Lessons Learned from Domestic Violence Tragedies: Emerging Research, Policies & Practices to Prevent Domestic Homicides

Peter Jaffe PhD
Academic Director, Centre for Research and Education on Violence Against Women and Children, Faculty of Education, University of Western Ontario

Myrna Dawson PhD
Associate Professor & Canada Research Chair in Public Policy in Criminal Justice, Department of Sociology, University of Guelph

Marcie Campbell MEd
Research Associate, Centre for Research and Education on Violence Against Women and Children, Faculty of Education, University of Western Ontario

Centre for Research & Education on Violence against Women and Children

Western Education

Social and Legal Responses to Violence in Canada Research Unit

UNIVERSITY of GUELPH

March 2011

This paper summarizes key ideas and recommendations from a national think tank on the prevention of domestic homicides that took place on October 24-26, 2010 at the University of Western Ontario in London, Ontario. The think-tank brought together 39 practitioners, researchers, and government officials representing Canada from coast to coast. The purpose of this discussion paper is to reflect on current research, policy and practices across Canada that has been directed at preventing domestic homicides and provides a framework for future directions. This paper does not reflect the individual views of each participant, individual provinces and territories or the Department of Justice who funded this initiative. The government policy experts were attending as resource persons and did not speak for their government in any official capacity. The authors are grateful for the funding provided by Canada's Department of Justice and the contributions of all the participants who attended the think-tank. The authors can be contacted via email – pjaffe@uwo.ca and mdawson@uoguelph.ca

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Executive Summary

This paper summarizes key ideas and recommendations from a national think tank on the prevention of domestic homicides that took place on October 24-26, 2010 at the University of Western Ontario in London, Ontario. The think-tank brought together 39 practitioners, researchers, and government officials representing all provinces and territories in Canada.[1] The purpose of the think tank was to discuss domestic violence and homicide prevention. The purpose of this discussion paper is to reflect on current research, policy and practices across Canada that has been directed at preventing domestic homicides and provides a framework for future directions. This framework represents the consensus of the discussion at the think-tank but does not reflect the individual views of each participant, individual provinces and territories or the Department of Justice who funded this initiative. The government policy experts were attending as resource persons and did not speak for their ministry in any official capacity.

Several emerging issues around domestic homicide and domestic violence prevention were identified. Forming effective domestic violence death review committees, conducting risk assessments, managing risk, engaging the family court, working with vulnerable populations, and enhancing the role of the workplace in addressing domestic homicide prevention were highlighted as critical issues to address. These issues present many challenges across Canada but various provinces and helping systems have implemented promising practices that should be shared on a broader basis. The think-tank participants recommended implementing the following plan to build on the current knowledge in the field and to reduce deaths from domestic violence on a national basis:

1. **Enhance Partnerships amongst existing and developing Domestic Violence Death Review Committees.** There are currently four DVDRCs (Ontario, NB, BC, and Manitoba) in Canada with other provinces and territories that would like to explore the possibilities of similar developments. Formal partnerships amongst these committees could provide a source of support and consultation on emerging and promising practices. Furthermore, the partnership may help smaller jurisdictions where there are more limited specialized resources and fewer homicides.

2. **Create a Canadian Domestic Homicide Prevention Initiative.** This initiative would provide a national website similar to the National Domestic Violence Fatality Review Initiative (www.ndvfri.org) established in the United States. The NDVFRI is a website that contains: over 50 annual reports from domestic violence fatality review teams across the U.S.; annual reports

[1] The Nunavut representative was not able to attend so only representatives from 10 provinces and 2 territories were present at the Think Tank.

from international fatality review teams; tools and protocols used when establishing a fatality review team; links to other websites associated with domestic violence and homicide prevention; and newsletters that discuss upcoming conferences and initiatives around the world associated with domestic violence fatality review and prevention.

3. **Develop a National Domestic Homicide Database.** This database would include all domestic homicide cases across Canada with the purpose of tracking risk factors and common trends over time and identifying unique factors associated with particular populations. The information from this database can be shared with researchers and professionals in the area of domestic homicide prevention to help create education campaigns and effective prevention initiatives.

4. **Develop a national strategy for consistent risk assessment and management strategies by different agencies and disciplines**. An essential process to prevent domestic homicides is utilizing risk assessment tools that facilitate communication and collaboration**.** Ongoing training opportunities are essential for creating an effective risk assessment process. Training should be considered mandatory for professionals that come into contact with victims and/or perpetrators of domestic violence and should be repeated on a yearly basis. Training and education needs to outline effective case management strategies that are inclusive of the cultural, spiritual, emotional, and physical well-being of the victim and children. Similar to training on risk assessment, professionals and agencies need to receive constant training on risk management practices to keep professionals up-to-date and collaborating with each other.

5. **Engage the family court and court-related professionals in recognizing the potential dangers to domestic violence victims and their children**. Professionals working with the family court system need to recognize the differential responses that are required for domestic violence cases. In the same way that the criminal courts have developed a more specialized framework of intervention with police, crowns and specialized court, the family court needs to examine the service system to address and manage these cases. Issues need to be addressed such as the increased level of risk during a separation/divorce; the dangers to children from a high-risk offender during visitation; and best practices for creating safe parenting practices. There needs to be enhanced communication between family courts and criminal courts. Family courts should have mandatory screening for family law matters that include screening potential high-risk offenders.

6. **Promote research that recognizes that Aboriginal communities have unique needs when addressing domestic violence and homicides.** Numerous studies and reports in Canada over the years have documented the higher incidence of intimate partner violence among Aboriginal peoples.[1,2,3,4] Statistics Canada and Amnesty International report that young Aboriginal women

[1] Ursel, J., (2006) "Over Policed and Under Protected: a question of Justice for Aboriginal women". In Hampton, M. & Gerrard, N. (Eds). *Intimate Partner Violence: reflections on experience, theory and policy*, Cormorant Press, Toronto

are five times more likely to be murdered than non-Aboriginal women. In many cases, the nature of the homicide is difficult to determine, (i.e. domestic or non-domestic) because a high proportion of missing and murdered Aboriginal women's cases are never solved. Some non-domestic homicides may be related to Aboriginal women escaping abusive partners, unsupportive communities and find themselves living on the streets. While some Canadian organizations have focused on researching cases of missing and murdered Aboriginal women (Native Women's Association of Canada: Stolen Sisters/Sisters in Spirit Project) no research projects focus specifically on domestic homicides of Aboriginal women.

7. **Identify other communities/populations with diverse needs and vulnerabilities.** Although Statistics Canada reported that there is an average of 76 victims of spousal homicide a year in Canada, we do not know how many of these spousal homicides involved immigrant and refugee victims.[55] Some researchers suggest that "immigrant and refugee families are at greater risk for domestic violence due to their migration history and differences in cultural values and norms".[5] This does not mean that immigrants and refugees perpetrate more violence but that they face unique challenges living in a new community and may be unable to access support resources due to language and cultural barriers. Other important communities that may be identified as vulnerable are people living in the North and in rural communities. Northern communities are extremely isolated and have a lack of available services. Victims of violence in the North are not always able to escape to shelters or receive supports. Many communities have extremely small policing services and family courts may be several communities away. Canadian researchers need to identify the specific needs of these communities and create programs and initiatives that will effectively provide supports to prevent domestic homicide and domestic violence in general.

8. **Promote cultural competency when conducting risk assessments and providing risk management in domestic violence cases.** There is little doubt about the importance of training and education, building trusting relationships with cultural groups, creating effective communication strategies and implementing new tools that are inclusive of many different cultures to improve on cultural competency. Professionals need to be aware of the challenges minority cultures face and how these challenges can act as barriers to accessing resources and reaching out for support. Training and education around cultural differences should be mandatory for professionals that work with victims and/or perpetrators of domestic violence. Victims may be fearful that their children will be taken away if they disclose abuse, victims may fear deportation, and both victims and perpetrators may feel that a professional from the dominant culture will not understand their own cultural customs and beliefs. Risk assessment tools that are currently being used do not necessarily take into account the vulnerabilities of victims (and perpetrators) from minority cultures. Factors such as poverty, isolation, cultural beliefs, languages, immigration concerns, and lack of resources can influence an individual's

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[2] Ogrodnick, L. (2008). *Family Violence in Canada: A Statistical Profile 2008*. Ottawa: Statistics Canada

[3] Proulx, J. & Perrault, S. (eds). (2000) *No place for violence: Canadian Aboriginal alternatives.* Fernwood Press, Halifax

[4] Ontario Native Women's Association, (1989). Breaking free: a proposal for change to Aboriginal family violence. Thunder Bay, Ontario: the Association

[5] Pan, A., Daley, S., Rivera, L.M., Williams, K., Lingle, D., and Reznik, V. (2006). Understanding the role of culture in domestic violence: The Ahimsa Project for safe families. *Journal of Immigrant and Minority Health*, 8(1), 35-43.

level of risk. Therefore, assessment tools that reflect these vulnerabilities need to be created and risk management strategies need to take all these factors into account.

9. **Addressing domestic violence in the workplace needs to be a priority.** Canadian employers should be encouraged to develop policies on measures they can take in their workplace to prevent and provide an effective response to domestic violence. Training should be promoted to all employees on how to recognize warning signs of domestic violence, how to respond appropriately when they recognize warning signs or witness incidents. Managers and supervisors should receive additional training so that they can appropriately assist victims or co-workers of victims who report concerns. Provincial government ministries responsible for labour and workplace safety should work with domestic violence experts to establish a non-profit initiative to engage employers in the work of preventing and responding to domestic violence. The new non-profit initiative should provide workplace specific information, resources and advice for employers. Examples for such promising practices exist elsewhere – such as the non-profit initiatives in the US to involve corporate partners in efforts to protect employees from domestic violence; The Corporate Alliance to End Partner Violence – see http://www.caepv.org/ and Workplaces Respond to Domestic and Sexual Violence: A National Resource Center – see http://www.workplacesrespond.org/ .

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Background and Context

A national think tank on the prevention of domestic homicides took place on October 24-26, 2010 at the University of Western Ontario in London, Ontario. It brought together 39 practitioners, researchers, and government officials representing all provinces and territories in Canada.[1] The purpose of the think tank was to discuss domestic violence and homicide prevention. Topics covered were domestic violence fatality review teams, risk assessment, risk management, the role of family court, challenges with vulnerable populations, and domestic violence in the workplace. The purpose of this discussion paper is to reflect on current research, policy and practices across Canada that have been directed at preventing domestic homicides and summarize some of the key ideas raised by think tank participants. These ideas represent the consensus of the discussion but may not reflect the individual views of each participant, individual provinces and territories or the Department of Justice who funded this initiative.

[1] The Nunavut representative was not able to attend so only representatives from 10 provinces and 2 territories were present at the Think Tank.

The paper begins by examining the development of domestic homicide review committees in Canada and outlining major findings from these committees (or related research). Both challenges and promising practices for creating death review committees are discussed. Findings from domestic violence death review committees point to several recurrent themes and important questions with regard to risk (threat) assessment, risk management, and responses to vulnerable populations. This paper summarizes the emerging issues and challenges around risk assessment and risk management, including the role of the family court, the issues related to assessment and management with vulnerable populations, and the function of the workplace in preventing domestic violence and homicide. Finally, the paper summarizes key ideas for the next steps in domestic homicide prevention.

The Development of DVDRCs

In the United States, more than three women are killed every day by an intimate partner. In 2005, just fewer than 1,200 women were murdered by a husband or boyfriend in the United States.[6] Canada has shown a decline in the rates of domestic homicide with four domestic homicides per million spouses in 2007 compared to nine per million in 1979.[7] Current rates are much higher when looking at female victims (6 per million in 2007) compared to male victims (3 per million).

When an unusual amount of deaths occur from a particular system failure, that system would normally be held accountable. Websdale uses deaths that resulted from a plane crash as an analogy.[8] Plane crashes are rare events that draw a lot of attention due to the large amount of fatalities that occur. The travelling public hopes that government departments responsible for safety in the aviation industry will conduct a thorough investigation to determine what went wrong and rectify problems in mechanical or human errors. Fatalities that occur due to airplane crashes are much smaller compared to fatality rates stemming from domestic violence incidents. By way of analogy, governments and public agencies could be examining the systemic causes of domestic homicides. Proper investigations and analyses may prevent tragedies in similar circumstances just as we work to improve safety standards in the airline industry on an ongoing basis.

Domestic violence death reviews have been conducted in North America since the early 1990s. The very first review was conducted in San Francisco, California after Joseph Charan killed his wife and himself in front of their nine-year old son's school.[9] The review resulted in identifying several key elements and recommendations that would help to predict and prevent similar tragedies. Since the Charan review, approximately 75 domestic violence death review committees have been created across the United States and the number continues to grow.[10] The purpose of a domestic violence death review is to identify risk factors to help predict potential tragedies and create recommendations aimed at preventing deaths in similar circumstances The overall goal of all reviews is to reduce domestic homicide and domestic violence in general. Usually recommendations target several service sectors (e.g., police, healthcare, justice) and fall under the general themes of: training and education; professional development; enhanced legislation; coordination of services; and resource development.

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[6] Family Violence Prevention Fund. (2010). *Get the facts: The facts on domestic, dating and sexual violence*. Retrieved October 13, 2010 from: http://www.endabuse.org/content/action_center/detail/754.

[7] Statistics Canada. (2009). *Family violence in Canada: A statistical profile 2009*. Ottawa: Ministry of Industry.

[8] Websdale, N. (2003). Reviewing domestic violence deaths. *National Institute of Justice Journal*, 250, 26-31.

[9] Websdale, N., Town, Judge. M., & Johnson, B. (1999). Domestic violence fatality reviews: From a culture of blame to a culture of safety. *Juvenile and Family Court Journal*, 50, 61-74.

[10] Watt, K.A. & Allen, N.E. (2008). *Domestic violence fatality review teams: Critical tensions and promising practices.* Paper presented at the Think Tank on Domestic Homicide, London, ON, Canada.

In 2002, the province of Ontario established the first death review committee in Canada.[11] The formation of the Domestic Violence Death Review Committee (Ontario DVDRC) was in response to recommendations made from two major inquests into the domestic homicides of Arlene May and Gillian Hadley.[12,13] Until recently, the province of Ontario has had the only death review committee in Canada. In March 2010, a Death Review Panel for the province of British Columbia (British Columbia DVDRP) conducted their first provincial domestic homicide review. [14] The panel reviewed 11 domestic homicide cases and produced 19 recommendations for systemic change to prevent similar tragedies. In November 2008, the Minister of Family Services and Consumer Affairs, along with the Minister of Justice & Attorney General and the Minister of Labour and Immigration (responsible for the Status of Women) for the Province of Manitoba announced the plan to create a domestic violence death review committee (Manitoba DVDRC) that will examine and review domestic homicides that occurred in the province.[15] The Manitoba DVDRC was formally established on June 16, 2010. [15] New Brunswick has put together a death review team that works as an advisory body to the Office of the Chief Coroner (New Brunswick DVDRC). The committee has commissioned a study on all domestic homicides that occurred in the province between 1999 and 2008. The results of the study will allow the committee to identify risk factors and form recommendations. The analysis on the homicide cases is expected to be completed by fall, 2010.[16] Finally, the Alberta Council of Women's Shelters created a position statement on the need for Alberta to create a domestic violence death review committee.[17]

Some provinces and territories have dealt with domestic homicides through inquests or special reviews (e.g., Lee family inquest in B.C. and the Turner review in Newfoundland).[18,19] Although individual inquests on specific domestic homicide cases are excellent tools to bring about awareness and promote systemic change, domestic violence death review committees are able to examine multiple homicides which allows for the identification of patterns, common risk factors, and themes. By identifying common trends and system failures, committees are able to call for system accountability without blaming individual organizations. Furthermore, committee reviews cost substantially less than conducting single inquests.

There is no standard framework for death review committees. Forming and implementing a committee can bring about many challenges.[10] A comprehensive study of various fatality review

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[11] Ontario Domestic Violence Death Review Committee. (2009). *Annual report to the Chief Coroner*. Toronto, ON: Office of the Chief Coroner.

[12] Ontario Women's Justice Network (2009a). *Arlene May-Coroner's inquest: Jury's verdict and recommendations,* July 1998. Retrieved October 13, 2010 from: http://www.owjn.org/archive/arlene3.htm.

[13] Ontario Women's Justice Network (2009b). *Suggested Recommendations to the Jury by the Ontario Association of Interval and Transition Houses (OAITH).* Retrieved October 13, 2010 from: http://www.owjn.org/owjn_2009/index.php?option=com_content&view=article&id=138&Itemid=107#1..

[14] Coroners Service. (2010). *Report to the Chief Coroner of British Columbia: Findings and recommendations of the domestic violence death review panel.* British Columbia: Ministry of Public Safety and Solicitor General. Retrieved October 13, 2010 from: http://www.pssg.gov.bc.ca/coroners/publications/docs/death-review- panel-domestic-violence.pdf.

[15] News Release. (2010). *Domestic Violence Death Review Committee Established*. Manitoba: Government. Retrieved October 13, 2010 from: http://news.gov.mb.ca/news/index.html?archive=2010-6-01&item=8880.

[16] News Release. (2010). *Domestic Violence Death Review Committee Established*. New Brunswick: Public Safety/Women's Issues. Retrieved October 13, 2010 from: http://www.gnb.ca/cnb/news/ps/2010e0200ps.htm.

[17] Alberta Council of Women's Shelters. (2010). *The Need for a Domestic Violence Death Review Committee in Alberta: ACWS Position Statement*. Retrieved October 13, 2010 from: http://www.acws.ca/documents/THENEEDFORADOMESTICVIOLENCEDEATHREVIEWCOMMITTEESINALBERTArevised.pdf.

[18] Representative for Children and Youth. (2009). *Honouring Christian Lee-No Private Matter: Protecting Children Living with Domestic Violence.* Retrieved October 15, 2010 from: http://www.crvawc.ca/documents/RCYChristianLeeReportFINAL.pdf.

[19] CBC News. (2006). *No need for Zachary Turner to die: death review*. Retrieved October 15, 2010 from: http://www.cbc.ca/canada/newfoundland-labrador/story/2006/10/04/turner-report.html.

committees in the US and Canada by Kelly Watt provided a helpful framework to examine the diverse approaches to examining domestic homicide. Watt found that these challenges can be classified under five main headings: a) legislation/governing body and membership; b) resources; c) sharing information/confidentiality; d) accountability; and e) local and centralized reviews.

a) Legislation/governing body and membership

Death review committees can range from a more informal community group brought together to review an individual death to a specific government mandated group. Many committees in the United States are formed under legislative mandate. "Several committees believe that a legislative mandate would help address problems of access to information, provide authority for the reviewing body, create a funding mechanism for the committee's work, send a clear message about the importance of the work, mandate participation of key players, and address confidentiality and liability issues".[20] In addition to deciding on a legislative mandate, death review committees need to establish where the committee will be housed. This decision is an important one because the committee needs to factor in whether or not the organization fits with their mandate, maintains positive relationships with health and services agencies and law enforcement, and fits in with the current political climate. Furthermore, the organization should be able to provide funds to the committee or have the potential to receive funding.[16]

The Ontario DVDRC, New Brunswick DVDRC, and British Columbia DVDRP are not formed under specialized government legislation but fall under existing rules and regulations for the Office of the Chief Coroner for the province. The Manitoba Domestic Violence Death Review Committee was also formed without creating new legislation. The committee reports to the attorney general and includes representatives from Manitoba Justice Victims' Services, Prosecution Services and Probation along with the Family Violence Prevention program, Manitoba Status of Women, Manitoba Women's Advisory Council, Office of the Chief Medical Examiner, Winnipeg Police Service, RCMP and RESOLVE, a regional family violence research network.

Another important factor when forming a committee that is tied in with the legislative mandate is membership. It is important for a committee to have representatives from the violence against women sector and all sectors that may deal directly with victims and/or perpetrators of domestic violence (e.g., healthcare; education; police). Individuals that were involved or affected by the fatality may also be included (ndvfri.org). In short, membership should include representatives from diverse populations. The Ontario DVDRC currently has representatives from victim services, child welfare, police, health care (physicians), justice (crown attorneys), corrections, and researchers (social work, psychology, and sociology).[11] The British Columbia DVDRP had members appointed to the panel under the Coroners Act. Members included representatives from police, justice, corrections and social services.[14] Committee members are usually appointed for a specific amount of time and can be reappointed or replaced when their term ends. Some death review committees have an established team membership and invite other professionals on an ad hoc basis to share their particular expertise for a review on a specific and complex case.

b) Resources

Resources, both financial and case specific, are always a difficult challenge when forming a death review committee. Usually the main concern is funding the actual committee. If the committee is formed under a legislative body, such as the Coroner's Office, funds may be allocated to the committee by the government. Other committees are funded through violence against women organizations and/or government grants. Smaller committees may not receive any funding and may rely solely on volunteers.

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[20] McHardy, L.W., & Hofford, M. (1999). *Domestic violence fatality reviews: Recommendations from a national summit*. [Electronic version]. United States: National Council of Juvenile and Family Court Judges. Retrieved October 15, 2010 from: http://www.baylor.edu/content/services/document.php/28824.pdf.

Ontario, New Brunswick, and British Columbia have their death review committees funded through government. Manitoba's DVDRC Working Group is comprised of government employees involved in the area of domestic violence (Crown Attorney's office, Victim Services, Probation Services, Chief Medical Examiner's Office, Winnipeg Police Service, and RCMP).

An additional concern around resources is creating a death review committee in jurisdictions that have a low number of domestic homicides. New Brunswick has an average of one domestic homicide per year and Manitoba has an average of three domestic homicides per year.[21] Both of these provinces have implemented a death review committee and the concern may be that reviewing a small number of domestic violence fatalities may be not be the best use of limited resources. However, more numbers do not necessarily mean a more thorough review. Higher numbers can help identify patterns or trends with domestic homicide cases, but a thorough "biographical" review can help obtain more detailed and relevant information about a specific case.[10] This kind of review can be especially helpful with a high-profile and complex domestic homicide.

c) Sharing information/confidentiality

Domestic violence death review committees require the sharing of personal information on both the victim and the perpetrator in a case. It is beneficial for the committee to receive very detailed information so that accurate recommendations can be formed. With the sharing of information come many challenges around confidentiality, respecting privacy, and gauging exactly how much information needs to be shared and with whom. Committees receive private information on the family involved in the domestic homicide case. This information is invaluable to a committee when forming accurate and detailed recommendations for prevention of similar tragedies. It is standard practice for death review committees to have an Oath of Confidentiality which states that none of the information obtained can be shared with anyone outside of the committee. Annual reports or presentations discussing statistics or cases are based on very general information and do not include any identifying information. It may be harder to comply with the spirit of confidentiality in smaller jurisdictions where the case summary may be more identifiable from the publicity about individual cases.

Many committees obtain information in paper format from police investigations. The Ontario DVDRC is part of the Office of the Chief Coroner which has the ability to properly obtain information on any case through the Coroner's Act.[11] The Coroner's office also has the right to subpoena any agency or professional for missing information that may be relevant to the case review. However, the Coroner's Office must adhere to the Freedom of Information and Protection of Privacy Act (FIPPA) which means that the Coroner's office is unable to obtain information on any victim and/or perpetrator that is still alive without their consent. This issue can create a challenge around obtaining information that may be pertinent to the review process. Committees have yet to find a best practice for obtaining this information without violating a person's right to privacy.

Finally, a challenge for any death review committee is determining how much information is needed for a comprehensive review. A thorough review may become an exhaustive process with access to all files from medical and social service agencies and interviews with friends, family, neighbours and co-workers. This process is expensive and time-consuming and at some point there may be diminishing returns to uncover new or critical information for recommendations. The committee needs to find a balance between thoroughness and cost-effectiveness in the investigation.

d) Accountability

[21] Statistics Canada. (2008). *Family violence in Canada: A statistical profile 2008*. Ottawa: Ministry of Industry.

Domestic violence death review committees call for accountability from different systems and agencies that may have played a role in the outcome of the cases reviewed. By taking responsibility and accepting the errors made, systems can start to implement changes that will ensure that similar mistakes will not reoccur. However, the difficult challenge for a committee is to uphold the philosophy of accountability without "blaming and shaming" particular systems.[8] If a committee points fingers or lays blame, systems and agencies will be reluctant to cooperate with a review and/or share information for fear of being criticized. A committee has to find a balance between accountability and creating a perceived blaming exercise.

One of the main goals of a domestic violence death review committee is to review domestic homicides and develop recommendations aimed at different systems that will help prevent similar tragedies from occurring. It is the assumption that these recommendations will be implemented to cultivate system change. A committee needs to develop a mechanism to ensure the implementation of the recommendations and for monitoring the corresponding systemic changes. In 2007, the Ontario DVDRC recommended that a committee be created to review all responses to the recommendations made by the DVDRC since its inception,

> *It is recommended that the Ministry of the Attorney General take a leadership role in creating an inter-ministerial committee that will methodically review all community, agency and government responses to recommendations that have been made by the DVDRC since its inception. It is suggested that this committee develop a work plan and timeline on the implementation of recommendations and consult with the Domestic Violence Advisory Council that currently reports to Minister for Women's Issues. It is hoped that the final report and plan could be forwarded to the Attorney General and made available to the public* (pg. 4).[51]

e) Local and centralized reviews

There is no standard framework for a domestic violence death review committee. Many committees are formed by way of what works best in their community. There are two different types of committees: 1) a centralized review committee and 2) a local review committee. A centralized review committee is based at a state or provincial level and is comprised of representatives from multiple sectors. Members of the committee are not directly involved with the cases reviewed but provide general information about different sectors involved with particular cases. Recommendations formed by a centralized review committee are aimed at provincial services and systems. Ontario, British Columbia, New Brunswick, and Manitoba all have centralized committees. A local review committee is formed under a local level, such as a county, region, or city, and is comprised of community members that were usually involved with a specific case. The membership of the local review committee will change with each domestic homicide case. Local review committees will also allow family and friends of the family from a particular case to sit on the committee to help in the review process. Recommendations formed by the local review committee are aimed at local services and systems[22] (Local committees do not exist in Canada as a model. Washington State is a good model for the occurrence of both local and centralized reviews.[23]).

The challenge of having only a centralized review committee is that people who were directly involved with the case and possess important information are most often not represented directly although they may have expressed their views with investigators. Therefore, the committee will not

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[22] National Domestic Violence Fatality Review Initiative (NDVFRI): United States Department of Justice. Baylor University, Waco, Texas. Retrieved October 15, 2010 from: http://www.ndvfri.org/index.php?id=37959.

[23] Washington State Domestic Violence Fatality Review. (2004). Every life lost is a call for change: Findings and recommendations from the Washington State domestic violence fatality review. Seattle, WA: Washington State Coalition AgainstDomestic Violence.

have access to potentially valuable information that is not already documented in the file. Furthermore, by being on the committee, family and friends may feel they have an outlet to personally voice their concerns about the issues surrounding the case. This procedure can be therapeutic for family and friends of the victim and/or perpetrator. Local reviews do allow family and friends to be members of the committee on a voluntary basis. Although this process may provide family and friends with a therapeutic experience, some individuals may find discussing the case brings up conflicting and unresolved feelings. The process for these individuals might be painful and may trigger further trauma. Therefore, it is important that counsellors be available to help deal with the fallout from this process. Another challenge to the local review process is the concern of confidentiality. People from the local community who were involved with the case can become members for that particular review. They will bring detailed and personal information in the hopes that it will help the review process. However, an individual's privacy may inadvertently be violated by someone who was closely involved with the case so safeguards have to be in place.

Independent of how fatality review committees in the US and Canada have been structured, they have provided several consistent themes which are critical to address in reducing domestic violence and homicides. These themes are outlined in the next section.

Benefits and Limitations of Domestic Violence Death Review Committees

Think tank members were asked to discuss the benefits and limitations of a domestic violence fatality review team.

Benefits:

- determines risk factors and common trends which help predict potentially lethal situations
- identifies gaps or missed opportunities in service provision
- shares information with helping systems which is especially helpful for areas that do not have a death review process
- educates the general public on the risks for lethality
- the review can initiate the healing process among family and friends of the victim and/or perpetrator, professionals involved with the case, and the community at large
- review process honours victims and boosts the morale of the community

Limitations:

- no accountability or assurance that recommendations are implemented
- no authority to enforce recommendations

The DVDRC of Ontario made a recommendation in the 2007 annual report regarding the need for more accountability in the implementation of recommendations:

> *"It is recommended that the Ministry of the Attorney General take a leadership role in creating an inter-ministerial committee that will methodically review all community, agency and government responses to recommendations that have been made by the DVDRC since its inception. It is suggested that this committee develop a work plan and timeline on the implementation of recommendations and consult with the Domestic Violence Advisory Council that currently reports to Minister for Women's Issues. It is hoped that the final report and plan could be forwarded to the Attorney General and made available to the public." (pg. 4)*[51]

- Review teams do not outline best practices on how recommendations should evolve into solutions
- It is difficult for review teams to find a balance between education and advocacy
- Lack of resources/minimal resources to conduct reviews especially in smaller communities where few domestic homicides occur
- Debate over the usefulness of using a "biographical" approach to a review (review one case thoroughly) in communities where there are few domestic homicides
- Some cases are not available to review until several years after the fact due to court appeals or backlogged cases and any recommendations made by the committee might be considered obsolete or redundant
- No resources available to create review teams for special groups (e.g., Aboriginal communities) that will address the specific vulnerabilities and needs of minority cultures
- Some feel resources are better spent on prevention as opposed to reviewing homicide cases that have already occurred
- Confidentiality concerns for clients and agencies and conflicting mandates of different agencies or professionals
- Building and maintaining trust between agencies and systems and between members of the death review team

Emerging Issues

1. Risk Assessment

Domestic homicide is usually a predictable and preventable occurrence. Domestic homicides are often preceded by several risk factors that are associated with an increase in the risk for lethality. Research has identified a number of risk factors that are associated with domestic homicide cases.[24] Based on the social science literature and patterns from reviews, the Ontario DVDRC has identified 39 risk factors with the most common being a prior history of domestic violence, an actual or pending separation, and obsessive behavior displayed by the perpetrator.[11] It is important to assess risk in domestic violence cases to capture the risk for lethality; to help victims and professionals develop an effective and realistic safety plan; to provide a common language on risk for professionals across different systems; to help the justice system identify high-risk offenders and provide continuous monitoring and high-risk case management; to provide insight for perpetrator treatment programs (e.g., Partner Assault Response programs) to help develop an appropriate treatment plan; and to predict and prevent similar tragedies in the future.[25]

The Ontario DVDRC 2009 annual report indicated that 18% of all recommendations made since 2003 were aimed at the importance of risk assessment.[11] In fact, out of the 16 cases the committee reviewed in 2009, just under half (44%) had repeated recommendations around risk assessment. The 2010 report of the BC DVDRP made recommendations around risk assessment that expressed the importance of a standard definition of a high-risk case that was based upon risk factors for lethality and other committee reports on risk assessment tools; and the need for practice guidelines and training on risk assessment.[14] Furthermore, the Domestic Violence Advisory Council for Ontario formulated a comprehensive action plan that included the importance of professional education and enhanced collaboration in risk assessment.[26] The Council published a report titled "Transforming our Communities" which outlined several recommendations regarding: a) the need for police to use a common threat assessment tool, such as the supplementary report; b) the need to create consistency and communication between police, crown attorneys, and other justice representatives; c) the need for mandatory training on threat assessment and management for professionals in the violence against women sector; and d) the need for high-risk teams to work with an accredited threat assessor to be able to understand and utilize many different risk assessment tools. The repeated recommendations of the Ontario DVDRC, the new recommendations of the BC DVDRP and the detailed plan created by the Council illustrate the importance of risk assessment when preventing domestic homicide. However, assessing risk can be very complicated and is not without its challenges.

One of the main challenges involved with risk assessment is the use of specific risk assessment tools. There are approximately 24 domestic violence risk assessment tools used across Canada.[27] Some tools are used to assess lethality (e.g., Danger Assessment Scale) and others are used to assess the risk of a repeated assault. Some tools help victims recognize their potential risk for future assault/violence and other tools assess the level of risk presented by the perpetrator. Different organizations and agencies

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[24] Campbell, J.C., Webster, D., Koziol-McLain, J., Block, C., Campbell, D., Curry M.A., Gary, F., Glass, N., McFarlane, J., Sachs, C., Sharps, P., Ulrich, Y., Wilt, S.A., Manganello, J., Xu, X., Schollenberger, J., Frye, V., & Laughon, K. (2003). Risk factors for femicide in abusive relationships: results from a multisite case control study. *American Journal of Public Health*, 93(7), 1089-1097.

[25] Laing, L. (2004). *Risk assessment in domestic violence*. Australian Domestic and Family Violence Clearinghouse. Retrieved October 15, 2010 from: http://adfvcnew.arts.unsw.edu.au/topics/topics_pdf_files/risk_assessment.pdf.

[26] Domestic Violence Advisory Council. (2009). *Transforming our communities: Report from the Domestic Violence Advisory Council for the Minister Responsible for Women's Issues*. Retrieved October 15, 2010 from: http://www.crvawc.ca/documents/DVAC%20Report.pdf.

[27] Department of Justice. (2010). *Inventory of Spousal Violence Risk Assessment Tools Used in Canada*. Retrieved October 15, 2010 from: http://www.justice.gc.ca/eng/pi/rs/rep-rap/2009/rr09_7/p4.html.

may use specific assessment tools that fit appropriately with their mandate. Usually these agencies or organizations are highly trained in the use of that particular risk assessment tool. The Domestic Violence Advisory Council noted that "finding one screening tool for the entire VAW system is a compelling idea but difficult to achieve." After reviewing threat assessment tools with leaders in this field, the Council concluded that there is not a single tool that can be used in every situation. They note that, "In fact, the situational specifics around domestic violence, the emerging research and promising practices suggest the use of a host of tools and interventions may be optimal".[22] Although it is recognized that different risk assessment tools are appropriate for particular circumstances or situations, how does one know when to use what tool? Furthermore, if different tools are used, how do we ensure that everyone understands each tool to be able to effectively communicate the findings of risk? For example, a Judge or Justice of the Peace (JP) may have received education on one specific risk assessment tool and may rely on this tool when determining bail conditions for an accused in a domestic violence case. If the Judge or JP is presented with an unfamiliar risk assessment on the accused, the Judge or JP may not fully realize the potential risk the accused poses to the victim and may release him into the community without appropriate bail conditions.

Included in the challenge around risk assessment tools is creating a standard definition of risk. Hart describes risk as, "a threat or hazard that is incompletely understood and therefore can be forecast only with uncertainty."[28] Risk assessment tools provide a common language for professionals. However, a tool does not necessarily encapsulate the nature of risk factors or the motives behind using violence. There may be several factors that help to define a level of risk. The causes or motivations behind the violence, the frequency and severity of the violence, and the nature of commonly recognized risk factors (e.g., separation) are all areas that should be represented in a definition of risk. Is it possible to create a standard definition of risk that incorporates an assessment score, motivating factors, frequency and severity, and the nature of risk factors?

A second challenge around risk assessment is the value of professionals' intuition or instincts from their experience in the field. Professionals that work with victims and/or perpetrators of intimate partner violence may have a sixth sense about risk. The results from a risk assessment tool may validate or affirm the professional's preconceived judgements. However, in some instances the assessed risk may appear low but the professional has an intuitive sense that the risk to the victim is higher than that captured by the assessment tool because of one significant factor (e.g. a new partner in the victim's life). Obviously it is not wise to discount the professional's intuitive sense but how does one explain to other professionals that a particular victim or perpetrator who was assessed as low risk should actually be considered high-risk based on intuition?

A third challenge is based on the fact that an effective comprehensive risk assessment requires multiple resources. Professionals need to be trained on how to appropriately use and read specific risk assessment tools. The specialized threat assessment unit for the Ontario Provincial Police requires two years to adequately train an officer in risk assessment. Therefore, there are not enough trained individuals to meet the demand. Each agency or organization involved in the violence against women sector should have a trained professional on risk assessment. However, attending training seminars can be costly and some agencies do not have the funds. How are small agencies with little funding expected to have trained staff to conduct risk assessments or access to specialized services?

A final challenge around risk assessments is gaining access to the victim and helping her understand the risks. Risk assessments are conducted by trained professionals at agencies or systems that deal with victims of domestic violence. How do professionals reach victims that are not involved in the violence against women sector? One approach has been to raise awareness about potential lethality in domestic violence cases with friends and family. These supports may reach out to professionals or encourage victims to do so. One example of this approach is the Neighbours, Friends and Families

[28] Stephen D. Hart, Presentation in London, Ontario (April 26, 2010)

campaign, a public education initiative that informs the public about the warning signs of domestic violence and what people close to a victim and/or perpetrator can do to help (http://neighboursfriendsandfamilies.ca/). It is the hope that people close to the victim will recognize the signs of domestic violence and encourage her to reach out for help from trained professionals. The campaign outlines how victims can find supportive services in their community.

There is concern that a victim will not truly understand the potential risk posed by the perpetrator. Research that examined the lives of women that survived an attempted homicide found that almost half of these victims did not believe that their (ex)partner would attempt to kill them.[29] Victims may also feel that they can handle or manage the perpetrator on their own. Sometimes a risk assessment tool such as the Danger Assessment (DA) may be helpful in offering feedback to victims about the dangers they face.[30] The first portion of the DA requires victims to mark dates on a calendar of past abuse and rank the level of severity for each incident. By viewing all the incidents of violence on one calendar, victims can see the pattern of abuse and how it may be increasing in frequency and severity. The second portion of the DA is a questionnaire which asks the victim to identify the presence of particular risk factors associated with domestic homicide.

The Alberta Council of Women's Shelters conducted a study with women attending a shelter who had completed the DA.[31] Some main themes identified around the usefulness and effectiveness of the DA were: a) women felt that they made the right decision to leave their abusive partner; b) victims had a better understanding of abuse and the escalating patterns of abuse in their relationship; c) there was more awareness around the need for personal change and/or action and the urgency of making these changes; d) victims began to view the perpetrator as the source of the problems in the relationship; e) there was more understanding around implementing a safety plan; f) victims recognized the importance of keeping their children safe; g) victims were more aware of community resources and intended to use them; and h) there was more understanding of the barriers for some women to change, such as a mistrust of authority and feeling powerless. While many women felt that completing the DA was an overall positive and useful experience, a large number of women felt that the process (especially completing the calendar portion) was uncomfortable and emotionally painful. Furthermore, some of the women felt that the DA made them more self-critical for not acting sooner.

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[29] Nicolaidis, C., Curry, M.A., Ulrich, Y., Sharps, P., McFarlane, J., Campbell, D., Gary, F., Laughon, K., Glass, N., & Campbell, J. (2003). Could we have known? A qualitative analysis of data from women who survived an attempted homicide by an intimate partner. *Journal of General Internal Medicine*, 18(10), 788-794.

[30] Campbell, J. (2005). *Danger Assessment*. Johns Hopkins University. Retrieved October 5, 2010 from: http://www.dangerassessment.org/WebApplication1/pages/product.aspx.

[31] Cairns, K. & Hoffart, I. (2009). *Keeping Women Alive – Assessing The Danger*. Edmonton, AB: The Alberta Council of Women's Shelters.

How to Ensure Risk Assessment Tools Facilitate Communication and Collaboration

The think tank participants discussed several ways to ensure that risk assessment tools facilitate communication and collaboration rather than creating roadblocks. The main focus of discussion was around training and risk assessment tools:

Training

- Training is essential for creating an effective risk assessment process
- Training should help professionals know what tool to use, what the results of the tool are saying, and what to do after the risk assessment has been completed
- Training will help professionals and practitioners recognize the importance of conducting an assessment and build confidence in using a risk assessment tool
- Training should be mandatory and repeated on a yearly basis
- It is important to provide a mentoring program
- Implement some form of quality assurance in different agencies and sectors to ensure the appropriate use of risk assessments
- Training should be conducted across disciplines and systems to promote collaboration and information sharing

Risk Assessment Tools

- Risk assessment tools should include a greater focus on psychological trauma
- Perpetrators need to be included in the risk assessment process especially with high-risk offenders during the time of a separation
- Risk assessment tools that are culturally sensitive and take into account vulnerabilities associated with minority cultures need to be created

2. Risk Management

Domestic homicides often appear to be predictable and preventable, especially if risk assessments and case management strategies had been in place. Many domestic violence cases that end with a fatality had several risk factors that indicated an increased risk for lethality. Once a domestic violence case has been assessed as high-risk, the risk factors need to be addressed in order to enhance the safety of the victim and her children. Risk management requires system collaboration, information sharing, and monitoring of high-risk offenders. The BC DVDRP made a recommendation in their 2010 annual report around the importance of information sharing with high-risk cases:

> *The development of information- sharing protocols between all service providers for all high risk cases under the leadership of the Ministry of Public Safety and Solicitor General Domestic Violence Working Group. This entails directives from respective ministries to commit to sharing information in instances where public safety is at stake by means of Memoranda of Understanding (MOU) or Information Sharing Agreements (ISA). The MOU's and ISA's detail each agency's duty to report on cases of domestic violence.*[14]

The Ontario DVDRC has made recommendations around high-risk case management in 27% of the cases reviewed since the committee's inception.[11] The Ontario DVDRC has referred to the Huron Assessment Risk Reduction Team (HARRT) in Goderich, Ontario as an example of a high-risk management team that assesses and manages high-risk cases.[32] The team is comprised of justice

[32] Huron Assessment Risk Reduction Team (HARRT). (2010). Report. Goderich, Ontario.

partners (crown attorney, victim witness, OPP, domestic violence coordinator for police, probation/parole) and may consult with other agencies when appropriate. HARRT relies on justice partnering, effective collaboration and shared case management planning. HARRT is an excellent best practice for identifying, monitoring, and managing high-risk domestic violence cases.

Even without an actual risk management team, some communities are still able to monitor and manage high-risk cases. Two important components to risk management are system collaboration and information sharing. Systems involved with high-risk cases need to communicate with each other and share the needs of the victim and the prevention concerns of the offender. However, system collaboration and information sharing can bring about several challenges.

An initial problem may lie in the difficulty of bringing together organizations that have different mandates. There may be competing interests amongst agencies protecting either children or adult victims. Not all organizations involved with the family may be part of the committee (e.g., health care) and, therefore, they may not have knowledge of domestic violence issues.

Secondly, system collaboration and information sharing create challenges around confidentiality. Confidentiality between an agency and their client may create roadblocks in sharing information and developing a collaborative plan. A perceived breach of confidentiality can lead to concerns around liability, breaking trust with a client, and/or increasing the level of risk if the information is used inappropriately or if certain information is shared with the offender. Additionally, if confidentiality is breached for the purpose of sharing valuable information, it is difficult to determine exactly what and how much information needs to be shared or when it needs to be shared. Although most professionals will share information when faced with imminent risk of harm to a victim, there are many cases that may represent different shades of gray where there is a genuine dilemma in sharing critical information.

Challenges and Promising Practices in Effective Risk Management

Think tank participants discussed the challenges to effective risk management and promising practices to overcome these challenges.

Challenge: Confidentiality and Information Sharing

- Professionals recognize the importance of protecting client confidentiality but may be uncertain of the point where imminent risk may override this principle.
- Failing to share critical information on a timely basis may create mistrust amongst professionals and agencies
- Some agencies outside of the justice system are unsure what information they are allowed to share without liability issues. In a similar manner, justice professionals are hesitant to share information with helping agencies except under extreme circumstances
- Legislation can be vague using terms like “may share” rather than “must or should share”

Promising Practices

- Systems create a privacy impact statement or memorandum of understanding that clearly outlines what information must be shared, to whom information can be shared, and what situations warrant information sharing
- With an outlined policy regarding confidentiality and information sharing, professionals will be able to inform their clients about situations where their confidentiality may be breached in order to provide protection
- Professionals need to tell a client beforehand about the potential for breaching confidentiality which will help the client understand the motive for information sharing and breaching confidentiality which in turn will create further trust in the client-professional relationship

Challenge: Establishing trusting relationships between systems to encourage communication and solidarity

Promising Practices

- Cross-sectoral training
- Using mock cases in training to prepare for real cases
- Encourage agencies to hold open houses to discuss with others their mandates and limitations with regards to information sharing and risk management

Challenge: Not knowing what to do after risk has been assessed

- Professionals may not understand what needs to be done once risk has been assessed
- Some professionals may not want to conduct a risk assessment for fear of identifying a high-risk case and not knowing how to proceed for fear of liability issues

Promising Practices

- Training and education need to outline effective case management strategies that are inclusive of the cultural, spiritual, emotional, and physical well-being of the victim and children
- Systems and agencies need to receive regular training on risk management practices to keep professionals up-to-date and confident in their management skills
- All systems need to receive training on risk management which includes information on high-risk management teams available in their communities

Challenge: Risk management teams are not inclusive to all agencies and systems that work in domestic violence prevention

- Risk management teams appear to be mainly comprised of professionals in the justice system and exclude most community services such as violence against women agencies

Promising Practice

- Ensure that risk management teams have representatives from all sectors that may come into contact with victims and/or perpetrators of domestic violence (e.g., violence against women groups; justice; healthcare; mental health; child protection services)

Another essential component to risk management is monitoring and working with perpetrators of domestic violence. There are many different systems that can be actively involved with a perpetrator of domestic violence. For instance, if the perpetrator is arrested and charged with assault, the courts are given an opportunity to create a risk reduction plan that includes different agencies and professionals. Perpetrators can receive strict probation conditions and will be forced to check in regularly with a probation officer. Perpetrators can be out on bail under the supervision of an appropriate surety. Courts can mandate counselling for perpetrators, such as a Partner Assault Response (PAR) program, where they will be monitored by professional counsellors. If there is concern that the perpetrator is high risk, the case can be referred to a high-risk management team that will assess the perpetrator's level of risk and implement the appropriate strategies to minimize risk and protect the victim.

It is difficult to manage risk with perpetrators who are not in the justice system. Many perpetrators may be resistant to any kind of assistance or have difficulty finding appropriate supports. Research on help-seeking behaviors with perpetrators of domestic violence indicates that abusers who were reaching out for help to doctors, counsellors, family and friends, did not perceive they received useful interventions.[33] However, some of the men stated that they would be open to a counselor, family member, friend, or doctor approaching them and offering support to help them manage their abusive behaviours. We need to ensure that these potential sources of support and information are able to provide useful interventions.

Some jurisdictions have had more explicit plans put in place to address risk management in domestic violence cases. For example, the Victorian government in Australia established a jurisdiction wide committee to help in the development of a multi-agency and integrated response to family violence.[34] The framework developed supports victims of domestic violence, including vulnerable women and children with unique experiences. There are six components that make up the framework on effectively identifying and managing risk: "1) a shared understanding of risk and family violence across all service providers; 2) a standardized approach to assessing risk; 3) appropriate referral pathways and information sharing; 4) risk management strategies that include ongoing assessment and case management; 5) consistent data collection and analysis to ensure the system is able to respond to changing priorities; and 6) quality assurance strategies and measures that underpin a philosophy of continuous improvement".[34] This framework has dealt with some of the challenges around risk assessment by requiring that risk be determined by the victim's own assessment, evidence-based risk factors, and the professional's intuitive judgment. Service providers in the family violence sector, justice sector and other mainstream service areas (e.g., education, healthcare, mental health) will all use the risk assessment and risk management framework.

3. The Role of Family Court in Risk Assessment and Risk Management

An actual or pending separation between a victim and perpetrator is a high-risk factor for lethality.[35] In many cases, a couple who is in the process of separating or divorcing will have some contact with the family court system. Often couples that have children may depend on family lawyers and the courts to establish custody and access agreements. This contact gives the family court an opportunity to assess risk and manage high-risk cases with particular attention to safe parenting plans when children are involved. Family courts are in an ideal position to help increase the safety of victims and their children as well as monitor and manage offenders.

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[33] Campbell, M., Neil, J.A., Jaffe, P.G., & Kelly, T. (2010). Engaging abusive men in seeking community intervention: a critical research & practice priority. *Journal of Family Violence*, 25(4), 413-422.

[34] Family Violence Coordination Unit. (2007). *Family violence risk assessment and risk management: supporting an integrated family violence service system*. Report. Victoria, Australia: Department for Victorian Communities. Retrieved October 6, 2010 from: www.women.vic.gov.au.

[35] Johnson, H., & Hotton, T. (2003). Losing control: Homicide risk in estranged and intact intimate relationships. *Homicide Studies*, 7(1), 58-84.

Family courts play a large role in identifying domestic violence with divorce/separation, child custody and access cases. However, in most courts there is not one specified person in charge of screening for domestic violence and there is not one standardized framework on how the screening should be accomplished. Most professionals agree that screening for domestic violence should involve more than one screening tool.[36] The challenge is determining what screening tools should be used and who should administer them.

It can be challenging to identify domestic violence in family court cases. There are many challenges for the courts when dealing with cases where domestic violence has been identified. Many of these cases vary in intensity and frequency of violence; the co-occurrence of other forms of violence (e.g., threats, sexual abuse, economic abuse); the extent of prior violence; whether the violence was an isolated incident or if there is a recognized pattern; the presence of co-morbidity issues such as mental illness and/or substance abuse; the involvement of children; the strengths and supports within the family; and prior or current counselling and support efforts involved with the family.[32] Each of these factors should have an influence over how the courts handle these particular cases. Risk assessments are invaluable to the family courts in that they identify the level of risk presented to the victim and the courts can provide strict conditions, mandatory counselling, no contact orders for protection, and safe parenting plans. In 2007, the National Council of Juvenile and Family Court Judges and the Association of Family and Conciliation Courts held a conference on the conceptual and practical tensions that family courts encounter when working with families experiencing domestic violence. A consensus was reached that several critical variables need to be examined to truly understand the level of risk presented and to determine the appropriate interventions;

> *"There was consensus among conference participants that each domestic violence situation must be closely examined to determine the potential for lethality, the risk of future violence, and the presence of other forms of intimidation. Critical variables identified included: the frequency, intensity, and recency of the violence; the presence of sexual coercion or abuse; the existence of nonphysical coercive strategies including verbal abuse, threats, isolation, and financial control; the presence of an established history of violence, criminal activity, substance abuse, or mental health issues; the determination of "who is afraid of what"; the needs, interests and well-being of children; any history of child maltreatment; and the extent to which the violence is consistent with a recognized pattern with proven implications for ongoing risk or the utility or impact of particular interventions or determinations. Family strengths and protective factors should also be taken into account and supported."* [32]

Differentiating amongst cases involving domestic violence is important in matching the most appropriate parenting plan to a particular family situation. It is important to examine patterns of violence (coercive control; self-defense; violence driven by conflict; violence due to mental illness) and perpetrator typologies that can inform judges about the level of risk, the motivation behind the abuse, and the likelihood of reoffending. If there is a misinterpretation of the patterns of violence or perpetrator typology, it can lead to inappropriate interventions (e.g., mandated anger management as opposed to a batterer intervention program). There needs to be a common language among family courts that describes patterns of violence and typologies. Furthermore, more research on the implications of these factors will help judges to make decisions that prevent future violence.[32]

Risk and context is extremely important to define and understand when dealing with cases of domestic violence in the family courts. However, there continues to be several challenges around putting this into practice. The previously-noted 2007 conference elicited some lingering questions

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[36] Ver Steegh, N. & Dalton, C. (2008). Report from the wingspread conference on domestic violence and family courts. *Family Court Review*, 46(3), 454-475.

around risk assessment and management in the family court system such as: "Which factors and variables have significance? What meaning should be ascribed to them? How can these factors be ascertained? Who will be responsible for making those determinations? What if mistakes are made?".[32] Some of these concerns may be addressed with the creation of specialized domestic violence courts. The United Nations made a recommendation for specialized courts with legislation to guarantee that cases of intimate partner violence be handled in a timely and efficient way and that officers of the court receive specialized training. There are now 208 specialized domestic violence courts in the United States and more than 150 projects internationally. One of the main advantages of a specialized DV court is that the judges gain an extensive knowledge and expertise on issues related to intimate partner violence cases, including risk assessment tools.[37]

The presence of domestic violence in a family definitely increases the risk for repeat assault and/or lethality for victims and children, particularly during or post-separation. Statistics Canada has indicated that violence can increase in severity and lethality post-separation.[38] As seen in the domestic homicide research, an actual or pending separation increases a victim's risk for lethality.[39] Between 2002 and 2008, 23 children were killed in Ontario in the context of domestic violence.[11] Children killed in the context of domestic violence are usually a direct target for retaliation against an intimate partner and are killed for the purpose of inflicting harm on the child's other parent.[40] In cases of familicide (killing of multiple family members), the perpetrator may kill the victim and the children. Familicide is believed to occur because "the perpetrator feels that his domination of the family is threatened - often by family members' threats to leave and/or report his abuse to others - and he resorts to homicidal violence in a misguided effort to maintain his control and prevent a complete rupture of the family unit".[40] Usually a considerable number of these types of cases are followed by the perpetrator committing suicide.[41,42]

The Canadian Incidence Study of Reported Child Abuse and Neglect (2005) found an estimated 49,994 child investigations by Child Welfare Services involved children exposed to domestic violence as either the primary or secondary form of abuse.[43] This represents one in five child abuse investigations in Canada. Exposure to domestic violence may result in serious ill-effects to a child's mental, physical, emotional, and behavioural well-being. As social learning theory suggests, children may model the behaviours of their parents. If they see their father dealing with conflict with their mother by using violence, it is possible that the children will adopt these practices in their own interpersonal relationships.[44] Furthermore, children exposed to domestic violence are also at greater risk of being victims of child abuse.[45] The Canadian Incidence Study of Reported Child Abuse and Neglect found that 2,979 children exposed to domestic violence also experienced emotional maltreatment, 2,484 children experienced a combination of neglect and exposure to domestic violence, and 2, 274 children experienced a co-occurrence of exposure to domestic violence and physical abuse.[43]

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[37] Domestic Violence Courts Effectiveness-Overview. Report prepared for 2010 Think Tank in London, Ontario.

[38] Hotton, T. 2001. "Spousal violence after marital separation."*Juristat*. Vol. 21, no. 7. Statistics Canada Catalogue no. 85-002-X. Ottawa.

[39] Brownridge, D.A. (2006). Violence against women post-separation. *Aggression and Violent Behavior*, 11, 514- 530.

[40] Ewing, C. P. (1997). *Fatal families: The dynamics of intra-familial homicide*. Thousand Oaks, CA: Sage Publications.

[41] Websdale, N. (1999). *Understanding domestic homicide*. Boston: Northeastern University.

[42] Dawson, M. (2005). "Intimate femicide followed by suicide." *Suicide & Life-Threatening Behavior* 35(1): 76-90.

[43] Trocmé, N., Fallon, B., MacLaurin, B., Daciuk, J., Felstiner, C., Black, T., Tonmyr, L., Blackstock, C., Barter, K., Turcotte, D., & Cloutier, R. (2005). *Canadian Incidence Study of Reported Child Abuse and Neglect – 2003: Major Findings*. Minister of Public Works and Government Services Canada.

[44] Wekerle, C. & Wolfe, D.A. (1999). Dating violence in mid-adolescence: Theory, significance, and emerging prevention initiatives. *Clinical Psychology Review*, 19(4), 435-456.

[45] Fantuzzo, J., Boruch, R., Beriama, A., Atkins, M. & Marcus, S. (1997) Domestic violence and children: Prevalence and risk in five major U.S. cities. *Journal of the American Academy of Child and Adolescent Psychiatry*, 36: 116–22.

It is very common for there to be multiple and serious allegations of domestic violence, as well as child maltreatment and substance abuse, in high-conflict custody and access cases. However, the challenge for the family court is investigating these allegations and identifying domestic violence. Jaffe, Johnston, Crooks, and Bala, (2008) describe a number of steps the courts should take to corroborate or negate allegations of domestic violence.[46] One important step is to have a trained professional examine different sources of evidence that either support or refute the claims. These sources include: police and medical records, eye-witness reports, and self-reports of incidents; reports from neutral third parties (e.g., neighbours, teachers); and the psychological state of the alleged perpetrator and victim. Once domestic violence has been identified in a child custody and access case, there are many challenges to assessing the level of risk and managing the risk. First, there are no specific risk assessment tools that assess the particular risk to children. Risk assessment tools are used to determine the level of risk posed for the victim. However, it could be assumed that if the victim is in danger, her children are also in danger and parenting arrangements will have to recognize that issue.[32] Judges need to be able to decide on effective parenting plans that will keep the children and the victim safe.

Engaging the Family Court in Recognizing the Dangers to Domestic Violence Victims

Think tank participants discussed how to engage the family court and court-related professionals in recognizing the potential dangers to domestic violence victims and their children.

- Judges and lawyers should receive training on domestic violence issues
- Training should include: the impact of exposure to domestic violence on children; the increased level of risk during a separation/divorce; the dangers to children from a high-risk offender during visitation; and best practices for creating safe parenting practices
- Training on domestic violence should be mandatory for assessors who carry out a child custody evaluation
- There should be a mandatory core educational requirement on domestic violence, risk assessment, and risk management for all law schools
- Family courts need to have access to critical information held by the criminal court
- A common database should be created where all information on the family can be appropriately accessed by decision-makers
- Internet-based applications should contain a short questionnaire for victims and families to complete so that the family court has all the information regarding potential risk for violence, custody and access issues, and any involvement with the criminal court, including violations of no contact orders or other threats arising from criminal violations
- Family courts should have mandatory screening for potential high-risk offenders

4. Challenges to Risk Assessment and Risk Management with Vulnerable and Select Populations

It may be argued that every person who experiences domestic violence or homicide is vulnerable by virtue of their experiences as a victim. However, there are people who may be considered vulnerable due to life circumstances which make reaching out for help or developing a safety plan more difficult.

[46] Jaffe, P.G., Johnston, J.R., Crooks, C.V., & Bala, N. (2008). Custody disputes involving allegations of domestic violence: toward a differentiated approach to parenting plans. *Family Court Review*, 46(3), 500-522.

Vulnerabilities may include the following: mental health issues, and/or addictions, disability, language and/or cultural barriers (e.g. new immigrant or isolated cultural community), economic dependence, and living in rural or remote locations. Vulnerability may also relate to lifestyle choices that place victims at risk (eg sex trade work or escort). Vulnerability is not defined by issues common to many people such as poverty or any one cultural group (aboriginal).

Women and children of minority cultures that experience domestic violence experience unique circumstances that can increase their level of risk for further violence and/or lethality. Approximately 12% of women living in the North reported being a victim of domestic violence compared to 7% of women in rural areas of other provinces.[47] Aboriginal women are also at significant risk for violence. More than 580 Aboriginal women and girls have disappeared or have been killed across Canada.[48] In many cases, these women have been driven from their homes and into homelessness or the sex trade due to domestic violence. Immigrant women are disproportionately affected by domestic violence and domestic homicide.[49] Vulnerabilities related to language barriers, racism, geographic location, lack of or no access to services, and distrust of the dominant culture can increase the risk for domestic violence or domestic homicide. These issues often cause victims to feel more isolated and less likely to reach out for help. Often women that do seek out support are ostracized by their own family and the community for publicizing private domestic disputes and seeking help from a culture that is seen as oppressive and distrustful. Before these women and children can be helped, they need to be identified. However, how does one identify a victim that does not wish to be seen? Or how does one encourage a victim that is overwhelmed with these issues and fears to seek help?

Even if a woman from a select population is able to seek out support, there are challenges around assessing and managing her risk. First, standardized assessment tools do not take culture into account. The different issues presented by a victim's culture can drastically increase her level of risk; however current risk assessment tools that only identify risk factors from the dominant culture may miss these serious factors and underestimate the level of risk presented. Second, language and cultural barriers may cause misunderstandings between professionals and victims and not all agencies or organizations have a trained interpreter available or staff with cultural competency training. Finally, not all safety plans or management strategies have tools or practices that are culture-specific. For instance, there are few batterer intervention programs that are aimed at immigrant or Aboriginal perpetrators of domestic violence. Shelters or safe housing may be inaccessible to victims living in the North. The question is, where do we get the resources to fund these new initiatives? How do we help victims from select populations without isolating them from their own culture? The situation is similar with respect to rural Canadians.

In a 2008 Senate report on rural poverty in Canada, the hidden nature of family violence in rural Canada was identified as one of two pressing crime-related issues that required federal government attention and "inadequate access to services" was identified as a key factor contributing to this ongoing problem (p. 239). To date, though, there is limited research or data that can provide concrete evidence to document the extent of the problem facing rural Canadians. The Senate committee recommended that "the federal government fund academic and community-based, action-oriented research into the causes of, and response to, domestic violence in rural Canada. Applying this research, it was also recommended that the federal government take a leadership role, through its Family Violence Initiative, and support regional forums that bring together federal, provincial/territorial and community leaders, non-

[47] Violence Against Women in Nunavut-General Statistics. Report presented at 2010 Think Tank in London, Ontario.
[48] Native Women's Association of Canada website, Retrieved October 5, 2010 from http://www.nwac-hq.org/media/release/21-04-10.
[49] Raj, A. & Silverman, J.G. (2003). Immigrant South Asian women at greater risk for injury from intimate partner violence. *American Journal of Public Health*, 93(3), 435-437.

governmental organizations, front-line service providers, and survivors of domestic violence in order to develop appropriate response to family violence in rural areas" (p. 239).[50]

[50] Dawson, M. (2010) Developing a pan-Canadian map of family violence services. Ottawa: Public Health Agency of Canada

Improving Cultural Competency in Addressing Risk Assessment and Risk Management in Domestic Violence Cases

Think tank participants discussed several ways to improve cultural competency in risk assessment and risk management of domestic violence cases.

Training

- Professionals need to be aware of the challenges minority cultures face and how these challenges can act as barriers to accessing resources and reaching out for support
- Training and education around cultural differences should be mandatory for professionals that work with victims and/or perpetrators of domestic violence
- Immigration and Border services need to receive mandatory training on recognizing domestic violence and providing appropriate referrals for families that need support

The Ontario DVDRC made a recommendation in the 2009 annual report aimed at training for Immigration services:
"Citizenship and Immigration Canada should develop training programs in the dynamics of domestic violence for all its agents and officers. Such training should emphasize that withdrawal of sponsorship or denial of immigration applications/claims may result in a volatile situation that could lead to violence. It should prepare agents and officers who may be adjudicating claims from remote locations to consider making appropriate local referrals to law enforcement and social service agencies when dealing with applicants, their families, and/or sponsors where there is a history or reported threats of domestic violence." (pg. 26)[11]

Building Trusting Relationships

- Professionals must attempt to build trust with minority cultures through education, training, and engaging with different communities
- Professionals need to build relationships with authoritative figures from minority cultures (for example, the Muslim Family Safety Project created collaboration between mainstream anti-violence agencies and the Muslim community in order to prevent domestic violence (http://www.lfcc.on.ca/mfsp.html). In this project, anti-violence professionals engaged with Imams in their work to end violence against women.)
- Building effective communication strategies between mainstream professionals and victims and/or perpetrators from minority cultures is important for accessing and relaying accurate information, building trust, and bridging the gap between cultures
- All agencies and systems that work with victims and perpetrators of domestic violence need to recognize different cultures and languages and provide appropriate resources to allow for effective communication
- Service providers should have access to interpreters
- Agencies should have forms and documents written in several languages that match their community needs
- Community-based programs should have an ethnically diverse staff and should receive continued cultural competency training (e.g., Prince Edward Island is known to use a service out of California for cultural and language interpretation; the city police of Regina, SK use cards that have cultural/country flags to identify the language of the victim and/or perpetrator)
- Agencies should use interpreters over the telephone for a faster response with victims in crisis

Risk Assessment Tools

- Assessment tools that reflect vulnerabilities (e.g., poverty, isolation, cultural beliefs, immigration concerns, languages, lack of resources) need to be created and risk management strategies need to take these factors into account

5. Domestic Violence in the Workplace

A number of well publicized tragedies that involved domestic violence in the workplace have highlighted the potential role of employers to prevent domestic homicides. In Ontario, Dr. Marc Daniel, an anesthesiologist at Hotel Dieu hospital in Windsor killed his ex-partner and nurse, Lori Dupont on November 12, 2005. The inquest that followed revealed several missed opportunities and system failures in the workplace when there was an obvious presence of domestic violence between co-workers. This inquest revealed the importance of the workplace when identifying, monitoring, and managing high-risk cases[51] The Ontario DVDRC 2007 annual report indicated that in 17% of all cases reviewed, co-workers were aware of the abuse that was occurring in the family.[51] This number is likely an underestimation of the actual number of cases in which co-workers knew about the abuse due to missing information. Regardless, statistics and high profile cases reveal that the workplace has a major role in identifying and managing domestic violence.

In response to the Lori Dupont inquest, the Ontario legislature passed amendments to the Occupational Health and Safety Act (OHSA) that incorporates workplace violence and harassment (www.makeitourbusiness.com). Bill 168 states that if an employer becomes aware of domestic violence occurring in the workplace, s/he must take every precaution to protect their employee. The Bill requires that employers address workplace violence by implementing a workplace violence prevention policy risk assessment, and information and instruction for employees on the policy and information disclosure. Under this new legislation, employees are allowed to refuse unsafe work on the grounds of potential for violence. Furthermore, all employers are required to assign a workplace violence and harassment coordinator.[52] Although Bill 168 is an important step in ending violence in the workplace, it leaves many questions and concerns. For instance, if an employee becomes aware of domestic violence in the workplace, is it that employee's duty to tell their employer? What if the victim of the abuse does not wish to disclose? And how much information is one required to disclose?

Bill 168 also states that employers are required to assess risk in the workplace.[52] This places responsibility on workplaces to conduct risk assessments, perhaps through their own training or hiring of consultants. Bill 168 also gives employees the right to refuse work on the grounds that the job is unsafe due to domestic violence entering the workplace. This may cause employees to be hesitant about disclosing abuse in the workplace for fear that they will be denied work. A recommendation from the Lori Dupont inquest was "to provide support to all workplaces to train all employees about the dynamics of domestic violence…as well as what to do if faced with a situation where violence enters the workplace…".[53] The passing of Bill 168 in December 2009 initiated the NFF campaign to provide training at workplaces on domestic violence and harassment. Since then, almost 200 businesses across Ontario have introduced the program into their workplace (http://neighboursfriendsandfamilies.ca). Part of the NFF workplace initiative is the development of the website "Make it our business" (www.makeitourbusiness.com). This website provides information about the warning signs, how to talk to victims, safety planning, risk assessment, and implementing a workplace policy that includes domestic violence.

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[51] Ontario Domestic Violence Death Review Committee. (2007). *Annual report to the Chief Coroner*. Toronto, ON: Office of the Chief Coroner.

[52] Fonseca, Hon. P.. (2009). *Bill 168, Occupational Health and Safety Amendment Act (Violence and Harassment in the Workplace) 2009*. Legislative Assembly of Ontario. Retrieved October 15, 2010 from: http://www.ontla.on.ca/web/bills/bills_detail.do?locale=en&BillID=2181.

[53] Neighbours, Friends and Families Campaign. (n.d.). Retrieved October 15, 2010 from: http://www.neighboursfriendsandfamilies.ca/.

Engaging Workplaces in Domestic Violence Prevention

Think tank participants discussed how to effectively engage workplaces in domestic violence/homicide prevention.

- Public education campaigns, such as Neighbours, Friends, and Families (NFF), are an excellent resource for providing education and training on how to recognize domestic violence in the workplace; how to effectively intervene to prevent potentially lethal situations; and how to promote healthy workplace environments
- Awareness campaigns should provide a checklist for employers and employees that will help them know what to look for when identifying at-risk individuals
- Each workplace should have an expert on domestic violence/risk assessment available to provide information and refer employers and/or employees to a qualified professional
- Public education should also include guidelines on implementing workplace policies and protocols that address domestic violence in the workplace
- A workplace policy should outline the steps an employee/employer must take when they become aware of domestic violence in the workplace
- Workplaces should make victims feel comfortable in disclosing abuse without fear of being penalized
- To promote communication and understanding across all sectors, the federal government should create legislation that addresses domestic violence in the workplace and provide a common workplace policy that outlines specifically what must be done to ensure employee safety
- Awareness and education campaigns should emphasize the potential of collateral damage for employers making the loss of productivity due to exposure to domestic violence an argument for implementing an effective policy
- Experts in domestic violence should engage with the Employee Assistance Plan (EAP) counsellors and workplace unions to further educate and engage with employers and employees

Summary & Recommendation

There are several emerging issues around domestic homicide and domestic violence prevention in Canada. Forming effective domestic violence death review committees, conducting risk assessments, managing risk, engaging the family court, including and working with vulnerable populations, and the role of the workplace in domestic homicide prevention all have been highlighted as critical issues to address. These issues present many challenges across Canada but various provinces and helping systems have implemented promising practices that should be shared on a broader basis. Through this think tank, experts were able to come together to share concerns and discuss promising practices in domestic homicide prevention. The question now is what are the next steps to developing a national plan for

domestic homicide prevention? The think-tank recommended implementing the following plan to reduce deaths from domestic violence on a national basis:

1. **Enhance Partnerships amongst existing and developing Domestic Violence Death Review Committees.** There are currently four DVDRCs (Ontario, NB, BC, and Manitoba) in Canada with other provinces and territories that would like to explore the possibilities of similar developments. Formal partnerships amongst these committees could provide a source of support and consultation on emerging and promising practices. Furthermore, the partnership may help smaller jurisdictions where there are more limited specialized resources and fewer homicides.

2. **Create a Canadian Domestic Homicide Prevention Initiative.** This initiative would provide a national website similar to the National Domestic Violence Fatality Review Initiative (www.ndvfri.org) established in the United States. The NDVFRI website contains: over 50 annual reports from domestic violence fatality review teams across the U.S.; annual reports from international fatality review teams; tools and protocols used when establishing a fatality review team; links to other websites associated with domestic violence and homicide prevention; and newsletters that discuss upcoming conferences and initiatives around the world associated with domestic violence fatality review and prevention. A good step in developing a national plan for Canada is to create a website similar to the NDVFRI that includes information on domestic violence death review and prevention initiatives from all provinces and territories, research updates on domestic homicides, and resources for information related to domestic homicides. This website would provide guides and templates for creating a domestic violence fatality review team so that communities planning to implement a team would not have to re-invent the wheel. This initiative could be guided by a national advisory group.

3. **Develop a National Domestic Homicide Database.** This database would include all domestic homicide cases across Canada with the purpose of tracking risk factors and common trends over time and identifying unique factors associated with particular populations. The information from this database can be shared with researchers and professionals in the area of domestic homicide prevention to help create education campaigns and effective prevention initiatives.

4. **Develop a national strategy for consistent risk assessment and management strategies by different agencies and disciplines**. An essential process to prevent domestic homicides is utilizing risk assessment tools that facilitate communication and collaboration**.** Ongoing training opportunities are essential for creating an effective risk assessment process. Some professionals that are in the position to conduct a risk assessment may not know what tool to use, what the results of the tool are saying, or may be confused about what to do after a risk assessment has been completed. Training will help practitioners and professionals recognize the importance of conducting an assessment and it will build confidence in using a risk assessment tool. Training should be considered mandatory for professionals that come into contact with victims and/or perpetrators of domestic violence and should be repeated annually so that professionals will be informed about the guiding principles of risk assessment and will be kept up-to-date on new

tools or effective strategies with assessing risk. It is important to provide a mentoring program for risk assessment and implement some form of quality assurance in different agencies or sectors to double check that risk assessments are done correctly. Effective risk assessment cannot be separated from risk management. Training and education should outline effective case management strategies that are inclusive of the cultural, spiritual, emotional, and physical well-being of the victim and children. Similar to training on risk assessment, systems and agencies need to receive constant training on risk management practices to keep professionals up-to-date and confident in their management skills. All systems involved with victims and perpetrators of domestic violence need to receive training on risk management and they need to be informed about the high-risk management teams available in their community or develop these teams.

5. **Engage the family court and court-related professionals in recognizing the potential dangers to domestic violence victims and their children**. Professionals working with the family court system need to recognize the differential responses that are required for domestic violence cases. In the same way that the criminal courts have developed a more specialized framework of intervention with police, crowns and specialized court, the family court needs to examine the service system to address and manage these cases. Issues need to be addressed such as the increase level of risk during a separation/divorce; the dangers to children from a high-risk offender during visitation; and best practices for creating safe parenting practices. There needs to be enhanced communication between family courts and criminal courts. Family courts should have mandatory screening for family law matters that include screening potential high-risk offenders.

6. **Promote research that recognizes that Aboriginal communities have unique needs when addressing domestic violence.** Numerous studies and reports in Canada have documented the higher incidence of intimate partner violence among Aboriginal peoples.[54,55,56,57] Statistics Canada and Amnesty International report that young Aboriginal women are five times more likely to be murdered than non-Aboriginal women. In many cases, the nature of the homicide is difficult to determine, (i.e. domestic or non-domestic) because a high proportion of missing and murdered Aboriginal women's cases are never solved. While some Canadian organizations have focused on researching cases of missing and murdered Aboriginal women (Native Women's Association of Canada: Stolen Sisters/Sisters in Spirit Project) no research projects focus specifically on domestic homicides of Aboriginal women.

7. **Identify other communities/populations with diverse needs and vulnerabilities.** Although Statistics Canada reported that there is an average of 76 victims of spousal homicide a year in Canada, we do not know how many of these spousal homicides involved immigrant and refugee

[54] Ursel, J., (2006) "Over Policed and Under Protected: a question of Justice for Aboriginal women". In Hampton, M. & Gerrard, N. (Eds). *Intimate Partner Violence: reflections on experience, theory and policy*, Cormorant Press, Toronto
[55] Ogrodnick, L. (2008). *Family Violence in Canada: A Statistical Profile 2008*. Ottawa: Statistics Canada
[56] Proulx, J. & Perrault, S. (eds). (2000) *No place for violence: Canadian Aboriginal alternatives.* Fernwood Press, Halifax
[57] Ontario Native Women's Association, (1989). Breaking free: a proposal for change to Aboriginal family violence. Thunder Bay, Ontario: the Association

victims.[55] Some researchers suggest that "immigrant and refugee families are at greater risk for domestic violence due to their migration history and differences in cultural values and norms".[58] This does not mean that immigrants and refugees perpetrate more violence but that they face unique challenges living in a new community. As well, they may be unable to access support resources due to language and cultural barriers. By knowing the risk posed to immigrants and refugees in terms of experiencing domestic violence and the risk for lethality, we will better understand how to prevent future homicides and how to keep these vulnerable populations safe. Certain life stressors or factors may be associated with having immigrant or refugee status that can exacerbate the risk for domestic violence or homicide in these families. Other important communities that may be identified as vulnerable are people living in the North and in rural parts of Canada. Northern communities are extremely isolated and have a lack of available services. Victims of violence in the North are not always able to escape to shelters or receive supports. Many communities have extremely small policing services and family courts may be several communities away. Therefore, we need to identify the specific needs of these communities and create programs and initiatives that will effectively provide supports to prevent domestic homicide and domestic violence in general.

8. **Promote cultural competency when conducting risk assessments and providing risk management in domestic violence cases.** There is little doubt about the importance of training and education, building trusting relationships with cultural groups, creating effective communication strategies and implementing new tools that are inclusive of many different cultures to improve on cultural competency. Professionals need to be aware of the challenges minority cultures face and how these challenges can act as barriers to accessing resources and reaching out for support. Training and education around cultural differences should be mandatory for professionals that work with victims and/or perpetrators of domestic violence. Many times immigrant families are very isolated and have difficulty accessing services. Victims may be fearful that their children will be taken away if they disclose abuse, victims may fear deportation, and both victims and perpetrators may feel that a professional from the dominant culture will not understand their own cultural customs and beliefs. Therefore, it is important that professionals attempt to build trust with minority cultures through education, training, and engaging with different communities. Building effective communication strategies between mainstream professionals and victims and/or perpetrators from minority cultures is important for accessing and relaying accurate information, building trust, and bridging the gap between cultures. Risk assessment tools that are currently being used do not necessarily take into account the vulnerabilities of victims (and perpetrators) from minority cultures. Factors such as poverty, isolation, cultural beliefs, languages, immigration concerns, and lack of resources can influence an individual's level of risk. Therefore, assessment tools that reflect these vulnerabilities need to be created and risk management strategies need to take all these factors into account.

9. **Addressing domestic violence in the workplace needs to be a priority.** All employers should be encouraged to develop policies on measures they can take in their workplace to prevent and

[58] Pan, A., Daley, S., Rivera, L.M., Williams, K., Lingle, D., and Reznik, V. (2006). Understanding the role of culture in domestic violence: The Ahimsa Project for safe families. *Journal of Immigrant and Minority Health*, 8(1), 35-43.

provide an effective response to workplace domestic violence. Training should be promoted for all employees on how to recognize warning signs of domestic violence, how to respond appropriately when they recognize warning signs or witness incidents. Managers and supervisors should receive additional training so that they can appropriately assist victims or co-workers of victims who report concerns. Government ministries responsible for labour and workplace safety should work with domestic violence experts to establish a non-profit initiative to engage employers in the work of preventing and responding to domestic violence. The new non-profit initiative should provide workplace specific information, resources and advice for employers. Examples for such promising practices exist elsewhere – The US has two non-profit initiatives to involve corporate partners in efforts to protect employees from domestic violence; The Corporate Alliance to End Partner Violence – see http://www.caepv.org/ and Workplaces Respond to Domestic and Sexual Violence: A National Resource Center – see http://www.workplacesrespond.org/ . The latter was launched by President Barack Obama and Vice President Joe Biden in November 2010.

The Next Steps to Developing a National Plan for Domestic Homicide Prevention

Think tank participants discussed the next steps to developing a national plan for preventing domestic homicides.

- Creating a national website similar to the National Domestic Violence Fatality Review Initiative (www.ndvfri.org) established in the United States. The website would contain annual reports from death review committees; tools and protocols used when establishing a death review team; links to other websites associated with domestic violence and homicide prevention; and newsletters that discuss upcoming conferences and initiatives for domestic homicide prevention
- Creating a password protected section on the website where more sensitive information can be posted and shared with professionals in the field across Canada
- Developing a national domestic homicide database that contains risk factors and descriptive data from all domestic homicide cases across the country to be able to identify trends, common risk markers, and unique factors associated with particular populations
- Creating both provincial and national legislation that provides guidelines for information sharing to avoid liability issues and to assure professionals of what information can and should be shared
- Effective training needs to be provided to all professionals that work with victims and/or perpetrators or who are involved with death reviews (e.g., coroners).
- The death review process should be designed to become a proactive approach by including examples and best practices for prevention initiatives stemming from recommendations
- More frontline professionals need to be engaged in this discussion who may not see domestic violence as their primary area of responsibility (e.g. teachers and family physicians).
- Seek support for national conferences, forums, and think tanks as a way of bringing everyone together to discuss systemic gaps, progress, and research

Appendix A: Think Tank Participants

Mohammed Baobaid
Executive Director
Muslim Resource Centre for Social Support and Integration

Brian Brown
Chair of the DVDRc
Deputy Chief Coroner, New Brunswick

Val Campbell
Director
I-TRACT Integrated Threat and Risk Assessment Centre

Lesley Carberry
Director, Community Justice and Victim Services
Department of Justice
Government of the Yukon

Shannon Davis Ermuth
Legal Counsel
Children's Law & Family violence Policy Unit
Justice Canada

Myrna Dawson
Canada Research Chair in Public Policy in Criminal Justice
Associate Professor, Department of Sociology & Anthropology
University of Guelph

David Day
Vice-President
Canadian Research Institute for Law and the Family

Myriam Dube
Visiting Professor
Faculty of Arts & Sciences
School of Social Work
University of Montreal

Claudette Dumont Smith
Native Women's Association of Canada

Deb George
Domestic Violence Unit Coordinator
Family Service Regina
Suzanne Gervais
Director
Victim Services
Criminal Justice Division
Manitoba Justice

Carolyn Goard
Director Member Programs and Services
Alberta Council of Women's Shelters

Lisa Ha
Department of Justice
Senior Researcher
Research and Statistics Division

Colleen Hanrahan
Managing Director
Institute for the Advancement of Public Policy

Debra Heaton
Behavioural Sciences and Analysis Services
Ontario Provincial Police

Lucie Henault
Executive Director
Maison La Source du Richelieu

Joseph Hornick
Executive Director
Canadian Research Institute for Law and the Family

Peter Jaffe
Academic Director
Centre for Research & Education on Violence Against Women and Children

Saleha Khan
Chairperson, Board of Directors
Muslim Resource Centre for Social Support and Integration

Randy Kropp
Psychologist
BC Forensic Psychiatric Services Commission

Rebecca Latour
GNWT Department of Justice
Family Violence Analyst
Community Justice Division

Dr. William Lucas
Regional Supervising Coroner
Chair
Domestic Violence Death Review Committee
Ontario

Barb MacQuarrie
Community Director
Centre for Research & Education on Violence Against Women and Children

Evelyn Marshall
Victim Services Worker
New Brunswick

Colleen McDuff
Supervising Senior Crown Attorney
Domestic Violence Unit
Prosecutions Division
Manitoba Justice

Michelle McGuire
Strategic Policy Liaison
Sisters in Spirit
Native Women's Association of Canada

Rod McKendrick
Manager Victim Services Training Initiatives
Interpersonal Violence Specialist
Saskatchewan Ministry of Justice & Attorney General

Cathy Lee Menard
Chief Coroner
NWT Coroner Service
Department of Justice

Robert Morris
Crown Attorney
Huron County, Ontario

David P. O'Brien
Senior Crown Attorney
Prince Edward Island

Tracy Ozark
Program Support Coordinator
Victim Services
Department of Public Safety
New Brunswick

Tracy Porteous
Executive Director
Ending Violence Association of British Columbia

Valerie Pottie Bunge
Director
Policy Planning and Research
Nova Scotia Department of Justice

Deborah Sinclair
Consultant
Member of Advisory Committee on Domestic Violence for Ontario Women's Directorate

Verona Singer
Coordinator
Halifax Regional Police Victim Services

Kelly Watt
Threat Assessment Specialist
ProActive ReSolutions

Adeline Webber
Whitehorse Aboriginal Women's Circle