Royal Commission into Family Violence

WITNESS STATEMENT OF JAMES OGLOFF

I, James R. P. Ogloff AM, Director of Psychological Services and Research, Forensicare, and Professor of Forensic Behavioural Science, Swinburne University of Technology, 505 Hoddle Street, Clifton Hill, in the State of Victoria, say as follows:

1. I make this statement on the basis of my own knowledge, save where otherwise stated. Where I make statements based on information provided by others, I believe such information to be true.

Current role

2. I am the Foundation Professor of Forensic Behavioural Science and Director of the Centre for Forensic Behavioural Science (**CFBS**) at Swinburne University of Technology.

3. I am also the Director of Psychological Services and Research at the Victorian Institute of Forensic Mental Health (**Forensicare**).

4. Attached to this statement and marked **"JO-1"** is a copy of the joint submission by the CFBS and Forensicare to the Royal Commission, dated May 2015. I agree with the contents of that submission.

Background and qualifications

5. I am trained as a lawyer and as a clinical and forensic psychologist. I am a Fellow of the Canadian, American and Australian psychological societies. I am endorsed by the Psychology Board of Australia in both clinical psychology and forensic psychology.

6. I have worked in clinical and forensic psychology in a variety of settings for 30 years. I have specific expertise in forensic psychology, forensic mental health, mental health law and the assessment and management of offenders.

7. I am a Past-President of the Australian and New Zealand Association of Psychiatry, Psychology and Law and a former Chair of the College of Forensic Psychologists of

the Australian Psychological Society. I am a Past-President of the Canadian Psychological Association and a Past-President of the American Psychology-Law Society. I have published 16 books, more than 230 scholarly articles and book chapters on a range of subjects including the assessment and management of offending and violence, mental illness and offending, stalking, threatening, policing mentally ill people.

8. I arrived in Australia in 2001 and have since worked as a clinical and forensic psychologist. In my clinical work I routinely carry out forensic evaluations for the courts, the Adult Parole Board, Forensicare, the Department of Justice, the Department of Health and Human Services, and other agencies. I have also conducted many reviews for various justice and mental health agencies. I have given expert evidence in all Australian states and mainland territories (except South Australia), and in courts overseas.

The diverse and inter-connected nature of family violence

9. Family violence is a broad phenomenon involving psychological, physical and sexual violence between partners, siblings, parents, children and more distant family members. Despite this complexity, the family violence service sector in Victoria responds almost exclusively to adult female victims and their dependent children, and to adult male perpetrators of intimate partner violence.

10. Victoria's model of service provision involves a range of agencies that respond to specific types of violence. A key deficiency of the current system is the lack of an integrated understanding and response to intimate partner violence, including within the GLBTI community,[1] stalking, child-to-parent violence, severe sibling violence and child abuse and neglect. Failing to implement joint responses to these inter-related behaviours will not only leave victims and perpetrators without much needed assistance, it will mean missing important opportunities to intervene early and potentially prevent transmission of family violence to future generations.

11. The message that is presently conveyed to the public regarding family violence, in its focus on intimate partner violence (**IPV**), is often too simplistic. A substantial majority of family violence does occur to women, perpetrated by men. However, by focussing

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[1] Research over the past 25 shows that IPV occurs at approximately the same rate in gay and lesbian relationships as it does in heterosexual relationship (e.g., Turell, Herrmann, Hollander, & Galletly, Lesbian, gay, bisexual, and transgender communities' readiness for intimate partner violence prevention. J. Gay & Lesbian Soc. Servs., (2012) 24, 289-310).

only on that violence, a substantial minority of cases will be missed that cannot be explained solely through the lens of gender inequity. Our estimate is that at least 30% of family violence situations are not characterised by conventional male to female partner violence.[2] Given the volume of cases, this is a significant number. Moreover, it is simplistic and misleading to say that domestic violence is caused be patriarchal attitudes, a need for power and control, and a sense of entitlement. While these factors are necessary and sufficient explanations in some case, in many other cases these factors are neither a necessary or sufficient explanation of the violence perpetrated.

12. The literature on family violence shows high rates of violence – of differing levels of severity – in both male and female partners, in heterosexual and same-sex relationships. The message that needs to be emphasised is that violence in all relationships is unacceptable, irrespective of the gender or sexual orientation of the perpetrator. Critical literature notes that there are different expectations around gender and violence: if a female does something violent, that may be seen as less serious than a male. However that behaviour is equally problematic and boys learn from their mother's behaviour as much as they do from their father's. Statistically, women kill almost as many of their children as men, often due to circumstances of depression or mental illness, however this does not fit with the gendered view of violence and it is not acknowledged in the public domain.

13. A significant proportion of people who perpetrate family violence have multifaceted needs that are implicated in their violent behaviour. For these individuals, a family violence intervention focusing predominantly on gender-related attitudes and accountability is most unlikely, on its own, to produce longer terms change in behaviour. Rather, intensive intervention programs which target the panoply of relevant risk factors are required.

14. One-third to one-half of all cases we see at Forensicare involve family violence. The vast majority of our patients have a serious mental illness. We need to be aware of the complexities around the role of factors on family violence, such as mental illness, personality disorder, substance misuse, anger issues and other sorts of behaviours, which a simplistic view of family violence often misses. Similarly we have seen that boys who are abused actually have a much greater likelihood of abusing people in

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[2] 30% is a conservative estimate, because we know that children are present in approximately 60% of intimate partner violence relationships, and this 30% figure captures the partner but not those children.

later life, and it is the same with girls. The problem is this issue is not addressed in the current framework of family violence and its focus on gender inequity. Many men who are violent to their partners are violent in other contexts as well. Very often IPV does not happen in isolation from other forms of violence, and the underlying factors that lead to the violence can be complex and multiply determined.

15. A broadening of the service provision for different types of family violence, and responding to the inter-related nature of family violence is essential. Specialist services that offer a response to the full range of family violence victimisation or perpetration are required. Service providers that focus only subgroups of family violence should establish referral pathways with external agencies that can provide assessment and intervention services for a comprehensive range of family violence as appropriate.

16. I think that there is a quite understandable fear within the Victorian family violence sector that if they start to recognise other potential causes of violence, that will cause a shift in funding away from programs directed at gender inequity, which they regard as incredibly important and which we agree are important, towards programs directed at alcohol and drugs, for example. The reality is, if it were not for this gender perspective of family violence, the sector would not be where it is today. We must not lose any ground that has been gained; however, we suffer from not being up to date and considering the broader array of family violence. It is not helpful to focus exclusively on one aspect of abuse when family violence involves a complex array of behaviours, with broader offence issues. While there are some men for whom outdated gender attitudes are the sole cause of their violence, it is simply not the case for many.[3]

17. One of my hopes for the Royal Commission is that it will be recognised that there is a need for high intensity programs designed to address multiple issues around men who are violent, in particular. At present, the men's behavioural change programs are low intensity options that have demonstrated questionable validity.

Personality disorder and mental illness

18. Mental disorder can be conceptualised as having the following two dimensions:

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[3] Richards, Jennings, Tomsich, & Gover, A longitudinal examination of offending and specialization among a sample of Massachusetts domestic violence offenders. *Journal of Interpersonal Violence*, 2013, 28, 643-663.

18.1. The first is personality disorder, which is dysfunctional personality functioning. All of us have personalities that make us unique as individuals. Personality is typically life long, and is dictated by a range of factors, including environment and approximately 30% from genetics. What happens is that people's traits that would otherwise be seen as normal become, to some extent, extreme and ultimately dysfunctional. Personality traits fall on a dimension (e.g., from shy to outgoing and extroverted). Anytime one presents extreme traits in either direction, it becomes dysfunctional. So personality disorders are really dysfunctional characteristics of the personality that permeate over time and across situations.

18.2. The second aspect is mental illness. Mental illness refers to a group of disorders characterised by a range of symptoms which affect one's thoughts, feelings, behaviour and interactions with other. The nature and severity of symptoms that ebb and flow over time. While personality disorders tend to be lifelong conditions, many mental illnesses have particular times where they start and they usually will end, although the symptoms vary over time. Personality disorders can make an individual more vulnerable to developing a mental illness and it is not uncommon for mental illness and personality disorders to co-occur.

19. Personality dysfunction is a significant underlying component of family violence. We know that there are high percentages of personality dysfunction amongst both those who engage in family violence, as well as victims of family violence. It is part of the reason we see a number of victims finding themselves back in violent situations. In our research with victims, we have shown that children who are sexually abused are much more likely, later in life, to be raped or sexually assaulted, or to be in problem relationships than others. This personality vulnerability is very damaging. Moreover, people with personality disorders who engage in family violence have been found to be less amendable to treatment.

20. The primary examples of personality disorders we see associated with perpetrators include borderline personality disorder, which is a disorder characterised by a low self-image, fear of abandonment, difficulty maintaining relationships, very little control over emotions, and concomitant behavioural dyscontrol. We also see high percentages of anti-social personality disorders, which manifests in a disregard for authority, self-focus, and anti-social values and views.

21. It is very unfortunate in Victoria, and indeed Australia, that so little attention is paid to the assessment and treatment of personality disorders. There are extremely limited services available in the criminal justice system, the forensic mental health system or the general mental health system. Hospitals will admit people with some types of personality disorders (e.g., borderline personality disorder) when they are acutely unwell; for example, if one is so distraught that they are suicidal. They might get admitted for a short time until they stabilise; however, these issues are not going to be met with conventional mental health solutions.

22. The new *Mental Health Act 2014* does allow for personality disorder to be classified within the Act, but because of the strains on the mental health system, and the emphasis on serious mental illness and psychosis in particular, people with personality disorders are just not able to be admitted.

23. In relation to mental illness, generally speaking, research and clinical experience has revealed three groups of people with mental illness who engage in violence (including family violence):

    23.1. The smallest group, where mental illness is a necessary and sufficient explanation of their behaviour. Within family violence, we certainly have seen people like that. I recall we saw a patient who was a health professional, who was married with at least one child; a normal life. He gradually became unwell with a psychotic illness, developed paranoid delusions, and killed his wife. He has since recovered fairly well and is now living with their child. That is one example where there was no personality disorder, no substance abuse or history of violence.

    23.2. The largest group are those who have concurrent mental illness and other problems. A person might have depression or some other mental illness, but they also have problems with personality dysfunction, substance abuse in a high percentage of cases, and other problems with say anger or aggression.

    23.3. The final group are people who develop anti-social attitude and behaviours and irrespective of their mental illness and mental state.

24. As the above categories show, the relationship between mental illness and family violence is variable, and can involve a range of other risk factors, such as substance

misuse. To effectively address family violence, these factors need to be identified and treated on a case by case basis.

The meaning of risk assessment and risk management

25. Risk assessment is the process of identifying the presence of factors that increase the likelihood of an adverse behaviour occurring. Specific risk factors have been found to relate to particular types of violence, such as spousal assault. While risk factors for different types of offending and violence may overlap, other risk factors have been found to relate more strongly to particular types of offending.

26. Research reveals three approaches for assessing violence risk:[4]

    26.1. *unstructured clinical judgment* (decisions about violence propensity in the absence of guidelines);

    26.2. *actuarial risk assessment instruments* (decisions based on algorithmic models where weighted variables are used to compute the probability of violence); and

    26.3. *structured professional judgment* (**SPJ**) (systematic framework to evaluate evidence-based and theoretically relevant risk factors to assist in the formulation of risk).

27. By their design, actuarial measures are based on so-called 'static' (i.e., unchanging) risk variables where SPJ measures include both static and 'dynamic' (i.e., changeable) risk factors. Thus, actuarial measures cannot measure change over time and once a risk level is established, it generally does not reduce. While it is important to know the likelihood of re-offending (i.e. risk prediction) to determine the intensity of supervision required, actuarial approaches cannot provide information about the risk factors that should be targeted for change/management, the nature of supervision and risk management strategies required that might prove most beneficial. SPJ measures and actuarial risk measures have been found to have comparable predictive accuracy; however, SPJ measures help identify treatment targets and provides a method to measure changes in risk factors over time.

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[4] Ogloff & Davis (2005). Assessing risk for violence in the Australian context. In Chappell & Wilson (Eds) *Issues in Australian crime and criminal justice* (pp. 301-338), Chatswood: Lexis Nexis Butterworths.

28. In a recent meta-analysis (a statistical compilation of data from individual studies) of 18 studies that have investigated the predictive accuracy of a range of IPV risk prediction methods,[5] Hanson and his colleagues found support for SPJ and actuarial risk assessment measures for IPV. They found that these measures performed, in general, as well as risk tools developed and validated for general violence and offending. They also found that measures based on women's appraisals of their partners' risk for violence as IPV specific risk assessment tools performed almost as well as the IPV specific risk measures. Thus, there are validated risk assessment approaches to be drawn upon in Victoria.

29. Risk assessment plays two roles: (1) risk prediction - the prediction of the likelihood that one will engage in the behaviour of interest and (2) risk management – the identification and amelioration of risk level and risk factors.

30. The process of risk assessment and risk management must commence with an appraisal of risk employing a validated IPV risk assessment measure. Management and interventions should then be commensurate with the level of risk identified, and the particular risk factors that are elevated should be addressed in order to help ameliorate the level of risk over time (e.g., if substance misuse is a risk factor that is present, then it must be addressed over time to ameliorate risk).

Perpetrator intervention

31. Victoria currently has no system allowing for assessment of the broad range of risk factors known to be related to family violence perpetration, or how they might interact in a specific case to increase or decrease risk.

32. Existing programs for family violence perpetrators in Victoria do not reflect best practice in offender treatment or rehabilitation.

33. Existing men's behavioural change programs are characterised by relatively brief and low intensity group interventions. Men may be deemed unsuitable for a men's behavioural change program for a number of reasons including being violent beyond the relationship, not being appropriately motivated for treatment, having substance

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5 Hanson, Helmus, & Bourgon, (2007). The validity of risk assessments for intimate partner violence: A meta-analysis. 2007, Ottawa, Canada: Public Safety Canada

abuse issues, having mental health issues or having an intellectual disability or cognitive impairment.[6]

34. They do not adhere to the tenets of the Risk Needs Responsivity model or other principles of evidence-based practice that have been shown to be effective in reducing recidivism. The focus of treatment and treatment intensity is not matched to the individual offender's assessed needs and a 'one size fits all' approach is provided rather than offering a range of treatment. In particular, complex offenders whose family violence is one of a range of problematic behaviours with multiple causes that include, but are not limited to, their attitudes to women, are not provided with sufficient treatment in the current model.

35. It appears that the developments in our knowledge of what works in offender rehabilitation over the past 30 years have had little impact in the family violence field in Victoria. To increase the efficacy of perpetrator interventions, a review and overhaul of the current system is required. Intervention programs need to be responsive to the complex needs of the wide variety of family violence offenders. In particular, we must improve provision of specialist interventions to those with complex and serious mental, personality, and substance abuse disorders.

36. There is a clear need for better integration and communication between mental health services, drug and alcohol services, and offence-specific program providers.

Risk assessment and the CRAF

37. The Department of Health and Human Services (**DHHS**) has developed and disseminated a protocol for health and social service professionals to assess risk in family violence cases, referred to as the Common Risk Assessment Framework (**CRAF**). The CRAF was designed specifically to identify the presence of risk factors for future violence and guide service provision for women who have experienced family violence victimisation and are presenting to health or social services.

38. An advantage of the CRAF is that it is a universal framework and, in my opinion, there needs to be a common approach to risk assessment across sectors. However, the CRAF does have a number of limitations.

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6 No to Violence Male Family Violence Prevention Association, Inc. (2011). Men's behaviour change programs in Victoria – A sector snapshot. Melbourne: Author.

39. First, we expect the CRAF to be used by people who are not well equipped to do so. In risk assessment, the less expert you are, the more reliant you will need to be on the tool, and on an actuarial or mathematical summation of known risk factors. The CRAF does not provide such a summation; rather it relies on the assessor's judgement. The level of reliance on the assessor's judgement is problematic given the generally low level of expertise people have understanding the risk factors related to family violence.

40. Second, the CRAF does not result in a clear indication of an individual's level of risk of repeat family violence nor does it provide an indication of the risk of escalating family violence decisions.

41. Third, the CRAF does not adequately allow for an assessment of the broad range of risk factors known to be related to family violence, including engaging in violent behaviour outside of the relationship. Conversely, many items listed in the CRAF that are purportedly relate to a risk of 'the victim being killed or almost killed' occur quite frequently in family violence incidents (e.g., controlling behaviours) or have not been empirically supported to relate to future harm (e.g., stalking of victim, unemployment). Due to the emphasis on gender inequity, as discussed above, these contributing factors are not sufficiently addressed.

42. Unfortunately, CRAF has not been empirically validated.

43. In my view, there is clear benefit in considering risk assessment from the victim's perspective, as the CRAF does, and separately, from the perpetrator's perspective. However, the CRAF does not provide guidance in how to weight the various factors and considerations listed in the assessment.

44. Victorian services for male perpetrators of family violence are operated, funded, and developed separately from one another, and there is no framework or shared protocol for the integration of service provision, risk assessment or risk management. Instead each service, including mental health, drug and alcohol, community corrections and offence-specific treatment services has its own established protocols and focus. There is no systematised assessment process to identify or provide a full range of individual service needs.

45. In relation to child protection, there is a struggle to even recognise the need for a specific, structured risk assessment, and I think that there are cultural explanations for this. I can say, from our internal work at Forensicare, that a risk assessment for

children is needed. We have studied child deaths in Australia and looking at those cases, tried to identify the risk factors that relate to a risk of increased child abuse and ultimately death. There is capacity to develop these systems but the child protection workforce really are not open to that suggestion. They completely reject the idea.

Improving risk assessment in Victoria

46. If the CRAF is retained, further work needs to be done to validate the framework. It must be evaluated and further developed so that it does what is required – provide an indication of the likelihood that family violence will be repeated and that the severity of family violence will escalate. The CRAF could be developed to include a series of tools that are useful in different circumstances.

47. The best risk assessment tools are those that include risk factors that are static (i.e., risk markers that do not change or change very gradually) and dynamic (i.e., that change over time). Examples of static risk factors include gender: generally men are going to be higher risk; history of previous violence: generally those who have engaged in violence in the past are more likely to repeat that behaviour; and age: younger people are as a group, higher risk than older people. The static risk factors establish the baseline of risk (what is known as the risk state).

48. Dynamic risk factors provide an indication of an individual's current risk status. Examples of dynamic risk factors include attitudes supportive of family violence, the presence of substance misuse. Dynamic factors can be measured over time to provide an indication of whether an individual's risk is increasing, decreasing, or remaining stable.

49. The problem at the present time is that we have the shell of the framework but we don't have all the necessary tools within it. I would advocate for taking some validated tools and using them as part of the CRAF framework.

50. Alongside the CRAF, a consistent and comprehensive procedure is required for identifying risk and treatment needs for family violence perpetrators. An effective assessment process should act as a pivot point to:

    50.1. identify the range and severity of needs in the individual case;

    50.2. identify the most appropriate treatment services and risk management options for intervention; and

50.3. provide a baseline that can be reviewed at completion of treatment to allow for comparison and evaluation.

51. I think that within the sector, there also needs to be a bringing together of people with different skill sets, not only to perform the risk assessment but also to do the intervention.

Family violence initiative

52. Forensicare and the CFBS are presently working with Victoria Police and a Medicare Local in a specialist family violence initiative. This innovative program involves having a senior clinical and forensic psychologist working on site with the Victoria Police Family Violence Team in Footscray to provide support and advice to the police, assess risk of family violence perpetrators, and assist victims and perpetrators in receiving needed services. The Family Violence Team are secondary responders. After the initial police response, if there is a family violence issue to follow up, then the psychologist will attend and her role is to really work with the victim and the perpetrator, depending on the circumstances, and ultimately to conduct a risk assessment. The program is being empirically evaluated by the CFBS and the preliminary learnings arising from the trial, while yet to be completed, are very positive.

Child protection

53. Child protection services need to shift to true protection rather than the role that they currently occupy. Families that need support are deterred to go to child protection in case there are custody implications of doing so. Violence remains in the family because people are afraid to come forward. Even a struggling parent who has to leave the children alone while she is at work, would never think of contacting child protection. Similarly, teachers often recognise the signs of child abuse, however they are reluctant to report it as they are uncertain of what the consequences may be for the child.

54. We see this non-disclosure particularly in the Indigenous Australian communities. I previously worked in New South Wales as part of a committee with Indigenous communities and a clear message that emerged from that was that many Indigenous people are so distrustful of white bureaucracy that they will sacrifice a lot before they ever seek assistance. We need a circuit breaker – a shift in this thinking.

A comparison with British Columbia

55. Prior to my arrival in Australia in 2001, I had worked for a long time overseas, including in British Columbia. British Columbia is remarkably similar to Victoria in terms of history, population size, and demographics; yet if one looks at family violence in British Colombia, there is a degree of organisation and professionalism that does not exist here. There is a broader recognition of the constitution of family violence, victims, and perpetrators.

56. Province-wide services, such as the British Columbia Forensic Psychiatric Services Commission regularly conduct assessments of family violence perpetrators for the courts. The Correctional Service of Canada has developed, implemented, and evaluated moderate and high intensity family violence programs with male offenders based adhering to the Risk Need Responsivity principles. [7] The programs have been found effective in reducing spousal assault recidivism:

> *"within the moderate-intensity group, untreated offenders were 3.25 times more likely than treated offenders to commit spousal violence. … Within the high-intensity group, untreated offenders were 4.5 times more likely than treated offenders to commit spousal violence. … Overall, when the moderate- and high-intensity groups are combined, untreated offenders were 3.76 times more likely than treated offenders to commit further spousal violence."*[8]

57. Family violence services in Victoria are dominated by the NGO sector, who have a particular vision of what family violence is and how it should be addressed. Experiences from other jurisdictions can be informative for future developments in Victoria.

James R. P. Ogloff AM

Dated: 20 July 2015

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7 Stewart, Gabora, Kropp, & Lee, (2014). Effectiveness of risk-needs-responsivity-based family violence programs with male offenders. *Journal of Family Violence, 29*, 151-164.

8 *Ibid*. at 160.