Psychological Assessment of Intimate Partner Violence

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Risk assessment is a controversial area of forensic practice, yet it has become an integral part of responding to Intimate Partner Violence (IPV). Given lethal consequences can arise from judicial decisions based on poorly executed risk assessments, it is incumbent on mental health practitioners to utilise best-practice methods and form evidence-based determinations of risk and intervention strategies. This article provides a best-practice guide to IPV risk assessment and summarises available information on the most prevalent IPV risk assessment measures for male and female offenders. The research indicates that caution is warranted as most risk assessment measures have not been normed for use outside North America or for female offenders, have small to moderate effect sizes, and a lack of adherence to administrative procedures and methodical rigour has undermined research findings. Nevertheless, structured risk assessment enhances the defensibility of expert opinion and is recommended.

Keywords: best-practice guidelines; evidence-based assessment; family violence; intimate partner violence; offender; partner abuse; recidivism; risk assessment.

1. Introduction

Intimate partner violence (IPV), refers to any actual, attempted, or threatened physical injury or sexual assault of a current or previous intimate partner that is deliberate and non-consensual (Hemus & Bourgon, 2011). IPV is a significant public health problem, with 1,479,000 adult females and 448,000 adult males in Australia experiencing violence by a current or previous intimate partner each year (ABS, 2012). Moreover, IPV is the leading cause of preventable disease, disability, and premature death in Australian women aged 15–44 years, primarily through its contribution to poor mental health including anxiety and depression (Victorian Health Promotion Foundation, 2004). Increasingly

more cases of intimate partner violence are being managed within the criminal justice system, mandating the need to identify a valid means of prioritising cases in need of greater attention (Campbell, Webster, & Glass, 2009). Hence, risk assessment has become an integral part of managing and combating IPV.

Psychologists' may undertake a risk assessment for IPV for a number of reasons, including to assist victims/potential victims to determine the level of risk posed by their partner and develop a safety plan; whether they should enact their ethical duty to warn/protect of IPV risk; an offender's eligibility and suitability for treatment; or to inform various decision-making processes within the judicial system (Klassen & O'Connor, 1989).

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Table 1. Common IPV risk assessment measures.

Tool	Type	Primary purpose	Description	Items	Scoring system	Type of offending predicted	Domains	AUC
SARA	SPJ	Risk assessment and management	Designed to guide completion of comprehensive risk assessments with males arrested for IPV.	20	0 = RA not present 1 = RA possibly present 2 = RA definitely present	Family violence including IPV	General violence Spousal violence	.52–.70
DVSI-R	Act	Risk assessment and management	Designed as a screening tool to predict future violence in males and females, over 16 arrested for IPV, child or elder abuse from official records.	11	Different values awarded for different items	Family violence including IPV	Behavioural Social	.61–.79
ODARA	Act	Risk assessment and management	Designed as a screening tool to predict future violence in males arrested for IPV based on victim interview and collateral information.	13	0 = RA not present 1 = RA present ? = missing information	IPV	Spousal violence General offending	.64–.77
PCL-R	Act	Diagnostic	Designed to diagnose Psychopathy based on clinical interview and collateral information.	20	0 = item does not apply 1 = item partially applies 2 = item definitely applies	General violence IPV	Affective Behavioural	.66–.71
DVRAG	Act	Risk assessment and management	Designed to predict future violence in males arrested for IPV based on clinical interview and collateral information.	14	Different values awarded for different items	IPV	Spousal Assault	.70
DA	Act	Safety planning	Designed to predict IPH based on victim interview.	20	Yes = 1 No = 0	IPH	Lethality	.62–.90

Note: SARA = Spousal Assault Risk Assessment Guide; DVSI-R = Domestic Violence Screening Instrument; ODARA = Ontario Domestic Assault Risk Assessment; PCL-R = Psychopathy Checklist-Revised; DVRAG = Domestic Violence Risk Assessment Guide; DA = Danger Assessment; Act = actuarial; SPJ = structure professional judgement; IPH = intimate partner homicide; AUC = Area Under the Curve; RA = risk factor. [NB.: None of these tools have been normed for use in Australia. As a result, clinicians should exhibit extreme caution when relying on or communicating the results of such tools.]

While a violence risk assessment previously referred simply to determining an individual's propensity for violence, i.e. *dangerousness*, contemporary use of the term incorporates the practice of identifying (whether actuarially or through clinical judgement) the individual factors predictive of future violence (i.e. recidivism), recommending strategies or interventions to reduce that risk, and communicating that information to agencies or individuals who can intervene (Mills, Kroner, & Morgan, 2011).

Given the loss of liberty and harm that could result from a poorly performed risk assessment, psychologists must ensure that they possess the requisite skills and knowledge necessary to undertake competent risk assessment for IPV. This article aims to provide the reader with a best-practice guide to conducting IPV risk assessments within the context of the judicial system and will also be of assistance to those working with victims in clinical practice as one of the risk assessment measures outlined is intended to be administered to victims to assist them in safety planning.

2. Assessment Process

There is no agreed gold standard approach to risk assessment (Vess, 2006). Conroy and Murién (2007) proposed a model based on the recommendations of the American Psychological Association for evidence-based practice, namely: review the evidence base; examine the characteristics and context of the person under evaluation in light of this; and apply clinical expertise to information gathering and interpretation to form an educated and considered opinion. In determining which assessment methods and instruments to employ during a risk assessment, Williams (2012) recommends that clinicians give thought to the context in which the assessment will occur; the time given to complete the assessment; who will be assessed, i.e. the victim, perpetrator, or both; the expertise required to conduct the assessment techniques or instruments; and the purpose of the assessment. Furthermore, clinicians should ensure

they possess the requisite skills, knowledge, and experience before embarking on formal risk assessments intended to inform the judicial system.

To address all of these components, there are at least 10 steps involved in conducting a competent IPV risk assessment as outlined by Kropp, Hart, Webster, and Eaves (1999). These include:

1. *Interview the accused and victim(s):*

Assessment interviews should follow a review of official records and with consideration that the legal context in which the assessment is likely to occur will affect the interview process, i.e. the involuntary nature of the assessment and lack of confidentiality offered may result in the offender being reluctant to openly discuss their offending behaviour (Kropp et al., 1999). Despite this, it is essential that clinicians work to establish rapport and obtain informed consent to participate in the assessment by being explicit about the limits to confidentiality governing the assessment, the purpose of the assessment, and the intended distribution of the assessment findings and associated report. This is equally important for the victim, as they may be reluctant to participate or disclose the extent of the abuse if they fear reprisal from the offender.

Structured or semi-structured interviews should be used to obtain information in a systematic and time-efficient manner. Topics to cover include: the history of assaultive/abusive behaviour; criminal history; relationship history and current social support network; occupational and educational history; childhood abuse and neglect experiences; physical and mental health history; current mental status and life stressors.

The primary purpose of the victim interview is to obtain information about the offender's behaviour and to corroborate information provided by them; however, the victim

may require emotional support and referral for further assistance (Kropp et al., 1999). Essential information to obtain from the victim includes: the relationship history, including history of assaultive/abusive behaviour and details of the most recent incident; their perceived level of risk; and the presence of any children. Bear in mind that exposure to IPV is a form of child abuse enacting mandatory reporting obligations in some jurisdictions.

2. *Administer questionnaires:* At a minimum, this should include administering standardised measures of physical and emotional abuse to both parties and measures of substance use to the accused (Kropp et al., 1999). While the results of self-report measures should be interpreted with caution due to the tendency of both victims (Campbell, 1995; Ferraro and Johnson, 1983) and offenders (Henning, Jones & Holdford, 2005) to minimise, justify, and even deny the abuse, they can assist clinicians to gather information that may not otherwise be disclosed; make comparisons to an appropriate reference group; counteract clinician bias; and demonstrate scientific rigor in the assessment process (Kropp et al., 1999).
3. *Consult collateral informants and official records:* For the reasons outlined above, it is essential that clinicians obtain collateral information from other informants, including partners, police, probation and parole officers, or past treatment providers familiar with the case or offender. It is incumbent upon clinicians conducting IPV risk assessments in a forensic capacity to obtain copies of incident records, victim statements, and the offender's criminal history. While this information may be difficult to acquire, it is required to corroborate interview data and vital to the accurate administration of the risk assessment scales outlined in this article.

4. *Conduct other assessments as necessary:* This may involve the administration of mood or personality inventories and/or cognitive/intellectual testing. Research indicates high rates of mood disturbance, Cluster B personality disorders, drug and alcohol use, and traumatic brain injury among IPV offenders of both sexes (Leisring, Dowd & Rosenbaum, 2005; Gilchrist et al., 2003; Henning, Jones, & Holdford, 2003; Kropp et al., 1999). The presence of any such condition may preclude or call for specialised treatment and should be incorporated into any intervention plan (Kropp et al., 1999).
5. *Assess conflicts between information sources:* Clinicians should always evaluate the veracity of assessment data and disregard information that clearly lacks credibility (Kropp et al., 1999). Furthermore, Wilson (2006) recommends that clinicians reconcile any disagreement between interview data and other sources in favour of collateral informants, unless the former can be corroborated by other reliable sources. Lack of agreement between information sources should be outlined in the assessment report. Justifications for decisions made as a result of and possible reasons for any discrepancy should also be provided.
6. *Determine the base rate:* It is essential for clinicians to identify the underlying rate of IPV in the population from which the offender has been drawn (i.e. the base rate) in order to place risk assessment results in context and avoid overestimating the likelihood of future violence (Conroy & Murrien, 2007). For example, according to Tasmania Police (2010), the base rate for IPV recidivism in Tasmania was approximately 30%.
7. *Utilise a formal risk assessment scale with sound psychometric properties:* The goals of standardised risk assessment tools are to prevent violence

through improved consistency and accuracy in decision-making and selection of intervention and risk management strategies; and to increase the transparency of decision-making, thereby protecting clients' rights and reducing the risk of liability. While the literature regarding the validity of risk assessment scales for IPV is limited in comparison to that available for general and violent offending, there is sufficient information available to assist clinicians to select appropriate tools. The best available are outlined in [table 1](#), along with empirical evidence supporting their use. It should be noted, however, that none of the scales described have been validated for use in Australia. Hence, clinicians need to exercise extreme caution in their use and interpretation. Clinicians must also remember that the completion of a formal risk assessment instrument is one part of the risk assessment process rather than its totality (Conroy & Murrien, 2007).

8. *Determine the level of risk and constituent risk factors:* Like any psychological assessment, a sound risk assessment will involve triangulating multiple sources of information from multiple methods to develop a case formulation and treatment plan. While structured risk assessment tools are superior to clinical judgement regarding risk, it is equally important to consider the presence of idiosyncratic risk factors not measured by standardised risk assessment tools. IPV offenders are a heterogeneous group, and no risk assessment tool can be expected to capture every possible risk factor. It is therefore important to remember that the actual level of risk presented by the individual assessed may differ from that indicated (Conroy & Murrien, 2007). Clinicians need to bear in mind that criminogenic (i.e. offence-

related) risk factors can be static (i.e. unchangeable), such as age of first conviction or dynamic (i.e. amendable to change, some more quickly than others), such as antisocial attitudes and access to firearms (Andrews & Bonta, 2015). However, they are correlational rather than casual in nature.

9. *Devise risk management strategies:* As mentioned above, the influx of IPV offenders into the criminal justice system and the rise of therapeutic jurisprudence and problem-solving courts have facilitated a shift away from probabilistic estimates of dangerousness towards the identification of individuals in need of greater intervention and the development of risk management strategies to reduce the level of risk they present. In this sense, risk has become synonymous with the intensity of intervention required to reduce risk (Andrews & Bonta, 2015). Hence, clinicians need to be familiar with legislative mechanisms available to manage risk of repeated IPV in their community as well as the service delivery systems that support it. Recommended risk management strategies might include: imposition of a no-contact order, relocation of the victim, or mandatory treatment of the offender.
10. *Communicate findings:* While there is no best-practice method of risk communication, a well-executed risk assessment is useless unless it can be communicated effectively and to the right people. Risk assessments need to feed into a broader response system, as it is unlikely that one individual or organisation will be able to meet all of the treatment and intervention needs of the client. Hence, risk assessments are a means to an end rather than an end in themselves.

As with any external request for assessment, the clinician should endeavour to

answer or appropriately reframe the referral question in the assessment report. Among other things, this may involve educating the referral source about the limitations of risk assessment (Mills et al., 2011). At a minimum, a risk assessment report should include information on the following (Mills et al., 2011):

- Demographic information
- Context of assessment
- Sources of information and assessments conducted
- Psychosocial details, including exposure to IPV or direct abuse as a child
- Medical and psychiatric/psychological history, including current medication
- History of violent and criminal behaviour; including details of the most recent incident and compliance with official sanctions
- Current level of psychosocial functioning
- Risk assessment results; including risk and protective factors
- Validity and/or limitations of the results
- Risk management and intervention strategies
- Barriers to treatment or intervention that may affect compliance

Clinicians need to bear in mind that the majority of the beneficiaries of their assessment report will not be mental health professionals and that it will be subject to legal scrutiny and possible cross examination. Furthermore, psychologists have an ethical responsibility to ensure that psychological assessment results are not misused (Australian Psychological Society [APS], 2007). Hence, clinicians need to ensure that they: (1) use plain, professional language that the audience will understand and explain any technical terms having a bearing on the assessment of risk, (2) point out the base rate for IPV in the community for comparison purposes; (3) present assessment results in an unequivocal manner; (4) accurately represent the science of risk prediction and the validity

of any risk assessment tools employed; (5) point out the limitations of the risk assessment conducted and the opinion offered and the dynamic nature of risk (Mills et al., 2011; McMaster, 2006; Vess, 2006).

There is disagreement in the field about the best way to communicate risk assessment results. For instance, supporters of actuarial risk assessment methods advocate the use of probabilistic estimates of risk and the use of specified time periods, while those in favour of structured professional judgement advocate the use of categorical/relative statements, i.e. high, medium, low. Hence, the approach taken is likely to be influenced by the method of risk assessment undertaken and personal preference. Nevertheless, categorical statements appear to be the most common approach in forensic practice at the present time. Furthermore, clinicians are encouraged to be explicit about the individual risk and protective factors constituting the overall risk level and the contextual and situational factors, such as access to the victim and substance abuse, that the assessment is prefaced upon, so that interventions and risk management strategies can be developed and co-ordinated across the health, welfare, and justice systems. Any recommendations for intervention should be commensurate with the level of risk posed by the individual, evidence-based, and tailored to the individual's intellectual functioning and capacity to benefit from treatment (Andrews & Bonta, 2015).

Should the clinician have concerns about the safety of an identifiable person as a result of their assessment, they have an ethical responsibility to warn/protect, disclosing the minimum amount of information necessary to protect that person from harm (APS, 2007). Where possible, clinicians are also encouraged to share assessment results with offenders and victims, as this can assist them to make a more accurate assessment of the likelihood of continued violence within their relationship and the degree of intervention that will be required to change that behaviour and to plan accordingly (Vess, 2006).

3. Assessment Methods

Risk assessment methods for IPV typically fall into one of three categories: unstructured clinical judgement, actuarial decision-making, or structured professional judgement. Unstructured clinical judgment is epitomised by a determination of risk based on clinical wisdom. It is notoriously unreliable, i.e. no better than chance, yet alarmingly remains the most common form of risk assessment (Grove & Meehl, 1996; Grove, Zald, Lebow, Snitz, & Nelson, 2000). Actuarial decision-making is the antithesis of unstructured professional judgement and is characterised by mathematical risk prediction based on the rigid application of algorithms. On the whole, clinicians have resisted the use of actuarial methods, despite their superior predictive validity, especially in the arena of violence risk prediction. A more recent development has been the introduction of structured professional judgement guides. They aim to assist clinicians to consider empirically derived risk factors in a systematic and consistent way but allow the clinician to determine the final risk rating based on an integration of assessment data and professional judgement.

Hanson, Helmus, and Bourgon (2007) were the first to employ meta-analysis to compare the predictive validity of the various risk assessment methods for IPV using male offenders. In total, 18 studies were located with an average follow-up period of just over two years. They found little difference between specialist IPV actuarial scales, generalist actuarial scales, structured professional judgment, and victim perceptions, possibly as a result of the small sample size. On the whole, scales developed to assess general recidivism such as the Level of Service Inventory-Revised (1995) (LSI-R; Andrews & Bonta, 1995) performed slightly better than specialist IPV scales such as the Domestic Violence Risk Assessment Guide (DVRAG); however, both types of scales performed better than scales based on

professional judgement, such as the Spousal Assault Risk Assessment Guide, or on victim perception, such as the Danger Assessment Scale. Nevertheless, all forms of assessment demonstrated only small to moderate effect sizes. Hence, the weight of empirical support for the use of risk assessment tools in the prediction of IPV is relatively light, especially in comparison with tools available to predict general violence and criminal recidivism.

4. IPV Specific Risk Assessment Tools

The aim of risk assessment tools is to assist the clinician to gauge the presence of empirically derived risk factors for IPV and, in some cases, calculate a score that reflects the degree of risk posed by an individual relative to their peers. It must be noted, though, that efforts to move from simply identifying risk factors to constructing empirically sound risk assessment scales are at an early stage of development, warranting a cautious approach to their use.

There have been five prominent literature reviews of IPV risk assessment/screening instruments: Roehl and Guertin, (2000); Dutton and Kropp, (2000); Hanson et al. (2007), Nicholls, Pritchard, Reeves, and Hilterman (2013) and Messing and Thaller (2012). According to these reviews, the six most prominent risk assessment tools used in IPV are: the Spousal Assault Risk Assessment Guide (SARA); the Domestic Violence Screening Inventory (DVSI); the Ontario Domestic Assault Risk Assessment (ODARA); the Psychopathy Checklist-Revised (PCL-R); the Domestic Violence Risk Assessment Guide (DVRAG); and the Danger Assessment Scale (DA).

The statistic that is most relevant when assessing the relative strength of one tool over another is the Area Under the Receiver Operating Characteristic Curve (AUC) from Radio Operator Curve analysis (ROC). The AUC statistic represents a scales ability to accurately differentiate between recidivists and non-recidivists. ROC analysis has

become the preferred method of analysis in violence prediction studies because it allows scales to be compared and, unlike other statistics, is not adversely affected by the underlying recidivist rate in the target population – i.e. the base rate (Rice & Harris 2005). AUC values range from 0.1 (completely inaccurate) to 1.0 (perfectly accurate). A value of .5 indicates that a scale is no more accurate than chance. Hence, a value of .56, .64, and .71 would indicate that a scale has low, moderate, and high predictive accuracy – i.e. 56%, 64%, and 71% chance of accurately identifying a recidivist respectively (Rice & Harris, 2005; Messing & Thaller, 2013). The other statistic commonly reported is Cohen's *d*; however, it can be unduly influenced by base rates and has not been reported here.

Of the IPV risk assessment tools discussed here, the ODARA was found to have the highest average AUC weighted by sample size for intimate partner re-assault (AUC = .67, $k = 5$), followed by the SARA (AUC = .63, $k = 6$), DA (AUC = .62, $k = 4$), and the DVSI (AUC = .58, $k = 3$), according to figures reported by Messing and Thaller (2013). They also found that these differences were significant. However, they noted that only 45% of the research included in their study had adhered to the administrative procedures of the risk assessment tool in question. While each of the measures is able to assess risk better than chance, the effect size for the average AUC's is small, except for the ODARA. See Table 1 for an overview of the assessment tools discussed.

4.1. Spousal Assault Risk Assessment Guide (SARA)

Rather than a psychological test, the SARA (Kropp et al., 1999) is a comprehensive guide to IPV risk assessment – that is, an aid to structured professional judgement. It is the most popular of the IPV risk assessment tools. It provides direction on essential topics to cover during the clinical interview with the perpetrator; empirically derived risk factors

to evaluate; ancillary tests to administer; collateral information to obtain and from whom; content to include in a risk assessment report and case management strategies to recommend. For this reason, it is highly recommended to the reader as a means of structuring a clinically sound and legally defensible risk assessment as outlined above.

4.1.1. Development and Content

Despite being designed as a guide to structured professional judgement rather than an actuarial risk assessment tool, the SARA has become synonymous with the 20-item list of risk factors (11 static, e.g. past assault history, and 9 dynamic, e.g., recent relationship problems) contained within it. These risk factors were identified through a review of the empirical and professional literature on risk for general and intimate partner violence, rather than traditional test construction methods, and refined through consultation with experts in the field and victim advocates. It therefore lacks a development sample; however, this enhances its generalisability (Helmus & Bourgon, 2011). Item content covers criminal history; psychosocial adjustment including mental illness and personality disorders; spousal assault history and detail of the most recent incident.

4.1.2. Administration and Scoring

The authors recommend that administrators should have a four-year degree in psychology or counselling, satisfactory completion of test interpretation, psychometrics, and measurement theory subjects, and a minimum of two years' work experience in IPV. The users' manual lists an operational definition of each item, research support for its inclusion, and specific scoring instructions. Each item is scored according to a 3-point scale: 0 (no evidence of risk factor), 1 (partial presence of risk factor), or 2 (presence of risk factor), to produce a maximum score of 40 (Kropp et al., 1999). It is also possible to designate any of the

20 risk factors, as a 'critical item' if the clinician believes that factor is sufficient on its own to indicate an imminent risk of harm.

The SARA also includes a section labelled 'other considerations'. It does not list any particular items or scoring rules but allows the assessor to identify additional risk factors or elements unique to the case that might increase the likelihood of further IPV, such as stalking, easy access to firearms, or animal cruelty. The presence of eight or more risk factors or a total score above 19 is considered high risk. While there are no algorithms to apply or recidivist probabilities provided, it is possible to obtain a sense of the relative risk posed by the offender under evaluation by comparing their total score and the number of risk factors present against the percentile distribution provided for the test sample, which are presented separately for inmates and probationers. Items 1–10 (Criminal History and Psychosocial Adjustment) can also be combined to provide an estimate of an individual's risk of general violence, while Items 11–20 (History of Spousal Assault and Alleged/Current Offence) can be combined to provide an indication of an individual's risk of further IPV.

The assessor combines all the information obtained about the case to determine whether the offender is at low, moderate, or high risk of causing imminent harm to their intimate partner and/or any other known person. This is referred to as the 'summary risk judgement' and provides an opportunity for the clinician to use professional override to adjust the risk rating. The authors warn against proceeding with an assessment when insufficient information is available. Unfortunately, 'imminent' is not defined, but it is understood in the literature to refer to within 6 months; there are no recidivist probabilities provided for the different risk levels.

4.1.3. Psychometric Properties

Despite the SARA's popularity, there is relatively little empirical evidence to support its use. Nevertheless, it is the most researched of

the IPV risk assessment tools, with a total of 11 validation studies conducted to date. While the SARA has good face validity, the inclusion of some of its items has also been called into question, as has the criterion used to score the items. A small study conducted by Grann and Wedin (2002; $N = 88$) found that four items had poor predictive validity – namely, recent relationship problems; past sexual assault/sexual jealousy; severe and/or sexual assault in current offence; and use of weapon and/or credible threats of death. Similarly, a larger study conducted by Hilton et al. (2004) failed to find support for some aspects of the criterion used to score individual items. For instance, separation prior to the index (i.e. current) offence, apparent suicidality, victim injury in current offence, and weapon involved in current offence all failed to predict IPV recidivism. Helmus and Bougon (2011) also point out that the criterion used to score items may not be calibrated sufficiently to differentiate between offenders of different risk levels, leading some items to become dichotomous variables, thereby reducing predictive power and over estimating risk. A third study (Wong & Hisashima, 2008) found only 7 of the 20 items to be predictive. This has led some to criticise the fact that the SARA has not been revised since its release in 2004, especially in light of the proliferation of research on risk factors for IPV since that time. It has also contributed to calls for the authors to clarify which of the items are intended to be predictive as opposed to being treatment targets (Helmus & Bourgon, 2011). Nevertheless, the SARA has sound concurrent validity when compared to other measures of violent and IPV recidivism (Williams & Houghton, 2004).

While not intended to be used as such Hanson et al. (2007) found the SARA total score to be more accurate in predicting recidivism than the summary risk rating; $d = .43$ (95% CI [.32, .53]) compared to $d = .35$ (95% CI [.15, .55]). Similarly, Williams and Houghton (2004) found that the total SARA

score performed as well as the overall risk rating assigned by the clinician. Grann and Wedin (2002) also reported that the total score was a valid predictor of IPV recidivism depending on the follow-up period. Singh, Grann, and Fazel (2011) recently reported a medium AUC of .70 for the SARA total score in one study involving 102 participants. Taken together, these results indicate that the SARA has moderate to high predictive validity. Research also indicates that the total score (AUC = .70) and summary risk ratings (AUC = .65) are moderate predictors of recidivism per se (Helmus & Bourgon, 2011).

Furthermore, inter-rater reliability has been found to be better for IPV than general violence and total scores (.84) compared to summary risk scores (.67; Kropp & Hart, 2000). Not surprisingly, Kropp and Hart (2000) found that the predictive accuracy of the SARA was influenced by user qualification and training and the quantity and quality of information available to the assessor.

4.1.4. *Limitations and Contraindications*

Although the authors indicate that the SARA can be administered to adult offenders of either sex, the literature used to create the scale was based on male offenders, and only two validation studies have included females. Hence, the SARA should not be used with female offenders at this time. Helmus and Bourgon (2011) also recommend against the use of critical item ratings due to poor inter-rater reliability. Given the moderate predictive validity of the SARA, it may be wise to restrict its use to its intended purpose – that is, as a guide to professional judgement – and avoid making predictive statements about risk until stronger evidence becomes available to support its predictive validity. Should clinicians be required to provide such advice, they are encouraged to utilise a well-established criminogenic risk assessment tool such as the LSI-R, which has also demonstrated an ability to identify IPV recidivists.

4.1.5. *Availability*

The SARA is not available in the public domain and must be purchased.

4.2. *Domestic Violence Screening Instrument (DVSI)*

4.2.1. *Development and Content*

The DVSI (Williams & Houghton, 2004) is a 12-item actuarial screening tool designed to allow first responders, such as police, probation, or court support personnel, to estimate the risk of IPV recidivism. It was developed by the Colorado Department of Probation Services, in response to the introduction of a mandatory arrest and remand laws for IPV offenders. It was designed to be complemented by a more thorough IPV risk assessment such as the SARA, following adjudication. Scale items were identified on the basis of an analysis of the social and behavioural correlates of repeat IPV offending in the US state of Colorado in the two years to 1996 and support from the empirical literature base. Behavioural items include violent and criminal behaviour and official sanctions, while social items include current employment and relationship status.

4.2.2. *Administration and Scoring*

The DVSI can be coded solely on the basis of official (i.e. court and police) records. Each item is scored on an ordinal scale ranging from 0 to 2 or 0 to 3 to produce a maximum score of 30. Missing data is labelled 'unknown'. The values on each of the 12 items are summed to produce a total score. While no cut-off scores are provided, higher scores are reported to be indicative of greater risk of recidivism and non-compliance with court or probation orders.

4.2.3. *Psychometric Properties*

Williams and Houghton (2004) used a prospective design and receiver operating

characteristic (ROC) analysis to validate the DVSI, using 1465 male offenders. They found that the DVSI had reasonable internal consistency ($\alpha = .71$) and concurrent and discriminant validity when compared to the SARA ($r = .567$) and the Level of Supervision Inventory ($r = .169$; Andrews & Bonta, 1993), which is used to estimate risk of general offending. More importantly, they reported an Area Under the receiver operator Curve (AUC) value of .61 for IPV reoffending and .65 for general reoffending, indicating that the DVSI has a moderate degree of predictive accuracy over an 18-month period. They also found that the DVSI was more accurate at predicting more severe than less severe forms of threatening and physically violent behaviour reported by victims at 6-month follow-up (AUC = .68, $p = .001$; AUC = .65, $p = .041$, respectively).

Domestic Violence Screening Instrument (DVSI-R)

4.2.4. Development and Content

The DVSI was revised in 2006, following hierarchical regression and ROC analysis of approximately 15,000 assessments of male and female offenders aged 16 years and older referred to Connecticut Court Support Services between September 2004 and May 2005. The majority of the sample were white males, aged between 22 and 44, who had engaged in IPV. This analysis resulted in two items being merged and a number of others being reworded. The 'unknown' scoring option was also removed in favour of 'no evidence' in order to improve clarity and to encourage assessors to obtain this information.

4.2.5. Administration and Scoring

The resultant DVSI-R consists of 11 items scored in the same fashion as the original, allowing a maximum score of 28. Two summary risk ratings were also added: imminent (i.e. within 6 months) risk to intimate partner

and imminent risk to an identifiable other. The latter two items allow clinicians to use clinical judgement to override the total risk score if they identify idiosyncratic risk factors that would undermine the accuracy of the total score (Williams & Grant, 2006). The summary risk ratings are scored low (0), moderate (1), or high (2). A total score of 0–4 indicates low risk of recidivism, 5–8 moderate risk, 9–12 high risk, and 13–28 very high risk (Williams 2011).

4.2.6. Psychometric Properties

Williams and Grant (2006) found that the DVSI-R total score was an accurate predictor of IPV (AUC = 0.71), and, to a lesser extent, so too were the two summary risk ratings of imminent risk to partner or other (AUC = 0.64 and AUC = 0.61, respectively). This indicates that the total DVSI-R score is a more accurate predictor of IPV recidivism than are the professional judgement items. They also found that incidents with multiple victims were the single best predictor of IPV recidivism (AUC = 0.79) and that the DVSI-R was capable of accurately predicting various forms of family violence, irrespective of the offender's age, gender, or ethnicity. It should be noted, however, that repeated referral for assessments was used to measure recidivism.

A subsequent validation study conducted by Williams (2011) sought to overcome the limitations associated with the recidivism measure used by Williams and Grant (2006) by examining the re-arrest data of an independent sample of 3569 offenders tracked over an 18-month period. The majority of the sample were white male IPV offenders in their mid-thirties. He found that the DVSI-R had slightly better internal consistency than the original ($\alpha = .75$) and that item-total scale correlations ranged between .24 and .72. Interestingly, he found that the DVSI-R was only a moderately accurate predictor of new family violence offences (AUC = .62); however, this accuracy was improved when new

offences and breaches of restraint or protective orders were considered together ($AUC = .73$). The same pattern emerged irrespective of gender for male ($AUC = .70$) and female offenders ($AUC = .79$). Williams (2011) also found that the addition of the clinical judgement items added little to the predictive accuracy of the scale, leading him to recommend that they be treated as a safety net but not used to override the DVSI-R total score.

4.2.7. *Limitations and Contraindications*

The DVSI-R has a distinct advantage among IPV risk assessment tools in that it is validated for use with female offenders and youth and is capable of predicting a wide variety of family violence. Having said that, credible inter-rater reliability estimates and independent validation studies of the DVSI and DVSI-R are lacking.

4.2.8. *Availability*

The DVSI and DVSI-R are available from Williams (2008) and Williams and Grant (2006), respectively.

4.3. *Ontario Domestic Assault Risk Assessment (ODARA)*

Like the DVSI, the ODARA (Hilton et al., 2004) is a brief actuarial risk assessment tool designed to allow first responders, such as police, victim services workers, and court support personnel, to estimate the risk of IPV recidivism. It can be used by a wide range of professionals without clinical training and is intended to inform police investigations, bail hearing, court processes, and victim safety planning.

4.3.1. *Development and Content*

The ODARA was the first IPV risk assessment tool to be developed via traditional scale construction techniques and empirically validated to predict IPV as well as the frequency, severity, and time to assault. It

consists of 13 yes/no items identified for inclusion through multi-regression analysis of 600 male offenders arrested for IPV in Ontario, Canada. As it was originally intended for use by police officers, only information routinely available to them was considered for inclusion. The items cover the offender's history of violent and criminal offending, response to official sanctions, details of the most recent incident and the victim's personal circumstances.

4.3.2. *Administration and Scoring*

Each item is coded on the basis of victim interview and police records using an ordinal scale ranging from 0 (risk factor absent) to 1 (risk factor present), to produce a maximum score of 13. A formula is also provided to adjust the score to compensate for any missing data. Scores fall into one of seven categories. A score of 7 or more is indicative of high risk, and 70% of offenders scoring 7 or more have been shown to recidivate. According to the authors, the higher the score, the more frequent and severe the offending and the more imminent the threat. Hence, in addition to partner assault, the total score is used to provide an indication of the likelihood of frequency and severity of assault, number of injuries, and time to reassault.

4.3.3. *Psychometric Properties*

The authors reported strong predictive accuracy for the ODARA during construction ($AUC = .77$), with a mean follow-up period of 4.79 years and cross-validation of 836 cases ($AUC = .72$; Hilton et al., 2004). Research indicates that the ODARA can accurately identify recidivists among individuals with less extensive (base rate = 27%, $AUC = .67$; Hilton & Harris, 2009) and more extensive (base rate = 49%, $AUC = .67$; Hilton, Harris, Rice, Houghton, & Eke, 2008) criminal histories. Moreover, a cross validation study conducted by Hilton et al. (2008) reported an AUC of .65 ($N = 346$). The ODARA also demonstrated reasonable

concurrent validity with the SARA, DVSI, DA, and PCL-R. Hence, the ODARA has demonstrated moderate to strong predictive accuracy for IPV recidivism.

4.3.4. *Limitations and Contraindications*

Despite the impressive results reported by the authors during construction, the ODARA is yet to undergo extensive independent validation. Clinicians should also bear in mind that the ODARA was designed to predict male on female violence and has only received preliminary validation for use with female IPV offenders (Hilton et al., 2014). Furthermore, the risk categories provided might not be applicable to Australian IPV offenders, given that the tool was developed from a Canadian sample. Clinicians are therefore encouraged to exercise caution in the use of this tool until more research data becomes available to support its use. Credible inter-rater reliability is also lacking.

4.3.5. *Availability*

The ODARA is available from Multi-Health Systems (<http://www.mhs.com>).

4.4. *Psychopathy Checklist-Revised (PCL-R)*

Originally designed to diagnose psychopathy, the Psychopathy Checklist - Revised developed by Hare (1991; 2003) has proven to be an effective means of identifying individuals more likely to engage in future violent and general offending. As a result, it has been used as a stand-alone violence risk assessment device and has been combined with other risk factors to create new ones, such as the Violence Risk Assessment Guide (VRAG) and, more recently, the Domestic Violence Risk Assessment Guide (DVRAG) outlined below.

4.4.1. *Development and Content*

The revised version of the PCL (PCL-R; Hare, 1991; 2003) is a 20-item actuarial scale

comprised of two factors: Factor 1 contains interpersonal and affective deficits, such as superficiality and lack of empathy, while Factor 2 contains behavioural deficits, such as impulsivity and criminality, characteristic of psychopathy.

4.4.2. *Administration and Scoring*

Administrators must hold a PhD or equivalent in social, medical, or behavioural science, be registered with the relevant body governing the assessment and treatment of mental disorders, have completed a placement in or have at least two years' experience in forensic practice, and have undergone specialised training in psychopathy and the use of the tool. The PCL-R is scored on the basis of a semi-structured interview and collateral information. The presence of each risk factor is rated on an ordinal scale from 0 to 2, where 0 indicates that the item does not apply, 1 indicates that the item applies partially, and 2 indicates that the item definitely applies. A score of 30 ± 3 is required to make a formal diagnosis of psychopathy.

4.4.3. *Psychometric Properties*

While not designed as a risk assessment tool per se, research indicates that the various forms of the psychopathy checklist developed by Hare (1991; 2003) are reliable and valid predictors of violent and general offending, even when scored solely from official records (Wilson, 2006). The PCL-R has been validated for use with both sexes, in forensic and clinical populations (Wilson, 2006). Serin (1996) found that the PCL was superior to other actuarial scales in predicting violent recidivism and that items on Factor 1 made a more significant contribution to this outcome than items on Factor 2, suggesting that the interpersonal and affective features of psychopathy have a unique bearing on future violent behaviour. As a result, the PCL-R has been incorporated into a number of risk assessment instruments including the

Violence Risk Assessment Guide and, more recently, the Domestic Violence Risk Assessment Guide. Bucking the trend, a recent meta-analysis of 68 studies ($N = 25,980$) found that the PCL-R had the least predictive validity out of nine commonly used violence risk assessment scales including the SARA ($AUC = .66$, $N = 2645$; Singh et al., 2011).

The Psychopathy Checklist Screening Version (PCL:SV; Hart, Cox and Hare, 2005) is comprised of 12 items and has the same scoring and factor structure as the PCL-R. While the PCL:SV cannot be used to diagnose psychopathy, research indicates that its total scores are directly related to total scores on the PCL-R (Cooke, Michie, Hart & Hare, 1999). The PCL:SV shares the same excellent psychometric properties as the PCL-R (Monahan et al., 2001). Research suggests that individuals classified as psychopathic using the PCL:SV are between 10 and 12 times more likely to engage in violent behaviour than are non-psychopaths (Douglas, et al., 1999; Skeem & Mulvey, 2001). A New Zealand study of 199 violent offenders found that a score of 16 or more on the PCL:SV was the most efficient cut-off score to identify those most likely to engage in a serious violent offence in the future (Wilson, 2006). A score between 8 and 12 on Factor 1 was also related to reduced time to offence. The PCL:SV also demonstrated significant predictive validity for serious violent offending ($AUC = .80$; i.e. 80% accuracy). Nevertheless, a high score on the PCL should never be used to make categorical or stand-alone statements about the likelihood of IPV, as it fails to indicate what dynamic or protective factors may be present to mitigate risk (Wilson, 2006). Hence, 'the PCL measures should only be used to support conditional risk prediction statements' (Wilson, 2006, p. 123).

A subgroup of IPV offenders is believed to possess psychopathic traits. This is not surprising, given that Hare (2003) points out that psychopathic violence tends to be instrumental in nature – that is, designed to achieve a

desired outcome such as compliance or submission. This type of violence is associated with increased risk of reoffending (Cornell et al., 1996).

4.4.4. Availability

The various forms of the PCL can be obtained from Multi-Health Systems (<http://www.mhs.com>).

4.5. Domestic Violence Risk Assessment Guide (DVRAG)

The DVRAG (Hilton et al., 2008) combines the ODARA with the PCL-R to create an in-depth actuarial risk assessment tool designed to predict the frequency and severity of IPV recidivism among males arrested for IPV (Hilton et al., 2008).

4.5.1. Development and Content

The DVRAG was developed during cross validation of the ODARA using a sample of 303 men arrested for IPV, with a base rate of 49%. It was designed to be administered by forensic clinicians or probation officers. The authors sought to identify an existing tool to complement the use of the ODARA by police officers who lack the time, information, and clinical expertise to conduct an in-depth risk assessment. The PCL-R was selected over the Danger Assessment (DA), SARA, DVSI, and a 9-item version of the Violence Risk Assessment Guide (VRAG) because it demonstrated the greatest incremental validity over the ODARA alone. Hence, the DVRAG consists of the ODARA items, scored continuously rather than dichotomously, plus the PCL-R total score. The AUC for the ODARA improved from .65 to .71 when the PCL-R total score was added.

4.5.2. Administration and Scoring

The DVRAG involves the completion of a comprehensive clinical interview with the

offender, in keeping with the standard administration procedures required for the PCL-R, collateral enquiries, and a review of official records. Hence, the PCL-R user qualifications apply. Each of the ODARA items has a different scoring system and is weighted according to their correlations with IPV recidivism. For instance, previous assault of a non-family member is given 8 points, while threat to kill in the index incident is given 1 point. Once all of the necessary information has been collected, values on each of the 14 items are summed to create a total score that falls into one of seven categories, with a known likelihood of reoffending based on 5 years of follow-up data; 14% of offenders falling into Category 1 reoffend, compared to 100% of those falling into Category 7. Like the ODARA, a formula is provided to prorata missing items, and the authors suggest that the scale remains valid with up to 5 missing items. Also like the ODARA, the DVRAG provides an indication of the likelihood of five outcome variables: partner assault, frequency of assault, severity of assault, number of injuries, and time to assault.

4.5.3. *Psychometric Properties*

Using an independent sample of 346 offenders with a reoffending base rate of 46%, Hilton et al. (2008) found that the DVRAG was a more accurate predictor of IPV recidivism than the ODARA alone – $AUC = .65$ and $AUC = .70$, respectively – suggesting that the DVRAG has strong predictive validity. The DVRAG also predicted frequency, severity, and time to assault more accurately than did any of the other risk assessment tools. They also reported an inter-rater reliability coefficient of .92, based on a random selection of 10 files drawn from an IPV intervention program. The authors found that the DVRAG and PCL-R predicted IPV recidivism more accurately than did the SARA, leading them to suggest that antisociality plays a larger role in the aetiology of

IPV than relationship attitudes and behaviours.

4.5.4. *Limitations and Contraindications*

The DVRAG is a relatively new assessment tool, hence there are yet to be any independent validation studies published on its use. As a result, clinicians should exercise caution when considering its use. It also shares the same limitation as the ODARA in that the risk calculation system cannot automatically be applied to Australian IPV offenders without knowledge of the local base rate. Clinicians should also bear in mind that it has not been validated for use with female offenders.

4.5.5. *Availability*

The ODARA component of the DVRAG can be found in Hilton et al. (2008). The PCL-R is available for purchase from Multi-Health Systems (www.mhs.com).

4.6. *The Danger Assessment Scale (DA)*

4.6.1. *Development and Content*

The DA (Campbell, 1986) is unique among IPV risk assessment instruments in that it aims to predict intimate partner homicide (IPH) and is administered to victims rather than perpetrators. The scale thereby aims to enhance victim's decision-making by assisting them to assess more accurately their risk of being murdered or seriously injured by their partner. It was developed on the basis of retrospective studies of femicide and serious assault and refined with the assistance of victim advocates and experts in the field. Items cover the offender's history of IPV and other violence, access to firearms, suicidality, and jealousy. The revised version of the DA consists of a calendar to help the victim to identify the frequency and severity of abuse over the past 12 months, 20 yes/no questions to examine the victim's exposure to known risk

factors for IPH, an algorithm to calculate a summary risk score, and suggested risk management strategies.

4.6.2. Administration and Scoring

The DA was initially designed to be administered by nursing staff to women presenting at emergency departments; however, it is now widely used in a variety of settings throughout the domestic violence, justice, and health sectors and does not require clinical skills to administer. It takes approximately 20 minutes to complete.

The victim is provided with a calendar of the past 12 months and asked to indicate when they were assaulted, and to describe the nature of that violence using an ordinal scale ranging from 1 to 5, where 1 equates to a push or a slap with no injuries or lasting pain, 3 equates to being beaten up and/or suffering a serious injury such as broken bones or burns, and 5 equates to assault with a weapon, causing injury. This activity has been found to increase the frequency and severity of violence reported (Campbell, 1986; Campbell, 1995). Interview questions elicit information about the offender's history of IPV and other violence, substance abuse, suicidality, jealousy, and access to weapons, as well as the victims' perception of the risk of death posed by their partner.

Each of the 20 items is weighted according to the strength of its correlation with IPH, as demonstrated in retrospective studies and combined to produce a summary score. Total scores of less than 8 indicate 'variable danger', between 8 and 13 'increased danger', between 14 and 17 'severe danger' and over 18 'extreme danger.' The results of the DA should be shared with the victim with the express purpose of assisting her to develop a safety plan commensurate with her risk level. The DA provides advice to the worker on feedback to give the victim and action to take according to their assessed risk level.

4.6.3. Psychometric Properties

The DA has sound psychometric properties, including test-retest reliability ($r = .89$) internal consistency (.60 to .86), and convergent validity with other measures of IPV (Campbell, 1995; Stuart & Campbell, 1989). It has also been shown to be positively correlated with subsequent violence and serious threats of violence 3 months after an arrest (Goodman, Dutton, & Bennett, 2000) and 4 months after a court-imposed sanction (Weisz, Tolman, & Saunders, 2000). More importantly, however, Campbell, Webster and Glass (2008) reported a ROC of .90 for the revised DA based on an analysis of femicides across 11 cities in the United States. Nevertheless, Hilton, Harris, and Rice (2001) suggest that the predictive accuracy of the DA could be improved further by removing items inversely related to recidivism, such as suicidality. The authors chose to retain this item even after revision because of the risk of femicide posed by suicidal offenders. The DA has recently been revised to predict IPV in female same-sex offenders, and the authors report sound predictive validity (Glass et al., 2008).

4.6.4. Limitations and Contraindications

Although the DA has sound psychometric properties and research indicates that victims are reasonably capable of assessing their risk of re-assault (AUC = .62; Campbell, O'Sullivan, Roehl, & Webster, 2005), caution is warranted as retrospective studies of women killed by their intimate partners indicates that victims of IPH tend to underestimate the level of risk posed by their partners. Although the authors indicate that the DA can be used with victims of either sex, it is yet to be normed for use with male victims of IPV.

4.6.5. Availability

The DA is freely available and can be downloaded from: <https://www.dangerassessment.org>

5. Ancillary Assessment Tools

The following ancillary assessment tools are recommended as supplementary tools to enable administration of the SARA and aid comprehensibility of any IPV risk assessment.

5.1. *Spouse Abuse Inventory*

The Spouse Abuse Inventory (Sonkon, 2000) is a more extensive version of the Conflict Tactic Scale, listing over 70 different acts of physical, sexual, and psychological violence and their frequency. The list also includes a checklist of over 100 injuries potentially resulting from the acts of violence. The questionnaire also includes a series of open-ended questions about specific acts of violence, the first act of physical violence, the most life threatening act of physical violence, the most frightening act of physical violence, the most humiliating act of physical violence, a typical act of physical violence, and an example of non-physical violence. It is commonly used in IPV research but does not appear to have been the subject of any published validation studies.

5.2. *Psychological Maltreatment of Women Inventory (PMWI)*

The Psychological Maltreatment of Women Inventory (Tolman, 1989) has been utilised in many research studies to identify patterns of psychological or non-physical violence; it is very easy to administer and score. Research indicates that it can accurately discriminate between abused, relationship distressed, and non-abused women.

5.3. *The Personality Assessment Inventory (PAI; Morey, 1991)*

The PAI is recommended over the Millon Clinical Multiaxial Inventory (MCMI-III; Millon, 1994), which is commonly used in IPV research, because it contains three indices of aggression and provides an indication

of an offender's receptiveness to treatment. It is a well respected and a validated measure of personality.

5.4. *Depression Anxiety Stress Scales (DASS)*

The DASS has sound validity and is widely used throughout Australia. It is recommended as a means of screening for the presence of a mood disorder.

5.5. *Drug Abuse Screening Tool (DAST)*

The DAST has sound validity and is widely used throughout Australia in the drug and alcohol sector to screen for the presence of illicit substance abuse.

5.6. *Alcohol Use Disorders Identification Test (AUDIT)*

The AUDIT has sound validity and is widely used throughout Australia in the drug and alcohol sector to screen for the presence of an alcohol use disorder.

6. Conclusion

Growing public recognition of the harm associated with IPV has led to the introduction of pro-arrest, pro-prosecution policies in many Australian jurisdictions. Hence, there is a pressing need to be able to accurately identify those most likely to reoffend and to tailor safety and intervention planning according to an offender's unique risk, need, and responsiveness profile. Psychologists have an opportunity to play a significant role in informing the response of the health, welfare, and justice systems to victims and perpetrators of IPV via risk assessments. While still in their early stage of development and not without their shortcomings, actuarial risk assessment measures of IPV enhance the comprehensiveness, objectivity, standardisation, and defensibility of expert opinion, especially when this information is triangulated with additional

information obtained from multiple sources and methods to arrive at an overall assessment of risk. Nevertheless, caution is warranted, as current IPV risk assessment measures have not been normed for use in Australia, published effect sizes are generally small to moderate, and research findings have been undermined by a lack of adherence to administrative procedures and methodical rigour. Hence, clinicians would be wise to consider the purpose, context, time constraints, access to information and informants, whether they have the requisite skills, knowledge, and experience necessary to render a competent risk assessment of IPV intended to inform the judicial system, before embarking on a risk assessment and deciding which IPV risk assessment method and measure to use and to articulate the limitations of any conclusions upon which a risk assessment is made.

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No potential conflict of interest was reported by the authors.

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