sector is the FLR area where the use of formalized risk assessment tools is predominantly in place in most of the participating countries. In **Germany**, formalized tools are only used in some locations. In Berlin, a standardised risk assessment tool ("Düsseldorfer Gefährdungseinschätzungsverfahren in Fällen häuslicher Gewalt - D-GEV") is currently being used in one women's shelter. In response to an inquiry to the institution that was involved in the development of the tool, it was confirmed that this instrument is used in the social sector in Düsseldorf, but also in individual institutions all over the federal state of North-Rhine Westfalia. Further, in Berlin, a translated version of Campbell's Danger Assessment will probably be available next year; social institutions that will cooperate with the police in case discussions have agreed on using the tool once it is accessible. In **Finland** and in **Portugal** formalized tools are only used in some of the locations. The countries vary in the scope of their risk assessment tools, some of them developed local, individual protocols used by each FLR's, others use standardized protocols, used nation-wide in all institutions with the same profile. The following table lists the categories, types and scope of risk assessment tools in the social sector:

Type and scope of use of risk assessment tools in the participating countries

	Category	**Type of tool**	mandatory	discretional
AT	standardized	diverse: Danger Assessment Dynamic Risk Analysis System (DYRIAS) Domestic Abuse Intervention Programs (DAIP)	DA: Mandatory during the first consultation in Women's Shelters in Cas location 1. Within the Centre for Protection Against Violence in Case location 1 the DA is also mandatory for the first consultation to assess the risk.	DYRIAS: Discretional in Centres for Protection Against Violence in CL2. DAIP: Discretional in Women's Shelters.
FI	standardized / No formal risk assessment in some places	diverse: MARAC and in some units no formalized tool	Mandatory in shelter services and discretional in NGOs and social services	
FR	individual	Individual risk assessment developed only by the most structured and professionalized NGOs.		X

GER	No formal risk assessment in most places	D-Gev. Standardized risk assessment tool, used in Berlin and other places in Germany		in at least one women's shelter in Berlin
HU	standardized	National level risk assessment protocol, developed by health professionals, psychologists, social workers and experts of social policy	Mandatorily used by the National Crisis Telephone Information Service	
PT	individual/ No formal risk assessment in some places	individual risk assessment developed by FLRs		X
SCT	standardized	DASH RIC		X
SLO	standardized	Assessment of the degree of threat to the victim of violence	X	

Shortcomings

The following shortcomings are mentioned by the participating countries regarding risk assessment tools used in the social work sector

Practical problems of implementation

- DYRIAS is regarded as requiring too much time (it takes about 4 hours) for daily use (Austria).
- In Berlin, the instrument is excellently suited for obtaining valuable information from which ideas for effective approaches often can be derived. However, the actual result is rather ignored, as the victim's assessment is not taken into account. This is not problematic as the intended objective to systematically obtain information is definitely achieved. (Berlin, Germany).There is often a great gap between the perception of risk assessed by the social worker and by the victim. Some signs are evaluated very differently by the social worker and by the victim. These ambiguities lead social workers to neglect standardised risk assessment tools (Hanover, Germany).
- Time consuming nature of the risk assessment (UMAR), too much paper work (Portugal).
- Lack of proper weight of the risk assessment results (APAV) by other FLR's (Portugal).

Methodological shortcomings

- Women's shelters in CL1 identified a missing tool for DV cases concerning forced marriages and specifically for family violence (Austria).
- Although the victim's own perspective of the risk is important, women are often traumatized and distressed when arriving into the shelters, which makes it difficult to use standardized tools for including the victim's individual perception of risks (Austria).
- Some FLR's used the MARAC form not according to instructions; some professionals working in shelters believe that the form makes the risk assessment process too mechanical, thereby not beneficial when discussing the violence with the victim (Finland).
- Risk assessment does not have a judicial weight, if there is no judicial decision (e.g. a permanent restriction order), regardless of the risk assessment results by FLRs there are no proper measures to protect the victim in the shelter from the perpetrator (Hungary).
- Children's opinions are not considered during the risk assessment process (Hungary).
- Risk assessment criteria are too strict. The risk assessment process does not consider the previous history and context of violence, but only the actual violent action that took place. As a consequence, they may filter out some DV cases (do not give access to shelters) that are in fact high risk (Hungary).
- Risk assessment tool is not detailed and sophisticated enough, which results in difficulties to decide on the level of risk (Slovenia).
- There are discrepancies (lack of clarity) between the level of perceived risk among police officer and social work sector (Slovenia).

Suggested improvements

A problem mentioned by more countries' interviewees is that formalized risk assessment tools can narrow the perception of frontline responders and may result in "tick boxing", less sophisticated categorization of the risks. Professional expertise and the thorough knowledge about DV cannot be replaced by any risk assessment tools, and are essential for the proper use of tools. Thereby a great emphasis should be put on the risk-related trainings of FLR's who are using the risk assessment tools. Slovenia suggests specifying the risk assessment tool further, while some Hungarian interviewees (directors of shelters) try to compensate the rigidity of the formal risk assessment tool used by the National Crisis Telephone Information Service, which often results in misdiagnosing situations by making decisions being contrary to the formal assessment.

Collaboration and information sharing in DV risk assessment

In **Austria**, there is no specific cooperation concerning the use of risk assessment tools. The results of risk assessments remain internal to specific organisations and are usually part of internal case-documentation. The formal sharing of risk assessment results is understood to be inhibited, if not prohibited, by data protection and the victim's privacy rights. Sharing risk assessment outputs is only possible with the victim's consent or in an anonymized form, an example being the (currently discontinued) MARACs in Vienna. Nevertheless, within the project "Living Free of Violence" the cooperation between health and social sector is in its early roll-out stage, designed to improve communication between the sectors. However, this will not facilitate the sharing of risk assessment outputs.

In **Finland**, MARAC consists ideally of two phases. Firstly, the risk assessment is performed in form of an interview with the client (in shelter services, social services etc.). In the second part if the client gives his or her consent and if there is an operative MARAC group in the client's area, information is exchanged at a multi-agency risk assessment conference and actions are planned for improving the safety of the victim. If there is not a MARAC group in the area, professionals can work by themselves and prepare a safety plan etc. with their clients.

In **Hungary**, the risk assessment used by the social work sector is officially not shared with any other agencies. Although, results of informal risk assessment processes used by shelters are often used in criminal procedures. E.g.: shelter workers try to compensate shortcomings of the formal risk assessment by the police and health care by photo-documenting the victims' injuries and sending it to the police. The medical report made by physicians captures the actual situation, but some injuries get worse by time. Shelters mention cases where minor battery was upgraded to a murder attempt by the police later based on the photo documentation of the shelter's informal risk assessment. This is an individual effort and the police can decide to take it into consideration as part of evidence. But according to the experience of the shelters, police usually make their documentation part of the case file, and thereby their risk assessment has an influence on the judicial procedure.

In **Scotland**, the police and other frontline agencies in the statutory and voluntary sector gather and share information from the risk assessment process where appropriate. Based on the DAQ and DASH RIC risk assessment processes conducted by the police and other FLRs, victims at high risk (who respond positively to 14 or more questions) are often referred to the MARAC process. MARAC takes place as a multi-agency cooperation among police, *health, social work, NGOs, housing and education.* The purpose of the MARAC is to assess and manage risk amongst victims of DV who are considered to be at very high risk.

In **Slovenia**, a multidisciplinary team covering all FLR's takes part in the risk assessment process. Risk is assessed within the framework of team meetings, where further actions and intervention of the different agencies are also discussed.

According to the results in **Germany** and **Portugal** only the respective FLR's of the social work sector are using the risk assessment tool. There is no information about any inter-agency cooperation or information sharing. There is no information about inter-agency

cooperation between the agencies in risk assessment processes from **France**.

In **Portugal**, a culture of mutual distrust between police institutions and NGOs prevails. The latter fear the reduction of domestic violence to a police case, considering that the victims are often unprotected, and require from the police a more muscular intervention on the aggressor that the law does not foresee. In turn, the police seek to obtain more information from NGOs, in a logic of partner entities of police investigation, and often NGOs reject such collaboration. In essence, a culture of partnership is what has to be built, and it is something that is not being done overnight.

Special focus on vulnerable groups in risk assessments

Austria describes the problem that DA and DYRIAS are focussed mainly on Intimate partner violence (IPV), they are also only limited available in other languages. They are less useful for elderly people and in cases of DV, which are not IPV. RA tools also face the challenge to be employed in cases with victims with cognitive disabilities.

2 Case documentation

Police

Case documentation procedures and response strategies

The police in the project countries document a variety of information in DV cases; there are some countries, where specific DV case documentation does not exist; some of the countries use a standard protocol for all kinds of crimes; others have specific protocols for DV cases.

In **Austria**, cases of DV are not documented differently than other criminal charges; these cases are recorded by police in their standard documentation system. The main elements of the general case documentation of police are the offences allegedly committed and a description of the circumstances of the restraining order. It is stored in the standardised internal electronic case documentation system used uniformly by LEA. However, there is no specific template for documenting DV cases beyond the general reporting template.

In **Finland**, police officers of the *response operations units* attending on the spot (where DV incident might have happened) document their observations in writing in the record of an offence (in the account section, or investigation meme, which is the non-public part of the record of an offence containing notes and observation of a patrol police officer or an investigator). Police do not have separate instructions about how detailed the information about risks should be when it is entered in the report of an offence. Principal rule requires that the police must report the details of events, parties' narratives, police patrol's observations about violence and used coercive measures. Additional information obtained from the recordings of the emergency calls or previous knowledge about suspect's attitudes towards violence influence police patrol's situation assessment, decision-making and actions at the scene, but they are not necessarily recorded in the crime report unless the police consider these to have substantial influence on matters. The patrol officers even photograph injuries and store them in the crime scene file with a crime report number. If any samples or objects are salvaged at the scene, a note is carefully filed in the police information system. Pieces of information that are relevant are entered into various information systems and registers. These information systems include emergency centre's information system (ERICA), police's field operations information system (POKE), and police information system (reports of offences). Police information system (PATJA) in which offences and police actions are recorded is most important in relation to case documentation. PATJA is a national system and police officers regularly use it to find information about persons and cases if they e.g. assess risks related to certain person.
An investigator of a *crime investigation unit* conducts preliminary investigation of a case. PATJA has a place for notes through which the patrol can pass information about their observations and other relevant information to detectives. Then detectives can check ERICA and PATJA information systems to find out whether the parties have previously been involved in any policing tasks and if the parties have a criminal history. The crime investigator enters a considerable amount of information into preliminary investigation documents that could be regarded as useful for risk assessment. This information does not move from these documents and interrogation narratives to PATJA unless the investigator does it. An investigator can fill in the report of an offence with additional facts found out in

interrogations and otherwise. More often investigators detect matters that are significant in the crime process such as improved descriptions of criminal acts and criminal claims of the parties.

In **France**, the investigator in charge of a case produces a summary of the facts, which is presented to the prosecutor (in writing and orally), on the basis of which the prosecutor takes the measures it deems necessary. This is not a risk assessment but a description of the case that contains elements, which are used by the prosecutor to evaluate the DV situation: evidence of the seriousness of injuries, indications on the psychological condition of the victims, criminal record of the perpetrator and situation of children, and so on (for more information see Deliverable 1.3). The pre-hearing questionnaire helps the investigator to produce a better description of the facts, and to not forget information and evidences useful to bring charges against the perpetrator.

German patrol officers (who first arrive at the crime scene of a DV incident) must always complete a document/form. The police in Germany are legally obliged to record, protocol and investigate criminal offences (principle of legality according to § 163 StPO). This also affects DV cases. In Germany, victims of criminal offences also receive an information sheet with data on reporting the crime (offence, place and time, contact details of the police, support facilities for victims and information on victims' rights). In a large number of cases of domestic violence, the perpetrators are expelled from their respective homes. This measure must be documented by the emergency services in Germany, too. In *Berlin*, in cases of individual threats, also in DV cases, a further document is filled in by the emergency services, in which, among other things, personal data, course of events, risk assessment, measures taken are documented.
Documentation of a DV case has to be done in the documentation system. Whenever a case documentation takes place at the police, the finalized report usually goes to the documenting police officer's supervisor for a quality check, before it will be handed over to the next department (like the responsible criminal police official for domestic abuse or the criminal police unit dealing with sexual offences) or party (state attorney) working with the file.
Specific information from some case locations of the field work can be also identified. A couple of years ago in *Münster*, a special tool for case documentation in cases of DV existed that allowed the police to get information about specific addresses and if DV occurred before. This tool does not exist anymore and they use the central system now to get those information. In addition, the finalised reports are not checked by a supervisor in Münster.
In Münster, patrol officers fill two to three documents at DV crime scenes: The first one is the criminal charge – the progression of events, personal data and the offence are documented. This has to be done at every crime no matter if it was DV related or not. In a DV case two additional documents have to be filled in that are called "Case documentation in cases of DV" – both include almost the same information (personal data, progression of events, risk assessment, medical certificate, interpreter attended or not, taken measures e.g.). Both will be stored at the police. The victim will get one document that he or she can use when he/she goes to the prosecution requesting a restraining order for the perpetrator. The other one with less information will be handed to the perpetrator informing him about the accusation, the taken measures and his rights. Because it is stored at the police they know if a breach against the restraining order occurs when the perpetrator goes to the

residence before ten days are over.
In *Hannover*, case documentation in a DV case has to be done at the day the police is informed about the offence (either by an emergency call when they had to drive to the scene or by a victim showing up at the police station). As soon as they have finalized the report, they have to fax it to the consultancy central (BISS), who forwards the fax to the consultancy being the most qualified for the matter and who then proactively contact the victim and the perpetrator separately. In *Berlin*, the case documentation is part of the regular system for the processing of information and communication (POLIKS).

In **Hungary**, police officers arriving at the scene after a report about DV, collect information about personal data, detailed description of the DV action that serves as a background case of the police measure, brief description of the police measures that had been taken (with a special emphasis on the coercive measures that had been used), description of those measures that serve as protection for the victim (e.g. providing information).
There are some specific elements of case documentation regarding restraining order: a) the criminal action that has happened, b) the proofs of evidence, c) the proof of the evidence (declaration of official document) for the victim's status as being a relative of the offender, d) the proof of evidence for the "legal capacity to act" regarding the offender. If the victim and/or the perpetrator are not in present when the officers arrive, they have to be informed about the restraining order (by phone, by text message or by e-mail).

In **Portugal**, DV case documentation is based on the collection of standard information which allows the transfer of information about the cases coming from different sources. The main requirements are based on the ecological systems theory[11] that considers the process, person (victim, aggressor), context and time, and gives space for a more accurate and efficient intervention. The accurateness enables the production of sustained evidence for criminal prosecution. During case documentation, statements of victims and independent witnesses, victim's injuries and testimony of police officers are also collected in the reports. The information is gathered in the police station, by the RDV1L (the first risk assessment for the victim) and RVD2L (the second assessment that aims to understand whether the level of risk, assigned in the RVD-1L, was maintained, decreased or worsened). All information regarding a case of domestic violence is recorded in a database (BDVD), from which relevant information is extracted, namely about cases of re-victimisation (from the point of view of the victim), about perpetrators who re-occur in their violent conduct (toward the same victim or others), and every year a report is produced to monitor the phenomenon of domestic violence. In addition, notification of National Commission for the Promotion of Rights and the Protection of Children and Young People (CNPDPCJ) could be also necessary in specific cases.

In **Scotland**, it is mandatory for a response officer to complete a Vulnerable Person (VP) entry following their call out to any reported DV incident. Their creation of VP report follows any DV incident they are called to. This Vulnerable Persons' Database (VPD) entry includes information from the completed Domestic Abuse Questionnaire (DAQ); indications of a victim's consent for referral to other agencies; the responding officer's thoughts about a situation out with the material facts of evidence.

[11] Bronfenbrenner, U. (1979). The Ecology of Human Development: Experiments by Nature and Design. Cambridge, Massachusetts: Harvard University Press.

In **Slovenia**, police react when they recognised that someone's safety is under threat of DV. However, police do not use specific risk assessment tools and do not have DV related procedures and documentation.

Shortcomings

During our fieldwork, we also collected information about critical shortcomings of the case documentation procedure, which were mentioned almost in all of the participating countries (except Germany). As the interviewees in **Austria** emphasised, case documentation implicitly records the officers' perception and assessment of the situation including risk factors. However, these are no standardised indicators but rather guiding questions. In **Finland**, information that may be relevant in assessing risks and threats are entered in different systems, which do not necessarily "talk" to each other. Consequently, valuable information can be scattered all over and it cannot be easily merged together. In addition, not every police officer has access rights to all information systems. Interrogation is also a situation that can produce information that is relevant to risk assessment, but the transfer of interrogation narrative to electronic police information system (PATJA) depends on the investigator's own initiative and habits. As relevant information is dispersed in various "locations" it is practically very hard, or even impossible to use or find all potentially relevant information from every source in actual risk assessment situation. Furthermore, the main risk indicators are not a mandatory part of the police case documentation. Also previous calls to the same location or previous crimes committed by the suspect are not part of the case documentation. In **Hungary**, police officers do not have follow-up information of cases referred to the prosecution. As there is no opportunity for follow-up, they do not know whether evidences were sufficiently firm, their decision about restraining order was correct etc. As colleagues of the **Portuguese** team underlined, the very nature of the case documentation process is strongly contingent and oriented to the present moment, presenting weaknesses that were implied in some way by their interviewees. In **Scotland**, VPD entries appear to act as a one-way channel of communication between police and their partners in social work, and other statutory agencies. As one officer notes, "*a lot goes out, but nothing comes back.*" On the face of it this appears to be a potential missed opportunity for meaningful interagency collaboration. Taking into account issues surrounding GDPR and privacy, it should be also noted that there are concerns within the public as to the manner in which the VPD operates without the consent of those listed on it, as well as a lack of routine procedures for removing older and/or no longer relevant entries. These wider political issues may prove critical for the ongoing use of the VPD in Scotland and beyond.

Suggested improvements

While conducting interviews with police officers, we collected recommendations about the way case documentation procedure could be improved and critical shortcomings can be addressed. As the interviewees in **Austria** underlined, the "Gewaltschutzdatei" (database on suspects/offenders of DV) should record qualitative data about the DV case according to how, when, where and who was involved in a case of DV. A checklist could also help the police officers to record the major indicators in the documentation system of a high risk DV case on site. In **Finland**, the Anchor team (that team will be introduced later on in the report)

recommends a shared platform for collecting, processing, exchanging and storing information (as information is stored now in separate registers). In **Scotland**, technology appears as a significant area for improvement. As one of the interviewees put it: "*the lack of technology to support us means the level of duplication at times is frightening*". To this end many officers commented on the labour-intensive task of entering information about the same case across different systems, suggesting that a single system for capturing case documentation would considerably improve the procedure. Similarly, response officers suggested that the use of mobile technologies (tablet devices) to record and process case documentation "out and about" could make a significant difference to their practice, as well as their ability to record cases in the most accurate and timely fashion.

In Deliverable 1.4, our consortium already identified Police Scotland and its very much-elaborated instruction of DV case documentation as a good example for other police. Training of police officers on case documentation seems to be also exemplary in Scotland: Job training throughout the career of the police officers considered to be a highly effective route to learning – especially if trainings are supported/held by their longer serving peers. With regards the Domestic Abuse Questionnaire (DAQ), officers consider this approach useful to their understanding of the mechanics of administering the questions, as well as developing their social awareness of how and when they might ask the questions; how and where they should record victims' responses; and their awareness of the wider context which may impact upon answers given. For specialised officers (Domestic Abuse Liaison Officers (DALOs); Taskforce Officers) who go on to develop a focussed role in DV, this peer-learning approach is similarly considered critical in developing their sense of the extent to which a DAQ administered by a response officer colleague might provide a different picture of risk to the one they get when they themselves conduct the DAQ, as well as confidence in trusting their own interpretation and discretionary responses.

Collaboration and information sharing in DV risk assessment

In the project countries not only the police but other statutory agencies also benefit from the information that is acquired, registered and stored by the case documentation procedure – although case-documentation (and risk-assessment) results themselves usually remain internal to the police.

The prosecution and the courts typically use case documents of the police when they issue a restraining order. If it is necessary, the documentation is completed by a medical report from a forensic medical expert. Child Welfare Services and Guardianship Offices receive documents from the police immediately whenever children are involved in a DV case.

If restraining order is issued in **Austria**, it is the duty of the police officers to notify three bodies: (a) the Centre for Protection Against Violence (who will then contact the victim), (b) the "security administrator" at the district authority (district public administration; Bezirkshauptmannschaft) who has no mandatory direct contact with the victim/perpetrator but can check the legality of the restraining order (whether all formal requirements have been complied with). If the procedures required for the issuance of a restraining order have not been properly followed, the security admin can reject the decision of the police officers, c) Public Child Welfare (if children are endangered).

NGOs working in co-operation with preventive policing unit also are involved in case documentation in **Finland**. Here, close cooperation among the members of the so-called “Anchor team”, that consists of a police officer, social worker and psychiatric nurse, can be also observed. The Anchor team reads through all reports of emergency center's information system that may have linkages to domestic violence. These reports may have notes about tasks involving "noises in the staircase", or "dispute between a couple." By using information from different registers (population register, PATJA, directory assistance) the police officer of the Anchor team tries to find out the parties reported in emergency center's information system. After this inquiry, a psychiatric nurse of the Anchor team contacts parties and asks their permission to information exchange between authorities. If the parties consent, the nurse and a social worker check parties' backgrounds using their own registers. Then Anchor team's police officer, social worker and nurse merge their information and produce a plan for action.

In **France**, there is a legal principle of secrecy of the criminal investigation, so that case documentation produced by the police can only be shared with other actors of the judicial system. Other FLRs can benefit from information acquired by the police only through informal contacts, which take place outside the regular process of case documentation. Such informal exchange of information is not unusual, since close collaboration in security networks which bring together DV stakeholders generates mutual trust and personal ties. One exception is when social workers who work inside police stations (intervenants sociaux en commissariats et gendarmerie – ISCG): they have partial access to case documentation and must use it for contacting and supporting victims, as well as for directing them to appropriate services. The ISCG may notify (discretionarily, and with the consent of the victim) DV situations to other agencies (such as victims support associations, social services, shelters, child welfare services), but cannot transmit to them official case documentation.

In **Germany**, the police inform the Youth Welfare Service only in DV cases with children involved (i.e. children living together with a DV victim and/or perpetrator; or in case of a woman’s pregnancy). In high risk cases, the police might involve the Youth Welfare Service to align further action. In the city of Hannover, the case documentation is forwarded to a consultancy central (BISS) via fax. The organisation uses the data to contact victims and offenders immediately. This is a unidirectional process, BISS does not feed information back to the police.

In **Hungary**, it is documented, if
1) a referral to the Child Welfare Services was initiated. In this case, main elements of case documentation: a) personal data, b) reasons/background of endangerment, c) brief description of the incident, d) details of the police measure (information about the notification, address of the venue, information about restraining order, etc.)
2) a temporary relocation of endangerment children was initiated. In this case, a specific document containing personal data and reasons of the decision is sent to the Guardianship Office.

3) a pre-trial detention and/or restraining order is initiated on the venue. In these cases, police officers have to document for the prosecution office what are those circumstances that make the re-offending or repeated offending probable (these circumstances supposed to help the prosecutor to make a decision on the pre-trial detention or the restraining instruction)

In **Scotland**, police share information from VPD entries with statutory bodies, including social work. Social workers review overnight VPD entries which concern the safety of children and/or other acutely vulnerable individuals, and are expected to visit these individuals, and their families, the same day. Police report that social workers rarely respond to or update VPD records on completion of their visits.

Perception of case documentation procedures

According to the respondents of our fieldwork, case documentation is adapted to their needs. In **Austria**, the criteria for issuing a restraining order are relevant, adapted to the needs of LEA and allow for issuing the restraining order in a timely manner. Conducting and documenting the SALFAG happens after the decision whether to issue a restraining order, and consequently is not regarded as useful for FLR police officers' decision making. However, case documentation is considered not only as mandatory but even the most time consuming part of the work of the police officers. In **France**, the respondents of the field work considered the process of case documentation easy and useful. In **Finland**, it is easy to enter observations and findings into the case documentation system. However, the utilization of such documentation is laborious, because information relevant to risk assessment is scattered all over in various information systems and registers. In addition, the breadth and quality of the entered information varies from person to person. Risk assessment that is carried out based on previously recorded and documented information is laborious, because it takes a lot of time to dig out relevant information from numerous sources. In addition, a lot of previously obtained information has not been documented, or it has been documented (recorded, stored) in such a form that it cannot be retrieved. According to some of our interviewees in Münster (**Germany**), case documentation takes too much time (although, respondents are allowed to copy information from the one document to another). However, interviewees were basically satisfied with this case documentation because the documents are standardized and can be used by the victim in order to request a restraining order for the perpetrator. In addition, there are not so many restrictions and guidelines which make the usage of case documentation very simple. In **Hungary** and **Portugal**, there are no reasons to evaluate the case documentation as inadequate. In Portugal, the process was even more problematic and subjective before 2013. In **Scotland**, case documentation of risk assessment appears standardised and relatively straightforward - but is considered to be an onerous task. Response officers often have to triplicate (or more) information from a single case across multiple systems of police record.

Special focus on vulnerable groups in risk assessments

In the participating countries, case documentation only rarely contains specific information about vulnerable victims (e.g. immigrant women, elderly, disabled, children, those under guardianship etc.) of DV incidents. In **Finland**, honour related violence crime reports are not always recorded if victim's life is endangered by a chance that a suspect accidentally hears that the victim has cooperated with the police. In honour related violence victims are extremely terrified and powerless. They may also be very dependent on the suspect and other family members who may inflict threat too. Therefore, victims are not willing to start criminal procedure and may inform the police that they would not tell anything during interrogations if an offence is recorded. If an offence is recorded an investigator usually contacts a suspect. This would expose victim's contact with the police to the suspect. In addition, everyone has a right to know (with few exceptions) what the police have recorded about him or her in person registers of the police. Therefore, it is possible that the suspect finds out information of the crime report. This may escalate the situation and lead to serious violence towards the victim, which could be a homicide or kidnapping. All these matters must be considered when thinking about recording an offence, and not in every case an offence is recorded due to concerns for victim's safety. In Münster (**Germany**), it has to be documented if an interpreter was needed. In addition, the aspects that are important regarding vulnerable groups might be documented in the risk assessment part. In **Hungary**, there is specific process if child abuse or endangerment was committed. In **Portugal**, only a few evidences were found about the elderly and the children.

Health sector

Case documentation procedures and response strategies

Case documentation on the topic of DV in **Austrian** hospitals is recorded in a patient's medical file. In addition, the Vienna General Hospital documents and stores the forensic evidence collected for a period of six months (and beyond in cases where charges are pressed). Also personal records on cases of DV are stored by some members of the Child- and Victims' Protection Groups themselves, which is not an official part of the case documentation. Unofficial data, usually attempting to gain an overview into the total number of cases of DV and child abuse, are compiled by medical staff. The general impression gained during interviews was that of lacking formalisation and comprehensiveness. Though members of the Child- and Victim's Protection Groups exhibit strong motivation toward the general improvement of the medical sector response as well as significant sensitivity for the topic of DV, the rollout of these groups across Austria and the formalized integration of the same into hospital procedure varies greatly and often leaves a gap in the response in this sector.
In Austria, differences between the capital and the rural settings should be also mentioned. Hospitals in Vienna appear to have the most advanced rollout of Child- and Victim's Protection Groups in hospitals with accompanying risk assessment procedures. Roll out in states with more rural settings is less advanced, resulting in greater gaps in case-documentation. This is particularly true for smaller hospitals with fewer resources and less expertise. Respondents from Upper Austria exhibited what appeared to be notable differences in awareness and use of available tools and accompanying documentation, depending on the location of hospitals in larger cities and towns and the amount of time Victim's Protection Groups had been active there.
Three main elements of case documentation exist: 1) A formalized questionnaire for the forensic documentation of evidence of violence, 2) a checklist for first contact and aid for victims of DV including an abbreviated version of the Danger Assessment, 3) standard medical case documentation for a patient's medical history. Internal sensitivity training for medical staff in hospitals includes efforts to increase and improve the documentation of DV as part of standard documentation.
Forensic evidence and corresponding case documentation is stored on an internal and secure server for the duration of six months. This period is extended if charges are pressed. No formalized data storage procedures exist however, for the checklist including the abbreviated risk assessment.

In **Finland**, health care sector uses so-called nation-wide "PAKE Abuse and Body Map form (PAKE)". PAKE abuse and body map form is used in each emergency room that has implemented PAKE form and procedure. The form was developed together with the Ministry of Social Affairs and Health, Institute for Health and Welfare (THL), The Regional State Administrative Agencies and one hospital in case location 2. While using PAKE, a nurse interviews the patient in private about the incident, and gathers details and background information. Then a nurse and a doctor document systematically all injuries. They also inform child welfare and protection if a victim has underage child/children. Documents are stored in the hospital archive. A note is made in patient's medical record about the use of PAKE form. PAKE form documents the following: personal details, date, the location of

violent event, the person who caused injuries, description of events, specific actions including threats, patient's assessment of pain, whether police was present in the incident, whether a crime report was made, number of children and their possible presence at the scene, patient's psychological condition, and follow-up treatment plan. Locations of injuries are documented in pictures of a body (front and back) and a head (front, back, sides). In addition, size, shape, type (e.g. bruise, wound, swelling, fracture), depth, direction and age of injuries are described.

In **France**, DV cases are documented in the medical certificates which are issued by medical professionals and have tremendous power certifying that a DV victim is a "real" victim, whether the offender should be detained, etc. Because medical certificates document primarily physical injuries, they are part of why physical violence is better handled than psychological violence (or habitual spousal rape).

In **Germany**, health practitioners do not differentiate between patients that are injured because of DV and any other patients they treat. The documentation is in both cases the same and focuses on the medical condition (medicine, treatments etc.). As no risk assessment takes place, there is nothing physicians document except the medical condition and how the victim got injured.

In **Hungary**, health practitioners are usually able to recognise the signs of physical violence only, given the lack of time that can be devoted to each client and the fact that victims usually do not talk about their abusive relationships in such contexts. In addition, healthcare practitioners do not really differentiate between patients that are injured because of DV and any other patients they treat. However, health visitors have to document the main elements of a crisis situation (a) personal data and contact information of the perceiver, b) personal data and contact information of the endangered person, c) date of perceived endangerment, d) fact of endangerment, e) contact information of supporter in contact with the endangered person, f) care provided by the supporter, g) measures carried out by the supporter, h) to whom, when and how the signal was given) and of endangerment or problematic situation (a) personal data and contact information of the child/family, b) description of the perceived problem, c) date of perceived problem, d) conducted measures, e) involved, interviewed persons, f) conclusion, g) outcome of the case).
Documentation of the cases needs to be relevant, retrievable, and traceable retrospectively. Documentation should contain information on the exact care given, the experts involved, and cooperation with other institutions. A referral of the inspector can be written or oral, and should be placed in the health documentation of the child. Documentation should be kept for 30 years. Personal and institutional data pertaining to abused children needs to be managed in an anonymous way (so that the children cannot be recognised).

In **Portugal** and **Scotland**, detailed information regarding DV case documentation by medical professionals is not available. Since officially in **Slovenia** there are not any tools for risk assessment, there is no connected procedure for case documentation. On the other hand, the guidelines, developed by Brecelj Anderluh et. al.[12], are considered by some of the

[12] Brecelj Anderluh, M., Brecelj-Kobe, M., Cvetežar, I. Š., Gregorič Kumperščak, H., Kocmur, M., Lokovšek, N., Rus-Makovec, M. (2015). Strokovne smernice za obravnavo nasilja v družini pri izvajanju zdravstvene dejavnosti [The Professional Guidelines for Responding to Domestic Violence in Health Care Services]. Ljubljana:

doctors as a risk assessment tool including also extensive forms for documentation of medical status (as well as of some contextual information).

Shortcomings

As lack of DV case documentation can be observed, only a few shortcomings were detected in the participating countries. In **Austria**, case documentation does not allow for easy and comprehensive overview on the topic of DV. Though it is possible to identify previous occurrences in a patient's file, DV is not always coded the same way (there being no formalized method) and it requires time and effort on the part of medical staff. To maintain an overview of the number of cases of DV, respondents mentioned keeping unofficial lists in which occurrences are tallied for ease of use. In **Finland**, the PAKE form is available only on paper, thereby case documentation takes extra time. There were also some problems when transferring digital photos about the victim's injuries and bruises from a camera to a computer. In **Hungary**, health practitioners often do not differentiate between patients that are injured because of DV and any other patients they treat and, as a consequence, do not report the incident to the police. In **Portugal**, medical doctors do not have proper conditions to make in-depth assessment (and documentation) of DV cases due to the general condition of the health services, namely hospitals.

Suggested improvements

In **Austria**, though coding for the type of injury is mandatory in some relevant departments of the hospitals, only the main injury/cause of injury is recorded. Large gaps occur in the documentation of DV causes. In this vein, a unification and formalisation of DV in case documentation is the main necessary improvement. In **Finland**, the PAKE form is only on paper. It would work quicker if information were gathered electronically. Also systematic training on how to use PAKE would be needed for the nurses and doctors in every emergency department.

It should be also mentioned that if police has launched a crime investigation and requests information, the doctor writes a statement about the abuse (which is based on the PAKE form documentation and photos). The health care professionals do not get any feedback from police officers about the quality of the statements: Are the statements good enough, precise for the needs of police officers, judicial authorities and courts? In addition, systematic trainings (on the way PAKE could be sued systematically) for the nurses and doctors in every emergency rooms are also needed. In **Portugal**, hospitals and police should have a closer cooperation (e.g. women police officers in the emergency rooms).

Ministrstvo za zdravje. Retrieved from http://www.prepoznajnasilje.si/.

Social work and NGOs

Case documentation procedures and response strategies

In **Austria**, every contact with victims and with other organizations, as well as the mandatory risk assessment (which has to be done by the *Centres for Protection Against Violence* during the first 3 days), has to be documented.
The case documentation systems are used on a "as much as necessary, as little as possible" basis. Individual case-workers document crucial information (e.g. every contact with the victim, mandatory risk assessment, woman's injury etc.) but not all biographical or case specific details, in order to protect the privacy of their clients. Some of the organisations, that were interviewed during the fieldwork, reported only emerging case documentation policies, leaving a lot of discretion to their staff regarding what and how to document. Documents are captured and stored in the internal documentation system of the institution (together with the notes of consultations).
Case documentation is regarded to document the characteristics and needs of a specific case, and also to function as organisational practice in recording time and resources allocated, for each consultant to demonstrate their use of resources (as well as for each institution).

In **Finland**, MARAC is in use at case location 1 (the MARAC group was disbanded at case location 2 a few years ago because professionals felt the area was too big and the use of MARAC group was inflexible). The MARAC risk assessment starts with an interview with the client. The risk is considered very high, if there are 14 or more out of 24 yes-answers on the risk assessment form or if the professional interviewing the victim, generally assesses the risk as being elevated. In the second part, if a specific multi-agency MARAC group is available in the area and if the risk is considered high and victim gives his or her consent, the victim's case is to handle by the local MARAC team. If the client gives his or her consent (a written document), information is exchanged between those agencies that victim allows. The main goal is improving victim's safety, planning victim's protection measures, planning necessary criminal justice measures (such as restraining orders) and child protection.
Actors involved in MARAC group store the necessary information and agreed actions in their own data systems according to their documentation standards. This is due to data protection laws. No extra customer registers are to be created by the MARAC processes.

In **France**, most organizations collect at best the numbers of people they treat per week / month / year for they report to funders. Otherwise case documentation is minimal to non-existent. The situation is exactly the same as in Austria: Individual consultants document only information they feel absolutely necessary to ensure that the follow-up of the victim is properly done but they avoid to keep record of the details of DV situations to protect the privacy of victims. Of course, individual consultants can have personal notes, but they are not stored in the NGO database. The only example of NGO having a serious process of case documentation is that of the NGO mentioned above which has developed the risk assessment tool, and that is how they document cases. Creating databases of victims is a tricky legal issue in France, so that NGOs are not encouraged to develop their case documentation process.

Within **Germany**, NGOs in Münster and Hannover document personal data, information about a case etc. but every social worker can decide on his/ her own if and what he/she wants to document (except psychologists who have to document information about their cases). NGOs seem to negate any official case documentation, documents and guidelines regarding case documentation that have to be used. Our researchers had even the feeling that social workers were quite irritated being asked about documentation. There is one possible reason behind this attitude: the documentation that is maintained by the social workers is not considered as valid information before court. This appears as very dramatically in the case of custody battles, when women accuse their ex-man in front of the court of having been abusive: The documentation of a counselling centre for women that the specific client receives counselling since 2 years because of her abusive relationship does not count as a proof. Only if the women reported domestic abuse to the police, the court would believe her. Nonetheless, some NGOs use a database to manage clients' contact information. One counselling centre for women in Hannover reported to use such a tool, where they record basic information on the client like name, address, number of children, migration background etc. This information is not only used for contacting and statistics, but also in some cases for risk assessment (especially the information about involved children). Counsellors' individual notes are stored up to a maximum of 3 years.
In Berlin, the software D-GEV provides documentation but our research did not provide enough information about the system. Basically, the situation described in the other German cities applies also in Berlin: social workers/counsellors do documentation mainly for themselves to keep track of all relevant information and important changes. Apart from that all Berlin NGOs that we interviewed are financed by the senate and need to send a statistical report with some risk-related aspects.

In **Hungary**, we gained information from social workers and family assistants at Crisis Centre, Temporary Home for Families, Secret Shelter, Children's Home of the Child Protection Service. We identified two types of case documentation: 1) There are different types of official forms in use at various institutions, 2) informal notes/logbooks providing information about the clients. In the latter case, professionals decide by themselves if and what they want to document. There is a paper-, and not digital-based-system. Forms are stored at the respective institutions but copies of these documents "follow" the clients receiving care from other social service providers/organisations.

In **Portugal**, central state organizations (with supervisory and oversight functions) seek to develop and enforce training standards, as well as normative documents that support the work of DV prevention and victim support. In many cases, these NGOs are financially supported by the state itself, directly through its budget or through funding programmes. However, this alleged supervision does not prevent NGOs from having a broad functional autonomy and from developing their own procedures, having no effective control over them. This situation seems, however, to be slowly transforming into a more regulatory model.

In **Slovenia**, Centres for Social Work have to manage and document cases in accordance with the demands laid out by Domestic Violence Prevention Act and instructions of the Ministry that manages Centres for social work (currently: Ministry of Labour, Family, Social Affairs and Equal Opportunities). Both the demands and instructions were summarised by

professional guidelines (written by Hrovat Svetičič, Horvat, Hrovatič, and Premzel, 2010) that are illustrative and suggest proper procedural form. This is done with the help of simply designed bullet numbers on numerous aspect of working with victims of DV and what to document in the process. According to persons that have participated in the interviews, the template is widely used. The main elements of documentation are:

- Information about violence, that includes: 1) Information on the victim(s) (all crucial data such as gender, education, employment status, family relationship to the perpetrator etc.), 2) Information on the perpetrator(s) (also all crucial data such as gender, education, employment status, family relationship to the victim, nationality etc.), 3) Information about the violence (form, duration, chronology, risk assessment, detailed description of individual occurrences etc.), 4) Consequences of violence and assessment of the threat of the victim (Risk assessment) (injuries, psychological damage, economic dependency, addictions, chronic diseases etc.)
- Information on children, that includes the state of the child, information whether they were witnesses to the violence.
- Information on the help that was offered or already implemented.
- Contact logs (data on contacts with the victim and measures taken).
- Data on all (safety) measures taken or implemented in order to protect the victim and other family members against the perpetrator(s).

The case officer usually conducts a form of interview with the victim and writes a report, which is stored on the premises of the Centre under which "jurisdiction" the case falls. According to the experiences of the field work, the way the form is filled in heavily dependents on the style of the individuals being responsible for the case. Forms are part of the DV case folder that is safeguarded by legislative postulates regulating personal data and work of social work centres.

From **Scotland**, detailed information regarding DV case documentation by the social sector (and NGOs) is not available.

Shortcomings

In **Austria**, it is unavoidable to "prioritise" cases by severity due to the high case load. This is in opposition to the goal of some institutions and seen as potential risk, as cases that present "less severe" initially can receive less attention, which can lead to loss of information and addressing the needs of victims.

In **Finland**, police officers sometimes do not attend meetings at case location 1. Overall, different agencies have difficulties to find replacement who are willing to attend the MARAC meeting if the permanent representative has no time. At Case location 2 there was a MARAC group working previously, but professionals felt the area was too big and the group was not agile enough, so the group was disbanded.

According to the **Hungarian** interviewees, 1) filling out various forms requires too much administration and time; and 2) as documentation is too formal and lacks meaningful/relevant information, it does not really support the professionals to understand the history/background/details of a case. In addition, 3) lack of feedback loop was also identified. Social workers / family assistants do not have information about the afterlife of

cases referred to other social institutions. E.g. a family returns home from a Temporary Home for Families but family assistants do not have information about the further steps of integration as information is not sent (back) by the local Child Welfare Service. All in all, there is no opportunity to follow-up.
In **Slovenia**, some of the respondents considered the process of case documentation as too bureaucratic.

Suggested improvements

In most of the participating countries, respondents did not recommend any improvements. In **Slovenia**, a few respondents argued for decreasing bureaucratic burden during DV case documentation. In addition, some interviewees recommended more IT support. The same opinion was underlined by the **Hungarian** respondents; digital-, and not paper-based-systems should be developed that are more efficient and require less time to handle. In Hungary, social professionals also recommend to ensure access to various service providers (e.g. Child Welfare Services, Temporary Homes for Families, Crisis Centres etc.) working with the same clients.

Collaboration and information sharing in DV risk assessment

In **Austria**, case documentation is primarily an intra-organisational practice and due to the sensitive nature of the cases, information sharing can only happen on the basis of the explicit consent of the victim. This holds true especially for *Centre for Prevention Against Violence* and Women's Shelters dealing with cases where restraining orders have been issued and women resorting to shelters respectively. However, mechanisms of sharing information exist between individual organisations or, in case location 3, within the umbrella organisation "Institut für Sozialdienste". But each agreement tries to minimise the case documentation shared to the relevant information only.

In **Finland**, agencies exchange their information at a MARAC group meeting (only if the client gives his/her consent). Based on the shared information, agencies prepare together an action plan in order to improve the safety of the victim.

In **Hungary**, copies of official forms are always forwarded to the institutions providing services for specific clients. Social workers / family assistants gain information about the antecedents of a specific case due to these forms.

3 Conclusions and recommendations regarding DV risk assessment and case documentation

Concerning risk assessment there were a few problematic aspects that emerged in all sectors. Many countries highlighted the rigidity of existing formal risk assessment tools. Some professionals do not prefer to use checklists, since those tools do not reflect the particularities of DV incidents in their understanding. Those tools that are too rigid and not sensitive enough to each case might result in false assessment and the negligence of risk situations that do not “fit in the boxes”. Thereby many professionals across the countries argued that using formal tools have to be accompanied by comprehensive and regular professional training and personal expertise.

Multidisciplinary cooperation across the sectors in risk assessment and case documentation was mentioned by many countries in all sectors as a favourable objective, which might result in more dynamic and comprehensive risk assessment processes. Unified risk assessment and case documentation protocols are the preconditions of such an endeavour.

In case of the **police**, risk assessment and case documentation seems to be a task that requires a copious amount of time; entering information into various systems and recording data in forms are labour-, and time-intensive. Therefore, an integrated, easy-to-use ICT platform, which might be available even on mobile technologies on the scene of a DV incident, could greatly support the work of police officers. Such a system could provide not only a guide during the process of case documentation but also contribute to information sharing between various organisations and institutions (especially but not exclusively among police, health and social sector) and thereby make interagency collaboration stronger. Of course, the regulations of GDPR have to be taken into consideration while developing such an ICT tool.

A further aspect to consider is the timing of the risk assessment process. It would be beneficial to use the approach of Finland, Scotland and Portugal or Berlin in terms of taking risk assessment as a dynamic process, and re-evaluate risks on an ongoing basis instead of only capturing a snapshot of the risk at a certain stage of the procedure.

Differences between the participating countries need to be taken into consideration both regarding risk assessment and case documentation protocols. Concerning risk assessment, in some countries formal risk assessment tools are missing, in other countries some sectors use risk assessment tools, others do not; we see examples for sector-specific, local and national level protocols alike.

In some countries there is specific DV case documentation, in some other countries a standard protocol for all kinds of crimes is used, while elsewhere specific protocols for DV cases are in place. On the one hand, one should be aware of these differences and must not develop (or re-design) general, “ubiquitously available to all” training materials. Also, when developing training materials, it is going to be a great challenge to take those great differences into consideration and to create basic standards and guidelines that can be useful for all countries, regardless the differences of existing practices. On the other hand, the diversity of the IMPRODOVA countries can serve as an opportunity to find and

disseminate good practices and initiatives; very elaborate DV case documentation processes can be introduced as ideal models.

Finally, we highly recommend that support should be given to the involvement of experienced, senior police officers as trainers in job trainings on DV risk assessment and case documentation. Diversity of DV risk assessment and case documentation even in the **health** sector prevails. Different countries developed different practices and processes, while the documentation of DV incidents is often not unified, standardised and formalised within specific countries. Concerning risk assessment tools, we can state that there is a scarcity of good practices. Most countries do not have formalized DV risk assessment processes in the health sector. Unfortunately, medical professionals of those countries where no formal risk assessment tools exist do not see DV-related risk assessment as part of their job. We believe that the training materials to be developed as part of the IMPRODOVA project are a good opportunity to challenge that attitude, and raise the awareness of nurses, physicians and other health care professionals that health care has a responsibility in recognizing DV cases, which might remain in latency in case of an insufficient risk assessment.

Furthermore, it can be argued that the case documentation by medical professionals is mainly limited to physical and health issues; FLRs of the field usually recognise only the signs of physical violence. The lack of appropriate case documentation may hinder effective response to violence; in some countries health professionals do not make in-depth assessment and documentation of DV cases and, as a consequence, incidents are not reported to statutory bodies and victims remain in a helpless situation, without access to services.

DV risk assessment and case documentation in the **social** sector is also very diverse. In some countries (e.g. in Finland) a specific risk assessment and case documentation tool is used (i.e. MARAC). In other countries (such as Slovenia and Hungary) professionals follow guidelines and protocols. Elsewhere (France) no DV specific case documentation has been developed for the sector.

Regarding risk assessment, the lack of unified protocols within the FLR’s and among the different agencies is problematic, since firstly the diversity of practices hinders cooperation among the agencies, secondly diverse practices do not allow unified, high quality risk assessment of DV country-wide. Thereby we recommend the wider implementation of good practices. The use of unified practices benefits collaboration among the agencies.

Where there is no unified system (and where these systems are not effective), regulations and practices often ensure a lot of discretion to the consultants of what and how to document (as in Austria, Germany, Hungary and Slovenia). This information is often recorded in informal notes/logbooks providing information about the clients. Discretionary processes, informal notes and lack of standards for DV case documentation hinder collaboration between statutory agencies.

Despite the diversity, several respondents agreed that decreasing bureaucratic burden during DV case documentation would be important. In addition, some interviewees recommended more IT support; a digital-, and not a paper-based system should be developed, which is more efficient and requires less time to handle.