# Country Reports and Cross-National Comparison on the Implementation of International Norms and National Best Practices of Frontline Responders

**Deliverable 2.2**

Deliverable report for

IMPRODOVA

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Authors of the IMPRODOVA Consortium involved in this report are:

Lisa Bradley, Oona Brooks-Hayes, Michele Burman, Francois Bonnet, Fanny Cuillerdier, Thierry Delpeuch, Sergio Felgueiras, Stefanie Giljohann, Gabor Hera, Paul Herbinger, Jarmo Houtsonen, Jean-Marc Jaffré, Karmen Jereb, Joachim Kersten, Norbert Leonhardmair, Charlotte Limonier, Branko Lobnikar, Paulo Machado, Marianne Mela, Sonia Morgado, Marion Neunkirchner, Suvi Nipuli, Martta October, Lucia Pais, Bettina Pfleiderer, Lisa Richter, Bostjan Slak, Dora Szegő, Margarita Vassileva

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## A. Executive summary

International organizations (e.g. UN, Council of Europe) have defined a set of minimum standards which governments and service providers (SP) should achieve and implement in order to meet their international obligation to exercise due diligence to investigate and punish acts of violence, provide protection to victims and prevent DV. There are international standards for service providers in general and for law enforcement in particular (but not specifically for NGOs or medical doctors). The foundations from which the basic standards are developed encompass confidentiality, safety, security and respect for service users, accessibility, and availability. Support should be available free of charge and interventions should employ the principles of empowerment and self-determination. Service providers should be skilled, gender-sensitive, have ongoing training and conduct their work in accordance with clear guidelines, protocols and ethics codes and, where possible, provide female staff. Each SP should maintain the confidentiality and privacy of the victim and should co-operate and co-ordinate with all other relevant services. It should monitor and evaluate service provision, seeking participation of service users. The expertise of the specialized NGOs should be recognized.

The research interviews were carried out in at least two locations in each partner country in accordance with the methodology (in Germany, interviews were conducted in three locations). The researchers conducted 296 interviews in total, with interviews involving police officers, social workers, medical staff and members of non-governmental organizations. 41 interviews from Austria, 44 interviews from Germany, 35 interviews from Finland, 48 interviews from France, 32 interviews from Hungary, 26 interviews from Portugal, 30 interviews from Scotland, and 34 interviews from Slovenia, were included in the analysis.

The main finding of this D2.2 report is that the international standards are relatively well implemented in all the partner countries. Based on the analysis we can conclude that police have powers to enter private property, arrest and remove a perpetrator. Protection or restraining orders are available for police to tackle all forms of DV. The important is also, that police agencies co-ordinate with, and refer to, specialist support services for domestic victims well, and that all analysed police organizations have protocols on information sharing on DV with other agencies. The IMPRODOVA partners also found that there are some areas that require special attention in the future, since gaps between the international standards and the actual practice were discovered. Police personnel should be better trained on all aspects of DV, victims should be seen as soon as possible by a specially trained officer and there should be at least one specialized officer per police unit, for DV and for sexual violence.

The comparison of the case studies in the eight partner countries yields many lessons, but one sticks out: frontline responders who are specialists of domestic violence probably serve the needs of victims in a better way than frontline responders who are generalists. By “specialist”, the deliverable means police officers (or social workers, or medical professionals) whose job specialty consists in handling domestic violence cases. By “generalist”, this deliverable refers to those police officers (or social workers, or medical professionals) who indifferently handle all the cases that they encounter in their work. The key variable therefore is whether victims make themselves known to specialists or generalists.

Summarizing the main findings, generalists will typically be less knowledgeable about domestic violence, less inclined to take non-physical violence seriously, more inclined to rely on personal discretion, and less likely to make informed and helpful referrals. Conversely, specialists will be better trained, knowledgeable about the different types of violence, abuse and control dynamics—and the risks they entail, more likely to follow protocols and procedures design to safeguard the victim's interests, and more likely to be part of a network of professionals from other sectors who will be themselves more likely to help the victim in their multifaceted needs.

In some countries, such as Hungary, Slovenia or Portugal, virtually all police officers on the frontline response to domestic violence are generalists. In other countries, such as Scotland and Finland, most frontline response is made of specialists. In France, Germany and Austria, it varies according to locations, with some places served with specialized units and other with only generalists. Beyond necessary discussions on the territorial equality, the pattern that the IMPRODOVA team has identified about specialists and generalists proves true both in cross-country comparison and within-county differentiation.

In general, in all countries, the basic steps of a domestic violence case are the same. Where victims' point of contact with frontline response to domestic violence is with generalists, police discretion comes into play in the determination of the level of help that the victim will receive. This is for instance documented in the Portuguese and Hungarian cases, and to a lesser extent in France and Austria. Police discretion is inherent to police work, but in the case of domestic violence, discretion has been analysed over the 1980s as a key factor in the under-servicing of domestic violence victims, with police officers traditionally tending to consider domestic violence as a private family concern, and not as the crime that is. Discretion means the quality of service depends on the quality of the particular individuals who are working that day, and not on the quality of the organizational processes that are implemented to insure higher standards of service. Generalists' varying skills and zealousness mean that some investigations can be critically crippled by mistakes made in the early stages of the procedure, leaving at-risk women in a particularly dangerous situation of having reported a crime to the police, not having been taken seriously enough, and now facing retaliation from her partner.

The question of discretion hinges upon that of police attitudes towards domestic violence. The deliverable reveals that generalists typically tend to think of domestic violence as serious, physical violence, at the expense of a broader definition that encompasses psychological harassment, conjugal rape, financial abuse, and other non-physical forms of violence against women (for instance in Slovenia or Portugal). Typically, generalists justify the focus on serious physical violence by pointing at the question of evidence (such as visible injuries or medical certificates), and may develop negative stereotypes about victims ("they always withdraw their complaint"), as evidenced in Hungary. In fact, the Hungarian case shows that social workers who lack training and specialization may also develop these negative stereotypes. In Portugal, this means that older officers tend to cling to outdated stereotypes, compared to younger officers. Generalists usually are overworked because of the variety of requests that they face, they have no time for partnerships (for instance, the Ljubljana case in Slovenia).

Where victims' point of contact with frontline response to domestic violence is with specialists, their experience is typically different. Obviously, there also is a varying quality to the service provided by specialists and specialized units. But in general, the IMPRODOVA team finds that specialists are well trained and have more experience. They are more likely to be able to routinely ensure a prompt and suitable treatment of "normal" cases, and to manage more complex and technical cases. Their organizational structure reflects an advanced process of division of labour (cf. the Scottish case and the task-sharing in the Scottish police between the local, divisional and national levels). Specialists are more capable of correctly interviewing the victim, of appropriately filling case documentation, of giving correct advice to the victim, of appropriately orienting the victim to support structures. This is manifest from the Finnish, German and Scottish cases. Being specialized on one type of crime, specialists do not face the problem of managing conflicting priorities—a problem typical of generalists. They usually have more reasons (and perhaps more time) to attend additional trainings, academic workshops, and to visit NGOs. They play the role of internal and external experts for DV prevention and investigation (towards non specialized police officers, NGOs, public administrations). They work to increase awareness of their non-specialized colleagues.

Specialized units also are more likely to work in close partnerships with other types of professionals, for instance the embedded social worker at the police station (cf. French case). They serve as a contact point for other police units and external actors (NGOs, schools…). Partnerships with social workers enable specialized units to focus on their core professional specialties, and to delegate other tasks to other specialists. Social workers who take care of the social-work needs of victims (housing, children, access to poor relief, etc.) allow police officers to focus on investigations and procedural aspects of the case (cf. Finnish case). The fact that the social worker operates at the police station facilitates information sharing and exchange of views on DV situations. The social worker can be present during the interview of the victim by investigators. In Scotland, Multi-Agency Risk Assessment Conferences assemble professionals from different sectors (including housing and education) to make sure that every angle of the victims' concerns are addressed.

## B. Methodology

The research interviews were carried out in at least two locations in each partner country in accordance with the methodology (in Germany, interviews were conducted in three locations). The researchers conducted 296 interviews in total, with interviews involving police officers, social workers, medical staff and members of non-governmental organizations. 41 interviews from Austria, 44 interviews from Germany, 35 interviews from Finland, 48 interviews from France, 32 interviews from Hungary, 26 interviews from Portugal, 30 interviews from Scotland, and 34 interviews from Slovenia, were included in the analysis. Here, it should be emphasized that all participants in interviews were experts on domestic violence, therefore the whole sample consists of competent professionals in the field of domestic violence.

Interviews addressed the following questions and related issues:

**Overview**

a. Which actors are involved in the handling of domestic violence?
b. What do they do? What is the nature of their involvement?
c. What types of domestic violence are considered?
d. Do involved actors have different conceptions of DV, and which?
e. Describe the education/training on DV that different actors have or have access to.
f. Which actors see DV as a priority? Which do not?
g. Which actors work to make DV a more central concern?
h. Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing)[1].

**Steps of a DV case:**

a. How are victims identified and detected? Are there active measures to maximize victim detection?
b. Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?
c. Describe the process of filing a complaint. Are there active measures taken around this topic?
d. Describe what happens after victims have filed a complaint: which problems arise then?
e. Describe victims' support networks, whether or not they have filed a complaint or gone to court.
f. In this process, what are the main obstacles and problems that victims face?
g. What do you see, in the frontline response to DV, as "working" and "not working"?
h. Overall, according to you, in this section, what is of key interest in your case?
i. Anything that you find relevant and that is not covered by the questions above

[1] This question will be addressed in-depth in T2.4.

## C. Overview of the results

International organizations (e. g. UN, Council of Europe) have defined a set of minimum standards which governments and service providers (SP) should achieve and implement in order to meet their international obligation to exercise due diligence to investigate and punish acts of violence, provide protection to victims and prevent DV. There are international standards for service providers in general and for law enforcement in particular (but not specifically for NGOs or medical doctors). The foundations from which the basic standards are developed encompass:

- confidentiality;
- safety, security and respect for service users within a 'culture of belief' and 'taking the side of' the victim;
- accessibility – ensuring all women can access support wherever they live and whatever their circumstances;
- availability – crisis, medium-term and long-term provision are all needed, with access 24/7 where safety is immediately compromised;
- support should be available free of charge;
- support and interventions should employ the principles of empowerment and self-determination.

Service providers – including the police – should be skilled, gender-sensitive, have ongoing training and conduct their work in accordance with clear guidelines, protocols and ethics codes and, where possible, provide female staff. Each SP should maintain the confidentiality and privacy of the victim. It should co-operate and co-ordinate with all other relevant services. It should monitor and evaluate service provision, seeking participation of service users. The expertise of the specialized NGOs should be recognized.

Standards also stress the importance of integration in approaches to DV. They insist on inter-agency co-ordination and the establishment of intervention chains and referral processes and protocols. The best way to deliver services is through 'one-stop shop' or multidisciplinary teams, or a 'one-stop person' approaches. Where appropriate, a range of protection and support services should be located on the same premises.

Below, Table 1 shows the results of international standards implementation for each country. The assessments are based on analysis of the responses gathered in each country, within defined sites. Nevertheless, for the most accurate understanding of results, country and site circumstances need to be considered, therefore, the comments written by the researchers at each of the analysed localities should also be taken into account. Only by following these comments can we accurately interpret the existing situation.

When comparing the responses in Table 1 (**Map of respect of international standards on service provision – standards for all FLR**,) we can see that the standards in this field are relatively well implemented in all the partner countries. Nevertheless, we can also observe some areas (i.e. standards) that are not fully implemented. These standards are:

- data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality;

- services should produce annual or bi-annual analysis of their users and their experiences;
- services should be holistic and user-led. The service provider should be competent to provide what the service user needs or is requesting and where this is not possible, refer the service user to relevant services.

On the other hand, we can conclude that the following standards are implemented at a very high level:

- the service user has a right to be treated with respect and dignity at all times. Face-to-face contact should be within a safe, clean, and comfortable environment;
- service providers should be mindful of the needs of children of service users;
- confidentiality must be guaranteed - any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent;
- crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year;
- service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service;
- service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are;
- there should be a help line covering DVs which is able to answer all incoming calls;
- there should be one specialist violence against women counselling service in every regional city; and
- all information, advice and counselling should be based on empowerment and victim rights models.

In Table 2 (**Map of respect of international standards for the police**), the state of implementation of international standards in police organisations is presented for each partner country. Based on the analysis we can conclude that police have powers to enter private property, arrest and remove a perpetrator. Protection or restraining orders are available for police to tackle all forms of DV. The important is also, that police agencies co-ordinate with, and refer to, specialist support services for D victims very well, and that all analysed police organizations have protocols on information sharing on DV with other agencies.

When we analysed the degree of implementation of international standards for police organizations, we also found that there are some areas that require special attention in the future, since gaps between the international standards and the actual practice were discovered. These issues are:

- police personnel should be trained on all aspects of DV;
- victims should be seen as soon as possible by a specially trained officer;
- there should be at least one specialized officer per police unit, for DV and for sexual violence;
- police should proceed to a risk assessment supported by timely gathering of intelligence - this intelligence should be gathered from multiple sources and seek victim perspective on potential threat; and
- police should develop and implement strategies to eliminate or reduce victim risks.

In addition to these standards, researchers also reported deficiencies in the following standards related to the effective dealing with domestic violence:

- police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes, and
- police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization.

**Table 1: Map of respect of international standards on service provision – standards for all FLR** (green = Yes, red = No; yellow = to some extent; white = N/A)

| | AUT | DEU | FIN | FRA | HUN | PRT | SCT | SVN |
|---|---|---|---|---|---|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | | | | | | | | |
| There should be one specialist violence against women counselling service in every regional city. | | | | | | | | |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | | | | | | | | |
| There should be a sufficient number of shelters available to victims of DV. | | | | | | | | |
| Service user has a right to be treated with respect and dignity at all times. Face-to-face contact should be within a safe, clean, and comfortable environment. | | | | | | | | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. … | | | | | | | | |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | | | | | | | | |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons related to their case, and staff. … | | | | | | | | |
| Services should be equitably distributed across geographic areas and population densities. | | | | | | | | |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | | | | | | | | |
| Services should be holistic and user-led. The service provider should be competent to provide what the service user needs or is requesting and where this is not possible, refer the service user to relevant services. | | | | | | | | |
| Services should be provided free of charge. | | | | | | | | |
| Service providers should be mindful of the needs of children of service users. | | | | | | | | |
| Staff should be appropriately qualified and trained … | | | | | | | | |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | | | | | | | | |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | | | | | | | | |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | | | | | | | | |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | | | | | | | | |
| All information, advice and counselling should be based on empowerment and victim rights models… | | | | | | | | |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | | | | | | | | |
| National and local governments should have funding streams for violence against women services. | | | | | | | | |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | | | | | | | | |
| Services should develop guidelines for multi-agency co-operation. | | | | | | | | |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality. … | | | | | | | | |
| Services should produce annual or bi-annual analysis of their users and their experiences. | | | | | | | | |
| There should be clear protocols in place for data collection and information sharing between organisations. | | | | | | | | |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | | | | | | | | |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | | | | | | | | |

*Legend:*

| No | | To some extent | | Yes | | N/A | |
|---|---|---|---|---|---|---|---|

**Table 2: Map of respect of international standards for the police** (green = Yes, red = No; yellow = to some extent; white = N/A)

| | AUT | DEU | FIN | FRA | HUN | PRT | SCT | SVN |
|---|---|---|---|---|---|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | | | | | | | | |
| Police personnel should be trained on all aspects of DV. | | | | | | | | |
| DV offences should be treated at least as seriously as other violent offences. | | | | | | | | |
| Victims should be seen as soon as possible by a specially trained officer | | | | | | | | |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | | | | | | | | |
| Specialist Police units should be created in densely populated areas | | | | | | | | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV… | | | | | | | | |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. … | | | | | | | | |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | | | | | | | | |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | | | | | | | | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | | | | | | | | |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | | | | | | | | |
| Police should have protocols on information sharing on DV with other agencies | | | | | | | | |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | | | | | | | | |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained and reports made are kept confidential | | | | | | | | |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | | | | | | | | |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. … | | | | | | | | |
| Police should develop and implement strategies to eliminate or reduce victim risks | | | | | | | | |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, … | | | | | | | | |

*Legend:*

| No | | To some extent | | Yes | | N/A | |
|---|---|---|---|---|---|---|---|

## D. Country reports

Aggregated country-by-country reports for each location are presented below. The reports are valuable support information for better understanding of international standards implementation analysis. These reports are also useful for potential meta-analyses and can be understood as a useful database for further scientific analysis.

# I. AUSTRIA

## 1. Methodology

### 1.1 Overview of interview and case locations

The analysis of *the implementation of policies and guidelines of frontline responder practices* in the context of domestic violence (DV) in Austria is based on forty-one interviews conducted in three case locations between March and July 2019. Care was taken to include interview partners representing not only the major sectors active in the response to DV, but also different functions and positions in organizational hierarchies within these. Respondents included persons working in law enforcement agencies, social sector organizations, the health-care sector, and regional government or administration; as well as in regional and national management or coordination positions.

Each case location was selected considering contextual criteria such as demographic, geographic, institutional and organizational differences to allow for insight into the complexities and differences in the networked response to cases of DV by all relevant actors active in this field.

| | LEA | Medical Sector | Social Sector | Regional Administration | Total |
|---|---|---|---|---|---|
| Vienna | 5 | 3 | 9 | - | 17 |
| Upper-Austria | 5 | 2 | 6 | 3 | 16 |
| Vorarlberg | 2 | - | 5 | 1 | 8 |
| Total | 12 | 5 | 20 | 4 | 41 |

The capital city of Vienna in the east of the country was selected as the first of three case locations to capture, in particular, the response to DV in urban areas. Vienna is the most populous state in Austria and exhibits the highest ethnic and socio-economic diversity in the country. Correlating with its population density, the state has the highest rate of DV per capita[1], while also concentrating the largest number of national and regional actors active in the response to DV. Vienna was of further interest, because in the past countering DV strategies in this state have included Multi-Agency Risk Assessment Conferences (MARACs), which are internationally regarded as a notable multi-agency response. A total of seventeen interviews were

[1] Measured as the number of retraining orders issued by law enforcement agencies per 100,000 inhabitants.

conducted in Vienna. With nine interviews, the social sector was most strongly represented in this case location, due to the geographic convergence of actors relevant both on regional and national levels and the inclusion of organisations offering offender programmes. Particularly notable among the five law enforcement officers, were the interviews conducted with a member of the *Victims at Highest Risk* (VHR) unit as well as persons employed in positions unique to the organisational structure of the police force in Vienna. Three interviews with employees of the health sector provided further insight into this important entry point to the networked response to DV.

The state of Upper Austria located in the centre of the country was selected as the second case location to gain an understanding of the response to DV in more rural areas with lower population density and a higher dispersion of actors active in this field. The reported rates of DV in this state correspond to the national average. Care was taken to include interviews with front-line responders active in smaller cities and villages where the sum of tasks and responsibilities, when responding to cases of DV, are often concentrated in a very small number of individuals. For this reason, emphasis was placed on ground-level activity and experience during the five interviews conducted with law enforcement officers. Interviews with two medical sector staff from different hospitals in the state illuminated the process of implementing *Child- and Victims Protection Groups*. A total of six interviews were conducted with persons employed on different levels of organizational hierarchies within the relevant social sector organizations. In contrast to the first case location, the particular role and differing organisational structure of regional administration in the response to DV in rural areas was captured in the course of three interviews.
Vorarlberg was selected as an additional case location in the west of Austria to complete geographic coverage from east to west. The organisational structure of the social sector is a regional particularity, contrasting other states and representing a possible best-practice case in Austria. Unique to Vorarlberg, all relevant social sector organizations share a common, coordinating superstructure. Five interviews were conducted to gain understanding of the particularities, benefits and possible drawbacks of this model. Two interviews with law enforcement officers and an interview with a member of the regional administration were conducted to provide contextual insight relating to the social sector in Vorarlberg. This region exhibits the lowest rates of DV, despite including areas of high population density in rural settings.

### 1.2 Selection Process/Criteria & Access & Description of Interview situations

The selection process for interview partners was rooted in the combination of three sampling strategies. In order to overcome customary difficulties of entry to the field and benefit to the greatest extent possible from the expertise of persons active in the response to DV, the initial selection of respondents was based on recommendations by our project partners working in law enforcement agencies. In each of the case locations, this facilitated access to at least one member of each of the relevant sectors. As initial interviews generally focused on reconstructing the network of actors involved in the response to DV in each region, relevant persons, organizations and institutions for further interviews were frequently suggested by interviewees. Augmenting the initial selection by our national project partners with such snowball sampling, we were able to make use of personal referrals, thereby profiting from a

greater ease of access, while selecting relevant interview partners for each new branch identified within the networked response to DV. Complimenting this approach, relevant organisational departments were identified during desk research and approached directly.

Within reasonable limitations, each interview conducted was approached in the same fashion. Prior to each interview, respondents received a copy of the invitation letter, consent form and, upon request, an abbreviated version of the interview guideline outlining our general topics of interest. With a few exceptions, all interviews were conducted within the workplaces of our respondents and always without the presence of third parties. In cases where this was not possible (such as interviews in women's shelters when the interviewer was male), a neutral place was agreed upon in advance. With few exceptions, all interviews were conducted by two interviewers, allowing the first to concentrate on maintaining the dialogue, while the second was able to take more detailed notes and refer back to topics mentioned by the interviewee, rather than interrupting a specific narrative flow. The average duration of all interviews was an hour and a half, the shortest lasting approximately fifty minutes and the longest over six hours (spread across three meetings). Respondents agreed unanimously to the recording of their interviews.

### 1.3 Limitations

The most relevant possible limitations of the sample design stem from the dimension of pre-selection present in two of the sampling strategies. The decision was made to prioritize access to the field and the expertise of those active within it, over a more randomized approach, which may have been able to counteract a pre-selection bias. While such a bias is unlikely to play a significant role in the higher levels of organizational hierarchies where the selection of interview partners was rooted in their institutional function, respondents on ground level are likely to have been pre-selected or recommended due to their particular level of sensibility, interest or engagement in the topic of DV. This bias is unlikely to adversely impact the structural analysis of the multi-agency response to DV in Austria. A positive bias may however be present in our understanding of the attitude and expertise of ground-level front-line responders, whose tasks far exceed the response to DV. As the study does not aim to be statistically representative of attitudes held by law enforcement officers, this bias may be less impactful.

Somewhat surprisingly, considering the sensitivity of DV as a topic, there were no grave limitations to our research regarding the discussion of specifics subjects. While it was evident that particular interview partners discussed specific topics with different levels of ease or where more or less vocal about their critiques, these differences did not follow a specific structure or were grounded in particular topics. The only obvious reservations existed while discussing topics, centred around personalized critiques. In the few cases where weaknesses in the response to DV were attributed to the actions of a specific person (not occupying a public office), these critiques where usually navigated carefully and in a few cases only after requesting a pause in the audio recording.

Most likely attributable to the reliance on referrals by previous interview partners, it was possible to conduct interviews with members of all main actor groups active in

the Austrian response to DV as envisioned by the IMPRODOVA project design. Beyond the scope of the project, including lawyers, prosecutors, and members of the judiciary could have increased the understanding of trajectories a case of DV may take through the networked response in Austria. Equally valuable, further research could include direct observation of case conferences, coordination meetings or round tables to better understand the dynamics of cooperation between the relevant actor groups. Access to these types of meetings may however be very difficult, particularly due to privacy rights of victims and perpetrators alike.

## 2 Overview of the networked response to domestic violence in Austria

For the description of actors the distinction by location is not indicated as LEA operates on a federal mandate in a centralised structure, with very limited variability across states. While the social and medical sectors are in principle organised on state level, the key institution of *Centres for Protection Against Violence* are directly funded by the Federal Ministry of the Interior and operate under the same national framework. Coordinated on state level, *Women's Shelters* share the same mandate and organisational structure, which further makes a separate description redundant. However, where regional differences were identified, these are indicated in the relevant sections. Highest variability exists in the medical sector, which was included as a best-practice case for closer examination where such differences were exemplified.

### 2.1 Law Enforcement:

#### 2.1.1 Non-specialized police officers on ground level

The overwhelming majority of law enforcement responses to cases of domestic violence in Austria are attended to by non-specialized police officers on ground level. Their central tasks consist of the immediate intervention into ongoing disputes upon arrival at the scene; an assessment of the situation based on the *Penal law* (Strafrecht – StGB), *Criminal Procedural Law* (Strafprozessordnung – StPO), and the *Security Police Act* (Sicherheitspolizeigesetz - SPG); the possible issuance of a criminal charge and/or restraining order; as well as the considerable amounts of accompanying processes (notification policies, etc.) and case-documentation.

During the interviews conducted, ground-level police officers predominantly listed visible physical signs of violence against persons, the state of the physical surroundings and the separate statements of all parties involved as factors shaping their intervention in cases of DV. Beyond such manifest factors, the majority of officers described relying on informal impressions of the situation and the feelings it evoked, informed mainly by past experience and in part by knowledge on less manifest indicators acquired during DV-sensitivity trainings. In general, the types of domestic violence considered by ground-level police officers are heavily tied to offenses as defined by *Penal law*. Most commonly this includes physical violence and injury (sustained or single incident), sexualized violence, damages made to property, coercion, threats of violence, as well as stalking. Domestic violence in the respondent's accounts mostly takes place within family relations or between intimate partners, but is not limited to these. A common example named for such an exception was violence in relationships where one party is employed as care-staff

(elderly, special needs, children, etc.).

Ground-level officers seldom consider more hidden or insidious types, such as financial or symbolic violence. This may in part be due to a lack of sensitivity on the topic of DV, but more likely is tied to the specific function of this actor group in the response to DV. Immediate responses to DV form the core part of the LEA intervention, which faces challenges in recognizing and addressing more complex structural violence. The duration of contact with parties involved is extremely short and mostly condensed to a moment of peak-conflict. More latent indicators and obscured types of DV may factor into ground-level police work in the context of the decision to issue a restraining order (see Section 3).

All police officers are required to attend a training module on DV as part of their basic training. Taken place during the course of one day, this module includes some sensitivity training, but is mainly focused on conveying the relevant legal provisions relating to DV in *Penal Law* and *Police Security Act*. Intervention skills or a specific knowledge on the complexity of a DV case are not part of the training. Central among these provisions, are those underlying an officers ability to issue restraining orders. This module also includes an introduction to the relevant social sector organizations active in the field. It is worth noting, that this basic training module has been reduced by half, having in the past consisted of two units.

### 2.1.2 Prevention Specialists (Präventionsbeamte)

As part of the initiative *Gemeinsam.Sicher* (Safe.Together), a select number of ground level law enforcement officers at district level receive additional training in crime prevention strategies along eleven categories of criminal offences. Usually, one officer is assigned one such category and is able to function as an internal expert for *crimes prevention* for this particular specialization. Additionally, these specialized officers act as liaison officers between the public and the law enforcement agency and give lectures to relevant populations corresponding to their specialization. The primary goal is to provide LEA at district level with internal expertise and communicate preventative measures to the public. "*Prevention Officers"* are allocated a portion of their working hours to fulfill these activities. Two such specializations are relevant for the topic of DV: *Violence in the Private Sphere* and *Victims' Protection*.

These officers receive additional training from members of the *Victims-Protection Unit* (see below) over the course of one week. The central goal of this training is to convey the importance of, and strategies for an increased sensitivity towards the topic of DV. Specifically, this entails a heightened awareness of the experiences of victims of DV and techniques for questioning such persons without causing secondary victimization.

In Upper Austria a regional specificity exists in the organization of prevention officers, where the part time positions have been consolidated into a single officer working full time on preventive tasks. The approach seems to improve the cooperation between law enforcement and other actors by establishing a single point of contact. The single *Prevention Officer* model has the further benefit of allocating more time for further specialization to this position.

### 2.1.3 AB04

Within the structure of law enforcement in Austria, *Section 04* (AB04) entails the only unit specialized specifically in the topic of DV at state level. Subordinate to the *State Bureau for Criminal investigation* (Landeskriminalamt – LKA) as part of the *assistance services* (Assistenzdienst), *Section 04* is tasked with *Crime Prevention* (Kriminalprävention). Subdivided into a number of specialized units, officers working within *Victims-Protection* (Opferschutz) focus solely on cases of DV and stalking. Though there are variations between states, the department usually consists of an equivalent of around 4 full-time positions focusing on the state-level response to DV.

The central tasks of this department mentioned during interviews, revolved heavily around cases in which restraining orders had been issued. Any time such an order is put into effect, a mandatory notification is sent to the *Victims-Protection* department. Officers examine all restraining orders issued within the state and conduct a rough categorization along the probable severity of risk. The majority of cases, having been categorized as low risk, are assigned back to non-specialized officers at district level for processing and follow-up. Highest-risk cases are passed on to the national *Victims at Highest Risk* (VHR) unit (see below). Middle-risk cases, which require more management, than would be possible for a regular officer, fall into the purview of the victims-protection unit.

In cases of medium risk, the department will assume case management and attempt to maintain regular contact with the persons involved based on the requirements of each case. Employees in this department regularly have a background in social work or psychology, which strongly shapes the work of this actor group. Compared to non-specialized officers, the *Victims-Protection Unit* will employ a much wider conception of the DV that includes more intangible forms of violence along with less visible risk factors. Prominently mentioned by respondents, culturally shaped or motivated violence against women play a central roll for this unit. Examples include female genital mutilation, forced marriage, violent acts of vengeance and violence within extended families[1].

Central to their ability to adequately respond, is the shared case-documentation with all other units within law enforcement. Members of the Unit are able to read the criminal records of all persons involved and more easily call upon law enforcement support for all precautionary measures. As such, their work strongly resembles that of the *Centers for Protection Against Violence* (see 2.3.1) while including measures and means reserved for law enforcement. At the same time, members of this unit underlie the same obligation to report any and all ex-officio crimes. Though respondents did not mention this during interviews the obligation to report ex-officio crimes is likely to stand at odds with their social-work-based approach. Relationships of trust between victimized persons and members of the *Victims-Protection Unit* are likely to be encroached upon by the necessary relinquishing of the victims say in what types of actions follow specific information imparted.

[1] The derogatory term used by officers during interviews was “clan structures”.

### 2.1.4 VHR

The *Victims at Highest Risk (VHR)* unit represents the highest level of support offered by Austrian law enforcement in cases of DV. Cases deemed to include a high level of risk for victims by the *Victims-Protection Units* at state-level, are passed upwards to *VHR*. Two relevant dimensions of this trajectory should be pointed out: Firstly, *Victims-Protection Units* function as a filter for all cases in which restraining orders have been issued, providing an initial risk-assessment and pre-selection for cases seen by *VHR*. As such, the specific understanding of DV, as well as the criteria for risk-perception of persons working in the *Victims-Protection Units*, has transferal effects for the *VHR* unit. Secondly, active criminal investigation into a case of DV is a formal condition for it to be eligible for support through the VHR unit. Furthermore, a person must experience concrete danger to their health, life of freedom or at least a credible threat so these, to be eligible.

*VHR* deals particularly with victims of ethnic and cultural violence, stalking, organized crime, human trafficking and high-risk domestic violence. As members of law enforcement, VHR-personnel have full access to criminal records of all involved parties, as well as ease of contact with on the ground officers with knowledge of the case. Of all actor groups interviewed in Austria, VHR conducts the most extensive risk assessment, grounded in police investigation and witness protection techniques. According to respondents, a single assessment will usually take several weeks, though protective measures can be initiated almost immediately. With very few exceptions, victims of *High-Risk Domestic Violence* will be placed under specialized protective measures based on witness protection. This entails the organized emigration to a different country, the provision of new identities for the victimized and the allocation of subsistence measures while minimizing and obscuring the paper trail.

Active members of the VHR unit consist of (predominantly female) police officers with backgrounds in psychology and/or therapy. Additional training for members of the unit was mentioned, though the main focus of such measures for improvement was the unit as a whole, rather than its individual members. Examples for this ranged from employing investigators to test the units ability to provide protective measures, as well as regular updates by cyber-crime specialists to inform the work of the unit.

## 2.2 Medical Sector

Beyond their role as health-care providers, the medical sector in general fulfills the function of identifying victims of DV, that have not entered the networked response through other actor groups. This facilitates the referral of cases of DV to law enforcement, which may otherwise have gone unnoticed. This relationship is formalized in §7 of the *Health Care Act* (GuKG – Gesundheits- und Krankenpflegegesetz), which stipulates, that medical and nursing staff are required by law to report any instances in which criminal offences are suspected to be the cause of grievous bodily harm or death of a patient. While similar to the arrangement of ex-officio crimes for law enforcement, an important difference must be highlighted. Section two of §7 formulates an exemption from the mandatory reporting of grievous bodily harm, in cases in which such an act would endanger the ability to provide care for victimized persons due to diminishing trust in the relationship. These cases must

instead be communicated to the *Child- and Victims Protection Groups in Hospitals*.

### 2.2.1 Child- and Victims Protection Groups in Hospitals

*Child- and Victims Protection Groups in Hospitals* are tasked with acting as support units for victims of DV and increasing the sensibility of health care professionals for the topic of domestic violence. Medical doctors may receive mandatory sensitivity training on the topic of DV as part of their specialization during the first years of practice. However, this is specific to certain hospitals and no formalized education on the topic of DV was identified for the health sector in Austria. As such, *Child- and Victims Protection Groups* are the central formalized institution in the medical sector response to DV. Internal to individual hospitals, groups focusing on child protection are required to consist of one doctor from the field of pediatrics or pediatric surgery, a representative of the nursing staff and a specialist from the field of psychological care or psychotherapy. Victims Protection groups must include two doctors (preferably from the fields of trauma surgery (Unfallchirugie) and gynecology or obstetrics), and as above, a representative of the nursing staff as well as a specialist from the field of psychological care or psychotherapy.

*Child- and Victims Protection Groups* fulfill the function of internal competence centers on the topic of DV, offering individual informal advice and supervision for colleges, as well as trainings for hospital staff. They are also expected to spearhead measures to increase the safety and security of employees within hospitals and assist colleges who themselves have become victims of violence. These units represent the medical sector in all cooperation with other actors in the networked response to DV and part-take in (or initiate) networking activities with these. As part of co-worker sensitization, they are tasked with improving internal case-documentation by advising others to include the documentation of acts of DV as part of the patient's health records and flagging these cases, to allow for the recognition of enduring violence and higher risk levels.

Non-formalized trajectories of a case through the networked response to DV often lead from *Child- and Victims Protection Groups* to organizations from the social sector. *Women's Shelters* and *Centers for Protection Against Violence* in particular count among the common referrals. Hospitals also frequently function as ad-hoc informal shelters for victims of DV. Particularly victimized persons who are not yet able or willing to verbalize their need of support, will instead request to be admitted to hospital for durations surpassing medical necessity. Informed health-care professionals sensitive to the topic of DV will often oblige, extending the duration of support and making hospitals the impromptu sites for intervention and aid usually provided by other actors in the network. This fact gains particular importance when taking into consideration the types of domestic violence considered by medical professionals.

The medical sector is charged with health care provision and the task of forensic documentation in cases of DV. This centers the sector's understanding of the phenomenon as encompassing mainly physical and sexual violence. Nevertheless, respondents from this sector exhibited high sensibility for two further types, not as strongly present in other sectors: Interviews revealed the health sectors acute awareness of neglect as a form of DV. Victims, particularly children or elderly

persons requiring some level of assistance or care, are most likely to enter the system of support through hospitals. Equally important, cases of psychological violence may enter the networked response through medical professionals more easily than other actor groups, as victims may approach healthcare providers with psychosomatic symptoms more readily than verbalize their victimization. Beyond medical doctors, nursing staff is the crucial actor in identifying victims of DV due to the proximity and intensity of contact.

The *Child- and Victims Protection Groups* are not homogeneously implemented across states and more likely to be found in large hospitals in regions with large population sizes. Though rollout is ongoing, many more rural areas are lacking these institutions (See: 3.1.2).

## 2.3 Social Sector

The social sector response to DV in Austria is divided amongst a broad range of non-governmental organizations. Though these receive public financing, they maintain a significant degree of autonomy while also sharing established and formalized ties to law enforcement and health sector.

### 2.3.1 Centers for Protection Against Violence / Domestic Abuse Intervention Centre Vienna

*Centers for Protection Against Violence* (Gewaltschutzzentren) share a formalized procedure with the Police and the *Victims-Protection* Unit (AB04) in law enforcement, meaning that every time a restraining order is issued, these cases must be referred to the NGO. Within forty-eight hours, social workers will attempt to contact victims in these cases and offer a range of support services. The duration of these services vary depending on the severity of the case, as well as the demand by victims. As such, these centers may accompany a case from anywhere between a few days and several years. Rooted in social work, tasks fulfilled by protection centers include assistance in most areas of everyday needs and assistance in (re-)gaining a state of well-being and autonomy. Chief among the tools at these center's disposal are counseling, *Legal* and *Psychosocial Trial Support*, as well as referral to other relevant actors such as Women's shelters, healthcare providers and law-enforcement.

While *Centers for the Protection Against Violence* include the provision of support for male victims of DV as well as violence in same-sex relationships, the majority of cases encountered are male perpetrated violence in heterosexual relationships. As such, the central understanding of DV is rooted in victim oriented intimate partner violence experienced by women. Compared to law enforcement, social workers at these centers are able to approach DV as a more complex phenomenon, including more intangible forms of violence and support or council victims for longer durations. Besides their qualifications as social workers, employees in *Centers for the Protection Against Violence* are allocated a yearly financial contingent and working hours for further education on DV and related topics.

Particularly notable, the specific experience of victims factors more strongly into risk perception, resulting in higher sensibility for cases, while at the same time introducing a bias in favor of the victimized. The formalized relationship of referrals in all cases

restraining orders are issued, also shapes the understanding of DV particular to these centers. Because the majority of persons receiving support by this actor group have entered the networked response by way of a restraining order, the underlying selection of cases of DV by law enforcement is informally transferred as well. It should be noted, however, that *Centers for the Protection Against Violence* have no formalized barriers to entry, though the number of persons seeking assistance independently of referrals is very small.

### 2.3.2 Women's Shelters

In the networked response to DV, Women's Shelters provide emergency accommodation to female victims. Women may be accompanied by their children, provided that these are also female or under fourteen years of age. While the duration of such emergency accommodation varies, support by these organizations can last for several months or even years. Social workers within shelters may have the closest and continuous contact with victims of DV. As such, a central task consists of ongoing counseling and as well as *psychosocial trial support*. A notable tool available to Women's Shelters in Austria is their ability to suspend the usually compulsory registration of accommodation for women in their care. This allows them to improve the level of protection for women seeking refuge, by reducing the paper trail leading such women in hiding.

The necessary gender based restrictions of support shelters are able to provide, shape the types of DV that are considered. Social workers at shelters formulated very expansive understandings of DV during interviews; including financial and symbolic violence, neglect, coercion, manipulation and other less visible forms of violence against women. Empirically, support in cases of gender related intimate partner violence concern male perpetrated violence against women, although support for female victims of DV in same-sex relationships is included as well. As with social workers employed in *Centers for Protection Against Violence*, employees of *Women's Shelters* are allocated yearly financial contingents and an average of ten working hours for further training on DV and related topics.

### 2.3.3 Child-Protection Centers

*Child-Protection Centers (Kinderschutzzentren)* provide similar services as *Centers for the Protection Against Violence,* focusing, however, on children and young adults. They are staffed with social workers, therapists and psychologists, and offer a range of services such as individual or family counseling, psychotherapy and other therapeutic services. These Centers typically share an expansive understanding of domestic violence rooted in social work, psychology and related fields, which includes a sensitivity for symptoms of violence other actors may not take into account. They represent notable entry points to the networked response to DV, as frequently schools or kindergartens may refer children or families to these centers upon noticing inconsistencies in a child's behavior.

### 2.3.4 Other Actors: NEUSTART & Men's Counselling Centres

The NGO NEUSTART has a monopoly position in Austria, tasked with supporting perpetrators during probation and managing mediations during diversion measures.

Diversion can take the form of *Victim Offender Mediation* and is an alternative judicial measure to other criminal proceedings. The employees of NEUSTART are mainly social workers with additional qualifications in related fields or other professionals from the juridical or therapeutic sector. They follow a victim-oriented approach when working with perpetrators. Similar to other social sector organizations, NEUSTART has a broad conception of the different for violence occurring within cases of DV, including coercion. Therefore, DV is defined as Intimate Partner Violence (IPV), beyond restraining orders and *Penal Law* provision.

In Vienna, NEUSTART has a cooperation agreement with the *Domestic Abuse Intervention Centre Vienna* (described in more detail in D2.4). In the event of a conviction for a DV related crime, the *Men's Counselling Centres* are in charge of implementing court mandated training to overcome violent behaviour. Perpetrators have to complete such trainings as diversionary measures or as part of their sentence. The organization's conception of DV is informed by Psychotherapy. However, in Vorarlberg, the *Men's Counselling Centre* has undergone a paradigm shift in their approach to counselling violent behaviour. Abandoning a perpetrator-centred therapeutic approach in favour of victim-centred one, the developments in this actor group have fundamentally changed to ease of cooperation with other social sector institutions.

## 2.4 Regional Administration and actors from the Judiciary

### 2.4.1 District administration – Security Administrator (Sicherheitsreferent)

Within the networked response to DV, the *Security Administrator* of the district administration is tasked with post-facto verification of all restraining orders issued by law enforcement. If the decision to issue such an order is seen to not fulfil the condition of proportionality, the *Security Administrator* is able to order a withdrawal of the restraining order (See 3.1.1). *Security Administrators* also produce reports on cases of DV, intended to inform prosecution. Similar to non-specialized law enforcement, the definition of DV held by this actor group is mainly informed by *Penal Law* and the *Police Security Act*. In some cases, non-mandatory sensitivity training was mentioned by respondents.

### 2.4.2 District administration – Child and Youth Welfare (Kinder- und Jugendhilfe)

The responsibility for under age victims of DV lies with *Child and Youth Welfare*. Their employees are mainly social workers. Mandatory referral of cases by Police follows every time a restraining order is issued and a child is present. Moreover, organizations from the social and the health sectors must inform *Child and Youth Welfare* in case of children's endangerment. Consequently, the definition of DV is always related to families in which children live. Their internal documentation system allows the distinction between violent acts and sexual abuse. Similar to other organizations of the social sector, employees of *Child and Youth Welfare* have possibilities to attend training courses. These courses may cover DV, though this was not mentioned as their main focus.

### 2.4.3 Judiciary

#### Legal Trial Support/Lawyers

Complementary to the *Psychosocial Trial Support*, the institution of the *Legal Trial Support* is available to victims pursuant to § 66 StPO (Criminal Procedural Law). It serves to enforce the rights of a victim in criminal proceedings and is useful and necessary when particular circumstances threaten the victim's rights to be upheld. If the victim has suffered pain or damage as a result of the offence, the lawyer may seek compensation for damages. Legal trial support is predominantly provided and organised by social sector organisations in cooperation with an established network of lawyers.

#### Courts

The most relevant courts in the context of DV are Family Courts, Guardianship Courts, and District Courts. Within the organisational structure of the court system, no specific roles or departments have been implemented for dealing specifically with cases of domestic violence. Victim's rights support is only institutionalised via the (psycho-social and legal) trial support system. Beyond this, ensuring victim's needs and rights within the conduct of the trial, falls within the discretion of the judge. Apart from criminal trials, the main tasks of district courts are comprised of confirming preliminary injunctions.

#### Criminal courts

Apart from regular criminal trials, resulting in acquittal or sentencing, alternative measures such as Victim-Offender Mediation are available to resolve cases of domestic violence. In addition to punitive measures, the court may order Perpetrator Counselling. However, while these measures can be applied in cases of domestic violence, they are not exclusively available or specific to them.

#### Public prosecution

Cases of domestic violence are not dealt with differently from other criminal proceedings by the office of the prosecution. As with other criminal prosecutions, the main task consists of directing the law enforcement agency in the collection of evidence and interrogations, before deciding on whether to file charges against a suspect.

#### 3 Steps of a DV-Case

Three main actor groups function as entry points to the networked response to DV in Austria. Actions taken by the social environs of parties involved are the fourth relevant entry point. Such persons may alert authorities to a case of DV or refer those involved to one of the other relevant institutions. However important this final entry point may be, it follows no formalized procedures or organizational structure and must therefore remain mentioned, but not described.

A central particularity of the networked response to DV in Austria lies in law enforcements obligation to prosecute ex-officio crimes. If not specified differently, offences pursuant to Penal Law are recognised as ex officio crimes. Authorities must prosecute these whenever they receive notice of them, whether reported or not. An ex officio crime can be reported by anyone, victims or witnesses, and cannot be retracted.

Exceptions to this are so-called “offences with private prosecution” (Privatanklagedelikt), which are only prosecuted upon the request of the injured party; as well as “authorizing offenses” (Ermächtigungsdelikt), which are punishable offences in Austria that are prosecuted only if the person concerned approves. All offenses, which are not expressly determined differently in the respective law, are ex officio crimes according to § 2 StPO (Criminal Procedural Law) and reverse conclusion of § 71 StPO. Thus, the ex officio crime is the normal form of prosecution in Austria.

Offences most commonly occurring in the context of (high impact) domestic violence, such as physical violence (homicide, bodily injury), psychological violence (dangerous threats, coercion, stalking), as well as sexual violence (rape, molestation) are ex-officio crimes. In this regard, LEA do not require authorization by the victim in order to prosecute such offences. In this context, measures taken to increase the likelihood of victims filing a criminal complaint play a diminished role in Austria compared to other countries. While not necessary in the context of criminal complaints, measures to increase awareness and lower the threshold to accessing law enforcement are nevertheless beneficial.

### 3.1 Entry Points to the networked response to DV

#### 3.1.1 Law Enforcement as an entry point:

The first primary entry point to the networked response to DV is law enforcement. Persons involved in a domestic dispute, or members of their social environs (friends, family, or neighbours), may alert law enforcement to an on-going domestic dispute or act of violence. In this scenario, officers intervene during a moment of peak conflict, an important factor when considering officer’s impressions of the situation and their subsequent actions, as well as any existing attempts and future plans to implement on-site risk-assessment tools. In some cases, law enforcement will be alerted to cases of DV post-facto, when parties involved, or from the social environs, approach officers in police stations at a later time. The relevant difference between these cases, is that officers responding in the field have no special training for dealing with DV, while entry points at police stations increase the possibility of first contact being with persons who have such additional qualifications. In both cases however, the major defining factor for steps that follow an intervention is an officer’s decision to file criminal charges or issue a restraining order. If neither applies, the case threatens to fall out of the actor network. Case-documentation in instances where no further police action is taken, should be considered as lacking, at least due to the fact that future occurrences are not easily linked to previous cases and no formalized procedures exist to record relevant information or indicators tailored to DV. A measure employed by law enforcement in the past (*Streitschlichtung* – Conflict Resolution) has fallen out of use since the last reform of the *Police Security Act*

(SPG), causing previously recorded cases of interventions (where no charges were pressed) to fall out of the statistics all together. If a restraining order is issued however, formalized processes come into effect, directing a case of DV through a number of organizations within the support network.

Restraining orders and criminal charges correlate strongly, and both can be issued at the scene of a conflict, as well as post-facto within a reasonable timeframe. If a restraining order is issued, the aggressor is required to relinquish his keys and forbidden to enter the premises of the victimized party under any circumstances for the duration of two weeks. This holds true, even upon the invitation to return by victimized person(s). Not upholding this ban has legal consequences for the aggressor, or upon invitation, for both parties.

In Austria, the decision to issue a restraining order lies within the purview of police officers present at the scene, this measure being included under administrative law and not requiring a judicial mandate or approval in advance. Restraining orders are subject to post-facto verification by district administration, although, by their own account, decisions made by officers at the scene are verified in the overwhelming majority of cases. The first of two notable aspects of an officer's purview to issue a restraining order, is that a condition for this decision lies in the officers assumption that *a dangerous attack on the life, health or freedom of a person is immanent*[1] (SPG 1991 §38a). As such, restraining orders can be issued without judicial mandate or approval and based on actions and offences that have not yet occurred. Several respondents from law enforcement emphasized their reliance on 'gut-feeling' and experience when making this decision – a narrative departure from the usually strong orientation around Penal Law. While the ability to issue a restraining order at the scene can be an immediate and powerful tool in the response to DV, it is also a very far-reaching and fundamental intervention based on a prognosis of future events. A number of officers addressed the implications of the scope and impact of this measure, both as a necessary and functional tool, as well as one whose use is accompanied by a great deal of experienced pressure. The second notable aspect of this purview, is that the act of issuing restraining orders is one of the few actions an officer undertakes, which presents as a judicial rather than law *enforcement* act – an aspect that clearly played into the pressures experienced by our respondents. It is relevant to highlight these factors relating to these pressures, as, in combination with the disproportionate quantities of case and procedural documentation accompanying such an act, these factors may inadvertently influence an officer's decision to issue a restraining order. No empirical claims can however be made to this effect, while relying solely on the qualitative interviews conducted.

When a restraining order is issued, the mandatory immediate communication of these cases to three actor groups follows. Firstly, all restraining orders are verified by district administration. Within administration, the responsible actor on district level for DV is the *Security Administrator* (Sicherheitsreferent). He or she is tasked with

[1] SPG 1991 §38a "Wegweisung und Betretungsverbot sind gleichermaßen an die Voraussetzung geknüpft, dass auf Grund bestimmter Tatsachen (Vorfälle) anzunehmen ist, ein gefährlicher Angriff auf Leben, Gesundheit oder Freiheit einer gefährdeten Person stehe bevor. Welche Tatsachen als solche im Sinne des § 38a SPG in Frage kommen, sagt das Gesetz nicht (ausdrücklich).[…]"

assessing the proportionality of the restraining order as a measure employed in each individual case (in the overwhelming majority of cases, restraining orders are upheld). In some cases, restraining orders can be extended beyond the timeframe of two weeks, involving the case being passed on to prosecution and the subsequent implementation of a preliminary injunction in court.

Secondly, every restraining order within a state is passed on internally to the *Victims Protection Unit (AB04)* within Law Enforcement. *Victims Protection* reviews all cases involving restraining orders and conducts a preliminary non-formalized risk-assessment. Though relevant indicators are informed by existing assessment mythologies, no specific single tool is used. Depending on the risk level perceived, cases are assigned back to non-specialized officers (low risk), adopted by the *Victims Protection Unit* (medium risk), or passed upwards to the national *Victims at Highest Risk (VHR) unit* (high risk). Corresponding to the risk level, actor groups at higher levels have a greater number and more far-reaching protection and support measures at their disposal (See 2.1).

Thirdly, all cases in which restraining orders were issued are imparted to the *Centers for Protection against Violence* at state level. Here, victims receive counselling, *Judicial and Psychosocial Trial Support* amongst other services (see Section 2.3). In the case of *Legal Trial Support* this includes the referral to external lawyers or law professionals, though costs for these services are covered by the budgets of the *Centers for Protection Against Violence*.

A highly relevant formalized deviation from this sequence of steps occurs when children are involved in a case of DV. In these cases, responsibility is transferred to the department for *Child and Youth Welfare* (Kinder- und Jugendhilfe) within district administration, who have different, and often more far-reaching measures at their disposal (see Section 2.4). In high-risk cases, *Child and Youth Welfare* may assume custody of a child.

**Non-Formalized Trajectories**

A number of actors are frequently mentioned by law enforcement as highly relevant partners in the networked response to a case of DV, whose cooperation is not however governed by mandatory provisions. A frequent step a single case will take, which entered the network through law-enforcement, is the referral to the medical sector. This will occur even when victims of violent acts do not require medical attention, as the health sector is tasked with securing forensic evidence in cases of DV. The process of securing such evidence is highly formalized, and is conducted by medical staff with additional sensitivity training for cases of DV. Evidence will be stored on location and in compliance with GDPR for the duration of six months. If no criminal charges are filed in this timeframe, evidence is destroyed.

Of equal importance, some persons affected by DV are referred to Women's Shelters. Aside from offering emergency accommodation, services provided by these shelters are very similar to those offered by *Centres for Protection Against Violence*. As such, women accommodated at shelters will often have less contact with *Protection Centres* than would otherwise be the case. A further notable difference is that victims seeking refuge in women's shelters will sometimes be referred to such

locations in other States, in order to provide better security. This can be done officially and with public knowledge, for example when shelters in one location are at capacity. The central relevance of this fact lies in the accompanying transferal of judicial and procedural responsibility between all other actor groups from one state to the next. This can also however be done without the accompanying public records and administrative transferal, to further increase security of victims. This is frequently a point of contention between shelters and the judicial system, as the transferal of responsibility in the interest of courts, lawyers and prosecutors stands in opposition to the increased safety and security of the victims. Social workers from shelters were vocal in their complaints about courts undermining their efforts to increase security by transferring cases to courts in other states. As such transfers are a matter of public record, it threatens to disclose the location of such women seeking shelter.

### 3.1.2 Health Sector as an entry point

The health sector differs significantly as an entry point to the networked response to DV, due to the fact that a majority of the cases entering the system at this point do so after with a greater delay between the act of violence and the moment of intervention. At the same time, persons seeking medical attention after an act of violence, may not be prepared to, or feel able to accept any other forms of support or attention. While deciding to involve law enforcement often entails the demand for direct intervention, seeking medical attention may not. These dual dimensions of cases entering the support network through hospitals, for example, require a different, if not greater, form of sensitivity for the phenomenon of DV. If persons seeking medical attention are able to, and choose to, openly state that they have been victimized through an act of domestic violence, medical staff will generally suggest the involvement of law enforcement. Cases where this suggestion is taken up will subsequently follow the steps outlined in the previous section.

Recognizing the need for increased sensitivity for DV among health-care professionals in particular, a law was passed to implement *Child- and Victims Protection Groups* in 2011. Interviews with active members of these groups evoked the impression that roll out has experience varying levels of success in different hospitals and regions. While bigger hospitals, particularly in the larger cities, have already implemented such groups, smaller hospitals seem to still be struggling. Considering the significant need for heightened sensitivity on the topic of DV in the context of health-care provision (See 2.2.1), further resources, guidance and assistance in this area promise to have significant positive impacts on the networked response to DV.

Hospitals with active *Child- and Victims Protection Groups* tend to develop a number of non-formalized trajectories cases of DV regularly take. While §7(1) of the *Health Care Act* (GuKG – Gesundheits- und Krankenpflegegesetz) stipulates the mandatory reporting of injury or death of patients as a cause of criminal offences without needing a victims consent, §7(2) exempts medical staff from this obligation in cases where the such an act would endanger the possibility to provide effective medical assistance, due to a loss of trust between patient and medical professionals (See 2.2.1). This provision formalizes the possibility of a case's departure from the trajectory typically initiated trough law enforcement involvement. To preserve a trusting relationship, medical staff may choose not to report a case of DV against the

victim's will, but rather refer such patients to social sector organizations such as *Women's Shelters*, *Centers for Protection Against Violence* or similar NGOs. Frequently, members of the *Child- and Victims Protection Groups,* as internal experts on DV, will provide the support usually fulfilled by external organizations. Based on the trust established between patients and medical staff in the early stages of contact, these relationships will often follow an ad-hoc, flexible structure unique to the requirements of each specific case. The duration of these relationships naturally coincides with a patients stay at the hospital. A notable exception previously described in section 2.2.1, is the intentional admission or extension of a patients stay beyond the point of medical necessity. In these cases the medical sector acts as an impromptu shelter. Several dimensions of these cases are notable. One the one hand, many of the restrictions Women's Shelters necessarily face, do not apply for victims seeking shelter in the medical sector. The gender and age of a victim do not represent barriers for their admission. Particularly elderly and under-age victims of DV tend to seek shelter at hospitals this way, rather than at Women's Shelters. Equally, victims of neglect as a form of DV, most frequently find support this way. On the other hand, the medical sector is not equipped, staffed or intended to fulfil this function. Every such case represents an exception, and the duration of stay is seriously limited when compared to shelters in the social sector. Furthermore, the medical sector introduces its own barriers to entry. Such assistance can only be easily accessed by persons with health insurance, and requires a medical staff that has been sensitized to a level in which they are able perform a departure form their habitualized heuristic of medical health, in favour of the broader heuristic needed to identify and deal with the phenomenon of domestic violence.

### 3.1.3 Social Sector as an entry point

A number of social sector organizations occasionally represent entry points to the networked response to DV. Particularly *Women's Shelters* or *Centers for Protection against Violence* reported a small proportion of cases, which were not referred by law enforcement or health sector. An important annotation to this fact is that these cases usually occur when victims of DV have received support from these social sector organizations in the past. Many of these persons may choose to forego the involvement of law enforcement and directly seek the services and support they require from the relevant NGOs. This may also be due to the fact that, despite existing efforts within law enforcement, the interaction with the social sector in general, is experienced as more congenial and welcoming than law enforcement is, or perhaps can be. Social sector services are much more adapted to victims needs than those of law enforcement. These organizations tend to foster this standing, seldom formulating strong critiques of a victims return to an abusive partner, but choosing instead to leave the proverbial door open, thus providing an entry point to the networked response.

This attitude is reflected in the number of formalized and non-formalized trajectories cases may take when originating in the social sector. As a rule, social sector organizations will not prioritize law-enforcement involvement over the will of a victim. The only exceptions are cases in which the acute endangerment of a victim or third party is evident, in which case police must be notified. In all other cases social sector actors may counsel persons to notify law-enforcement or secure forensic evidence at a hospital, but ultimately prioritize a victim's choice. More common trajectories lead

between different organizations within the social sector. The close relationship between *Shelters* and *Centres for Protection* for example, facilitates the ease of referral between the two. This holds true for most organizations included in our interviews.

## 3.2 Further important findings

### 3.2.1 The role of state borders

As portrayed in the previous sections, the networked response to DV in Austria follows rather homogenous organizational und procedural structures across all states. Particularly the list of actors, as well as their formalized and non-formalized relationships, tends to follow the same national framework. Though this is the case, state borders play an important role and pose a significant challenge to the effective response to some cases of DV. The root of this challenge lies in the regional concentration of competencies and information sharing.

Actors involved in the networked response, focus the majority of cooperation and networking activities on state level. Social sector organizations frequently communicate with other organization from the sector, only within their particular region. Cooperation between medical-, social sector and law enforcement is strongest within state borders. This is influenced mainly by the shared boundaries to their jurisdiction, the demarcation of financial and accountability structures by provincial and national government, and not least by the simple fact of geographic proximity and the personal relationships of front line responders that accompany this. A frequent critical narrative offered by respondents reflects this fact: The ability to respond to a case of DV is severely diminished once the involved parties cross state borders. As soon as they do, a whole new group of actors gains jurisdiction over, and responsibility for the case. At the same time, these new actors usually have little or no knowledge on existing conflicts or on-going violence. Phrasing by several respondents implied that an aggressor in a violent relationship need only move across state borders to obscure a previously known case of domestic abuse. While actors on national level have insight into cases across state borders, this challenge predominantly effects ground-level front line responders on state level. This problem is amplified by challenges in information sharing and with GDPR described below.

### 3.2.2 Challenges in information sharing, case documentation and with GDPR

Though the challenges with case documentation will be described in more detail in deliverable D2.3, it is worth mentioning a few key challenges in this context. Generally case documentation may be wanting in at least one of two dimensions. The first of these could be classified as challenges with isolation of case-documentation. Many actor groups rightfully keep all case documentation internal to their organizations, as these include extremely sensitive information about persons involved. When these policies are not only reinforced, but formalized by GDPR however, the isolation of information on a case may become a barrier to effective interventions. The central examples for this are the hindrances to communication between social sector organizations, as well as the termination of law enforcement participation in MARACs in Vienna. When put into context of state barriers, these challenges are increased. Law enforcement, for example, hast insight into criminal

records and internal case documentation for all cases at state level. If parties in abusive relationships move across state borders however, this information is lost to ground-level law enforcement officers now responsible. A notable exception to this is the VHR unit. Operating with special purview on national level, they are more easily able to access information from all states. Other police units are also able to request such information, though this requires individual officers heightened commitment.

### 3.2.3 Restraining orders as the linchpin of the networked response to DV

As may have become obvious in the description of all formalized trajectories through the networked response to DV in Austria, the restraining order as a measure initiated by law enforcement acts as a major entry point and sometimes even as a condition for much support offered to victims of domestic abuse. Accessing support by the VHR unit, for example, requires an active criminal investigation prior to their involvement. Though not necessary on paper, empirically almost all cases where criminal charges are filed and/or criminal investigation is initiated will also include restraining orders. The formalized involvement of *Centers for the Protection Against Violence,* as well as the *Victims-Protection Unit* within police, only comes into effect once a restraining order has been issued. This point becomes particularly important when considering the highly unique status of this measure for law enforcement officers intended to employ it. As mentioned before, restraining orders are one of the few tasks law enforcement officers are expected to fulfil in which judiciary functions are allocated to them. This, combined with the severity of the intervention, makes restraining orders one of the more contested measures available to law enforcement. At the same time, it has displaced less invasive measures such as *dispute resolution (Streitschlichtung)*. The overall effect is, that one of the main conditions to ensure the timely and adequate formalized response to DV is tied to one of the most complex and ambivalent measures regularly employed. Moreover, it is a measure implemented regardless of a victim's judgment or wishes. Lastly, a restraining order is a legal safeguard, which does little however, to offer protection from an aggressor who may (temporarily) not be concerned with penal consequences.

## 4 Respect of international standards on service provision (SP) by the police and other FLR

### 4.1 Standards for all SPs

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Y | Help line exists available 24 hours, however it is not specific to DV. |
| There should be one specialist violence against women counselling service in every regional city. | Y | |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | Y | However, barriers still exist, especially regarding outreach activities and translation services. |
| There should be a sufficient number of shelters available to victims of DV. | N | Some regions face difficulties regarding space for accommodation, and shelters tend to be at maximum capacity.<br>In some regions policies have been enacted to increase the number of shelters, due to a lack of availability. |
| Service user has a right to be treated with respect | Y | |

| | | |
|---|---|---|
| and dignity at all<br>Times. Face-to-face contact should be within a safe, clean, and comfortable environment. | | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. … | Y | |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | N | LEA does not necessarily adopt a culture of belief, while however aiming to maintain respectful conduct. |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons. Related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | Y | Some legal provisions pose challenges to services' ability to uphold the safety and security of all parties involved (e.g. children of age not having access to women's shelters) |
| Services should be equitably distributed across geographic areas and population densities. | N | Some rural areas remain underprovided. |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Y | |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Y | |
| Services should be provided free of charge. | Y | |
| Service providers should be mindful of the needs of children of service users. | Y | |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | Y | An exception is the medical sector, which is in the beginning stages of DV sensitivity roll out. |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | Y | Coverage of female police officers is a committed policy, however due to staff restrictions and shift work not always available. |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | Y | |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Y | |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Y | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service user's decision whether to make an official report to the police. | Y | |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | Y | |
| National and local governments should have | Y | |

| | | |
|---|---|---|
| funding streams for violence against women services. | | |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Y | |
| Services should develop guidelines for multi-agency co-operation. | Y | High regional variability exists with respect to the level of institutionalisation of multi-agency cooperation. Missing a multi-agency format, guidelines are mostly informal and result out of individual commitment. |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | Y/N | Certain SPs publish annual reports with detailed statistics, others maintain internal case documentation of varying detail. |
| There should be clear protocols in place for data collection and information sharing between organisations. | Y | This is a point of critique for many SPs as GDPR (together with official secrecy) tends to limit possibility for cooperation. |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | Y | However, early stage roll out resulting in uneven coverage. |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | Y | |

## 4.2 Standards for the police

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | Y | |
| Police personnel should be trained on all aspects of DV. | N | |
| DV offences should be treated at least as seriously as other violent offences. | N | DV as a wider phenomenon is generally treated as seriously as other violent offences when visible physical violence has occurred. |
| Victims should be seen as soon as possible by a specially trained officer | N | Specially trained officers exist in each district; however staff restrictions and movement result in high variability of available expertise. |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | N | Specialised DV officers are only available on district level; and for high-risk victims on national level (VHR). |
| Specialist Police units should be created in densely populated areas | N | Specialist units only exist for protection against violence in general, not specific to DV. |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | N | No, as in Austria certain crimes do not require the consent of the victim and law enforcement has an obligation to prosecute (ex-officio crimes; Offizialdelikt). |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | Y | |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | Y | |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Y | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | Y | However, as DV is covered by Penal Law as well as the Police Security Act (SPG), uncertainties often emerge concerning the presence of support persons. Victims' have the right to support persons only within the mandate of the SPG; within the Penal Law provisions this is not the case. Thus, variance relates to officer discretion for which regulation is applied. |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | N | Not systematically available with all cases. Only restraining orders can be identified. |
| Police should have protocols on information sharing on DV with other agencies | Y | |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | N | |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained and reports made are kept confidential | N | |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | Y | |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | N | |
| Police should develop and implement strategies to eliminate or reduce victim risks | N | Police refer to social sector. |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents | N | Most frequently, this relates to officer discretion and staff restrictions concerning the availability of specially trained officers. |

| | | |
|---|---|---|
| secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | | |

## Appendix: Glossary of Translations (Austria)

| German | English |
|---|---|
| AB04 | Section 04 |
| Anti-Gewalt Training | Court mandated training to overcome violent behaviour |
| Bezirkshauptmannschaft | District Administration |
| Bezirkshauptmannschaft | District administration or magistrate |
| Einstweilige Verfügung | Preliminary Injunction |
| Ermächtigungsdelikt | Authorizing offences |
| Fall Konferenz | Case Conference |
| Falldokumentation | Case-Documentation |
| Frauenhaus | Women's Shelter |
| Gefährliche Drohung | Treats of Violence |
| Gewaltschutzzentren | Centres for Protection Against Violence |
| GuKG – Gesundheits- und Krankenpflegegesetz | Health Care Act |
| Kinder und Jugendhilfe | Child and youth welfare |
| Kinder- und Opferschutzgruppen im KH | Child- and Victims Protection Groups |
| Kriminalprävention | Crime Prevention |
| Landeskriminalamt | State Bureau for Criminal Investigation |
| Nötigung | Coercion |
| Offizialdelikt | Ex-officio Crime |
| Opferschutz | Victims' Protection |
| Pflegekraft | Care-staff |
| Physische Gewalt | Physical violence |
| Polizei | Police |
| Präventionsbeamte | Prevention Specialists |
| Privatanklagedelikt | Offences with private prosecution |
| Prozessbegleitung | Legal Trial Support |
| Psychosoziale Prozessbegleitung | Psychosocial Trial Support |
| Sachbeschädigung | Damages (made) to property |
| Schwere Körperverletzung | Grievous bodily harm |
| Sicherheitspolizeigesetzt | Police Security Act |
| Sicherheitsreferent | Security Administrator |
| Strafprozessordnung | Criminal Procedural Law |
| Strafrecht | Penal Law |
| Streitschlichtung | Dispute resolution |
| Verhältnismäßigkeit | Proportionality |

## II. FINLAND

Altogether 25 interviews have been conducted by POLAMK. Of these interviews 11 were carried out in case location 1 and 15 in case location 2. One of the interviews was conducted in the co-operation of POLAMK and THL. 19 of the interviewees were police officers. 4 senior constables, 4 sergeants and 1 chief inspector were from the response operations. 6 detective senior constables, 2 detective sergeants, 1 detective chief inspector and 1 detective superintendent were from the investigative sector. From the multi-agency teams of police POLAMK interviewed 1 social worker, 1 senior social worker and 2 psychiatric nurses. In addition, 2 of the interviewees were NGO workers.

In case location 2 POLAMK interviewed 2 senior constables, 2 sergeant, 2 detective senior constables, 2 detective sergeants, 1 detective chief inspector, 1 social worker, 1 senior social worker and 1 psychiatric nurse.

In addition to POLAMK's interviews, THL interviewed four shelter workers, one doctor, one nurse, two social workers, one psychiatric nurse and one paramedic. In Case location 1 these interviews consisted of two shelter workers, one social worker and one psychiatric nurse from the Anchor team. In Case location 2 THL interviewed a doctor, a nurse at accidents and emergency, one paramedic, one social worker at Emergency services social work, and two shelter workers. The THL conducted 9 interviews (excluding the psychiatric nurses that who was interview together with POLAMK).

### Case location 1

### 1. Methodology

Case location 1 is a city and municipality of about 68 000 inhabitants. Most of the people speak Finnish as their native language; foreign-language speakers are only about 5 % of the inhabitants. Case location 1 provides an interesting environment for the study since it consists of one small city and a wide surrounding rural area. According to statistics, 72 crime reports classified as domestic violence were registered in case location 1 during the year 2018.

The population in case location 2 is heterogeneous. 15 % of the about 650 000 inhabitants are immigrants or their descents. Case location 2 also provides a wide range of services and actors working with the victims and perpetrators of DV. According to statistics, 1315 crime reports classified as domestic violence were registered in case location 2 during the year 2018.

An introduction letter was sent to the superintendents and chief inspectors of two police departments (the case locations of the study) in March 2019. In the letter we explained the purpose of the study and kindly asked the supervisors to motivate the police officers to participate in the study. The voluntary police officers and multi-agency team members contacted the researcher of POLAMK who sent more detailed letters to the participants. The researcher of POLAMK contacted workers of two non-governmental organizations (Victim Support Finland and an association that works

against honor related violence). The NGO workers expressed their motivation to participate. Getting an access was very easy. No challenges were faced.

In social- and health care sectors it was easy to find interviewees from shelters and social work, but we had problems having health care professionals for interviews. An introduction letter and request to point professionals for interviews was sent in social and health care sector for the head of the units.

The average length of the interviews was 2 hours. The longest interview took 3 hours 30 minutes. The shortest interview took 1 hour 10 minutes due the shortened schedule by the interviewee. The interviews were recorded.

All the voluntary participants who contacted the researcher were interviewed. The number of interviewees was satisfying and there was no need to find more participants. Only one person withdrew from the interview due the workload.

## 2. Overview

**Which actors are involved in the handling of domestic violence?**
Most often uniformed police officers of response operations units (senior constables and sergeants) are the first officers involved handling of domestic violence and filing a report of it. A crime can also be reported personally by a victim or some other individual visiting the police station, by phone or in case of some minor crimes that do not require immediate police action, it can be made with an online form.

After a crime has been reported, the police carry out a preliminary investigation. Detective senior constables and detective sergeants question the victim of a crime, the suspect and witnesses. They also collect evidence such as doctor's statements, photos, and carry out technical investigations. Detective sergeants supervise the daily work. Detective chief inspectors and detective superintendents and manage investigation units and decide about the use of coercive measures.

Multi-agency teams ("Anchor teams") work in several police departments in Finland. Anchor teams consist of police officers, a social worker and a psychiatric nurse. The team's involvement in handling of domestic violence depends on the particular police station.

Paramedics, nurses and doctors working in emergency room (ER), shelter professionals, social- and crisis services (including acute child welfare and protection) are involved in the social- and health care sector handling of frontline DV cases. In case location 1 rape cases are taken care in emergency room and municipal health center. In case location 2, sexual violence cases are handled in Sexual Assault Support Center if rape has happened in the last 30 days, which means that older cases are not treated there.

**What do they do? What is the nature of their involvement?**

***The work of senior constables and sergeants in the response operations unit***

Uniformed police officers working in the response operations units are responsible for maintaining public order and security by patrolling, handling emergency tasks given by Emergency Response Centre, providing advice and guidance, and preventing unlawful activity.

In a domestic violence case the basic procedure is as follows: to interrupt the unlawful activity, calm down the situation, question the parties in different rooms, take pictures of injuries, inform the child welfare protection if there are children in the family, apprehend the suspect on the basis of Police Act or Coercive Measures Act depending the seriousness of the crime or the risk for another conflict and to file a report.

***The work of detective senior constables and detective sergeants in the investigation unit***

After a crime has been reported, the police carry out a preliminary investigation. Due to police resource shortages, the preliminary investigation may sometimes take months. During the preliminary investigation, the police investigate what has happened and what damages have occurred to the victims of crime. Detective senior constables and detective sergeants question the victim of crime, the suspect and witnesses. They also collect evidence such as doctor's statements, photos, and carry out technical investigations. They arrange translators if needed.

With the victim's consent the police can provide Victim Support Finland with a crime victim’s personal data. The police can also provide information on other forms of support offered to crime victims and on other organizations offer assistance.

The record of the pre-trial investigation is prepared after the investigation is closed. The record will include the official interview records and collected evidence. The record of the pre-trial investigation will be submitted to the prosecutor for consideration of charges or for issuing a fine. Alternatively, the police may close a pre-trial investigation without submitting the case to the public prosecutor, if the investigation shows no offence has been committed.

***The work of Anchor teams***

The Anchor (‘Ankkuri’) model is geared towards early intervention in juvenile delinquency and intimate partner violence, as well as preventive work within these areas. The model is based on multi-agency cooperation between different public authorities. The model is also used to prevent domestic and intimate partner violence by intervening in incidents at the earliest possible stage and by referring the parties involved to relevant help services. The model is also used in preventing extremism and violent radicalization.

The Anchor model is based on multi-agency cooperation, which involves different public authorities working together at police stations. An Anchor team of case

location 1 is made up of a police officer, 2 social workers, a social adviser, a youth worker and a psychiatric nurse. All other persons except for the police officer are municipal employees. They cooperate closely as a team, each bringing to the team their own professional competence and the support and expertise of their own background organization.

Multidisciplinary cooperation makes it possible for professionals to relate to clients in a holistic manner and the client to receive services based on a 'one-stop shop' principle. While the police officer from the investigation unit investigates the crime, the Anchor team's health care and social work professionals look into the overall circumstances of the client and his/her family. The Anchor team's social workers and the nurse assess the needs of the client and refer the client to further services. The benefits of this holistic approach and multi-agency co-operation are evident in challenging situations where the client suffers from multiple problems like domestic violence, substance addiction, mental disorder, or unemployment.

***The work of the shelters***

Victims of DV get support, guidance and counselling from professionals at the shelter as well as assistance and information for dealing with practical arrangements. Shelter has staff available 24 hours a day and victims can go there either on their own initiative or on referral. Shelters try to make sure that victim can get long-time support if needed and victim is willing to receive support. The aid is provided by municipalities or NGO's. The shelter is meant to be a short-term refuge during a crisis but length of stay is always individual. On average one client spent 16 days in a shelter.

**What types of domestic violence are considered?**

Uniformed police officers deal almost solely with physical violence and assaults (illegal threatening) of all forms of violence in close relationships. Mental, economic, sexual, religious or cultural violence is not on the focus of their work. These issues were thought to be investigated during the later phases of preliminary investigation by criminal investigators. One patrol officer told us that he feels that the mental violence that women exercise may cause more severe damage to the victim than the physical violence exercised by men. Uniformed police officers did not consider essential to solve psychological violence during the house calls, because it is hard to prove. The resources of a single police patrol are not sufficient to investigate this type of violence during an acute house call situation.

The violence that the criminal investigators encounter in their work is much more multifaceted. Detectives' work covers physical, psychological, economic, and sexual violence in addition to other forms of violence such as assaults (illegal threats), harassment, extortion, and malicious damage.

In the work of the police officer of the Anchor team violence in close relationship is similar to what the investigators encounter in their work. The emphasis of the Anchor team is in the guidance of the victim and the perpetrator to the services they need, and not so much the types of crime.

**Do involved actors have different conceptions of DV, and which?**

The interviews with the uniformed police officers produced more a less similar type of conception of DV. Most often violence is related to alcohol abuse. Typically interviewees boiled down the description of violence to physical violence that occurs between two equal adults. One interviewee believed that a victim who has good social standing can easily be persuaded to leave a violent relationship by offering her advice.
In sparsely populated areas the mutual dependence between the partners was sometimes recognized as a problem that could raise a threshold to seek for help or leave an abusive relationship. Interviewees did not see the police intervention as a remedial measure but a compulsory action required by the law, which could, however, cause further problems to the family as the fine for a assault and battery is paid from the family's common funds. It is noteworthy that the uniformed police officers did not have knowledge about the services offered to a victim and a suspect by the investigative police officers or the members of the Anchor team.

If the officers have found out in the house call that a partner has "in anger slightly smacked" the victim and victim does not want the police to record a crime, it is possible the crime is not reported. Instead, the patrol officer may try to discuss with the victim and the perpetrator and offer them advice. Although the intention is well-meaning, the patrol officer did not understand that the consequence of this procedure leave the family outside professional help as the crime is reported forward to investigation.

Uniformed police officers were very frustrated on violence in close relationship especially when the parties were under the influence of alcohol, or when the emergency call was considered as a means to impinge on other party's life, a dispute about the custody of children, or just a wish to outdo the other party in a quarrel by calling the police.

Interestingly, one of the uniformed police officer's had substantially deep and diverse conceptions of violence in close relationships. The police in question was interested in the phenomenon and told in the end of the interview that he had to spend his childhood in the middle of domestic violence.

Crime investigators had significantly more diverse and thorough knowledge of violence in close relationships than uniformed police officers. The interviewed detected understood the importance of sensitivity when meeting the victim, the influence of traumatization and why the victim has difficulties to depart from the violent relationship. The investigators might contact the victim after an interrogation and ask about the victim's condition. They could also advise the victim to seek health care after hearing that victim's psychological well-being had deteriorated. An interesting observation was that also one interviewed crime investigator, who was highly motivated to help the victims of domestic violence and improve the services from the victim's perspective, had experienced violence when young.

The members of the Anchor team had similar ideas of domestic violence as crime investigators. Anchor team workers understood the importance of multi-professional assistance in cutting off violent life circumstance the victim and the perpetrator. The

interviewees of the Anchor team also brought forward an alternative approach that highlights the interests of the family and the importance of work processes that are tailored to the whole family so that the already stressed family members won't get into overloaded psychological pressure.

Social workers and health care staff considered violence being trans-generational. Both victims and perpetrators have been experiencing and/or witnessing violence in their childhood by their parents or other relatives.

**Describe the education/training on DV that different actors have or have access to.**

Uniformed police officers had not received much training on the topic. The basic training includes a separate home call scenario, but they did not get any education on the impact of violence on the victim or other persons being exposed on violence. Most patrol officers had a narrow conception of violence in close relationships. Nevertheless, most interviewees did not feel in need of further education and training in violence in close relationships. Only, the one patrol officer who had experienced domestic violence as a child was interested in the phenomenon and eager to receive more information about it.

One crime investigator, who also investigates crimes against children, had participated a year-longs training on hearing and interviewing children, and also participated in other trainings in violence in close relationships provided by the non-police partners of the Anchor team. Until recently, Finnish police could provide only one course - "Child in the preliminary investigation" - that is slightly related to the topic of violence in close relationships. EU funded project entitled as "Enhancing Professional Skills and Raising Awareness on Domestic Violence, Violence against Women and Shelter Services" launched an electronic and modularized multi-sectorial (multi-professional) self-study training program for social and health care professionals and the police in the spring of 2019. Other detectives did not have any specific training on violence in close relationships.

The members of the Anchor team had more training on domestic violence than other interviewees. These trainings were organized by partners, but none was offered by the police organization itself.

During basic training social and welfare professionals didn’t have training on DV or it was voluntary. Some professionals had access on-the-job training, but it was also voluntary.

**Which actors see DV as a priority? Which do not?**

Uniformed police officers did not prioritize violence, but managed all policing duties according to the emergency classification defined by the Emergency Center. The highest priority among the policing tasks is given to an ongoing crime or a case of suspect fleeing the scene of a crime. Consequently, if violence in close relationship is under way or there is an imminent threat of violence, the task will be given the highest priority among the emergency tasks. In addition, to secure the arrival and provision of health care often requires the presence of the police patrol. If the

perpetrator has left the scene, the task is no longer regarded as being high in the list.

Crime investigators regarded it as very important to solve crimes related to domestic violence as quickly as possible. An investigator working a "Long-term Cases Unit" had to prioritize sometimes other more acute cases before domestic violence cases. An investigator working in a "Short-term Cases Unit" was chose a month before the interview to take care of domestic violence cases, and the investigator had a strong motivation to open preliminary investigations very swiftly.

Anchor team gives priority to the cases that involve families with under-aged children. It is important to guide the family to the services. Another priority is to take care of crimes committed by minors.

The system seems to somewhat marginalize adult victims (working age victims) who do not have children. Violence in such relationships is seen more as an "own choice."

**Which actors work to make DV a more central concern?**

A young investigator at short-term crime investigation unit who had chosen to take care of all domestic violent cases wanted to have more training for the whole organization. The investigator was worried about a common practice of "explaining away" cases at house calls, or that petty assaults are not reported as an offence or that cases are too easily send to Mediation. The detective in question had experienced domestic violence when he/she was younger and therefore could understand what it is all about. The investigator has had negative experiences of trying to get help for his/her close relative from the police.

The detective at the long-term investigation unit had experiences of working at the Anchor team. At that time his/her tasks included preliminary investigation of violence in close relationships. Presently his/her main task is crimes against children, but he/she is also a member of the MARAK team of the department. He/she also organizes training to his/her own police organization together with the Victim Support Finland. He/she had formed a very comprehensive understanding of the phenomenon of violence in close relationships and its consequences on the basis of training on education he/she had received. He/she was worried whether Commanding Officers take violence in close relationships or MARAK activities seriously.

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**

Uniformed police officers worked in cooperation with social work, Emergency Center duty officers and health care. Social workers receive information from the Emergency Center if any children are living at the task address. The social worker contacts the police patrol in order to obtain information and comes to the scene if required. The cooperation with social work facilitates police work, for instance, when one parent has to be taken to the police station and the other need to go to the hospital or health center. In those circumstances the social worker takes care of the children and the police patrol is free to deal with other tasks. The social work duty officers used work at the police station and the cooperation regarded smooth, because it was easy to

exchange information just by entering the room of the other agency. After the social worker moved from the station the phone contact was not regarded as good as the meeting of a person with a familiar face.

The problems in the cooperation appear at personal level. For instance, the way social workers use time to hear customers was regarded aimless and police officers wish for a more assertive approach. The goals of social work were not always understood, which causes frustration. They felt that the police could have dealt with the matter without social worker's interference.

Uniformed police officers saw that the cooperation with the ambulance crew was good even though they could not tell many concrete examples of cooperation. Both agencies were regarded working in parallel fashion. Some unformed police officers who knew the work of Anchor team could tell the Anchor team about possible problematic family circumstances and also considered this option when patrolling.

On victim's consent crime investigators passed his or her information to Victim Support Finland. One investigator organizes internal training to other crime investigation units in collaboration with a worker of the Victim Support. The same police officer is also the member of the MARAK work group. Investigators of domestic violence communicate with the Anchor team and may ask a social worker or a psychiatric nurse to join the interrogation as a witness. Then the customer does not have to tell the same story several times to many authorities and the information about the victim's situation and need for support passes to other authorities.

A member of the Anchor team, particularly the psychiatric nurse, organizes conversational therapy both the victim and the perpetrator. This service is organized by the city. If the customer gives consent, the Anchor team shares information with the police and social and health care authorities. Information sharing is easiest and most effective when the customer has a child. In such a situation the cooperation can be justified by the interests of the child and the cooperation does not necessarily require customer's consent. Childless couples are losers in this system, if they do not want to receive help from the multi-professional team or from other services. The core of Anchor work - multi-professional cooperation and exchange of information between the police, social work and health care - is based on an agreement between the police and the town.

MARAC work group in Case location 1 receives customers sent mainly by shelters. In the MARAC process, it is the customer who decides which authorities are allowed to have access to their information.

### 3. Steps of a DV case

#### How are victims identified and detected? Are there active measures to maximize victim detection?

When the house call is classified as a family violence the patrol officers hear the victim and the suspect in separate rooms. After that the police officers exchange the information they obtained from the parties and hear, they swap the interviewees and hear them again. If the narrative is consistent the police can draw come conclusions

about the event and circumstances. If the parties seem to conceal the events, the patrol officers use more time to hear the parties.

The investigator in short-term investigation unit was recently chosen to the specialization of domestic violence investigation. The investigator had told the unit about his/her interest to take domestic violence cases, and encouraged other investigators to contact him/her if the cases they investigate involve some aspects of domestic violence.

The police officer in the Anchor team goes through all emergency task reports twice a week and selects the cases that may involve domestic violence. Emergency task report could have been classified originally as "family violence", "vandalism", or "disturbing behavior" and the patrol could have carried out the task with an expression of, for instance, "only quarrel". In addition, police tasks that are described as "disturbance in the staircase" are examined. The police member of the Anchor team tries to figure out the name and the address of target person and if the case has any indication of possible domestic violence. The histories of the persons related to the cases screened in this way are checked by the police information system. Then the police officer introduces the selected cases to other members of the Anchor team in a weekly team meeting. Next the psychiatric nurse of the team calls the customers and introduces her-/himself as a nurse of the multi-professional team. He/she invites the customers for a voluntary meeting and discusses through the family situation. It often turns out that during the house call the couple has told the patrol officers only about verbal quarrelling, but the discussion with the psychiatric nurse uncovers the existence of physical and other type of violence in the family.

The psychiatric nurse in the Anchor team produces the MARAK assessment. Consequently, crime investigators do not need to master the protocol, but it is enough if the investigators ask the nurse to meet the victim. Then the psychiatric nurse hears the victim and takes the case to the MARAK team if needed.

**Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?**

Uniformed police officers report an offence if the case has clear indications of violence. If the incident classified as family violence has unclear circumstances, the victims has no visible injuries and the victim does not have any claims for compensation or punishment, an offence may not be reported. According to law, the police have to report an offence also in the case of petty violence in close relationships. But in practice if the victim does not want to talk about the incident and the perpetrator denies it, and there are no visible injuries or other external witnesses, an offence is not recorded. An assumption is that in such a case a report of an offence would be a worthless process that keeps the investigation busy, but would be presented to the prosecutor as a restricted case (a prosecutor can decide, based on the head investigator's proposal, that the preliminary investigation is not carried out or it is closed if it is obvious the prosecutor would not press the charges).

Uniformed police officers do not have instructions on the use of interpreter in the domestic violence cases. The police department has one phone that has an application for interpretation. That application can be used for phone calls to a ring of

interpreters divided into language groups. The first available interpreter answers the call. The problem is that the phone is kept at the police station, and then the patrol has to get the phone first from the station or ask another patrol to fetch it for them.

An anchor police officer also reports an offence if they find out violence in close relationships through their customer contacts. In addition, sometimes domestic violence is found out in investigation of other types of crime.

**Describe the process of filing a complaint. Are there active measures taken around this topic?**

The patrol reports an offence, if it is handling the case on the spot. Another way of reporting an offence is that the victim comes to the police station to report an offence by him- or her-self. Alternatively, he or she can fill in an electronic online crime report.

When the patrol has been on the crime scene it describes carefully circumstances and events of a crime, parties involved, injuries, content of the hearings in outline, and other relevant facts, such as the presence of minors. When the report of an offence is made at the police station, e.g. by victim, the duty officer asks the information mentioned above.

**Describe what happens after victims have filed a complaint: which problems arise then?**

When the victim reports an offence by her- or himself or the police officer reports an offence after being on the crime scene, the problem may come from the fact that the victim is not necessarily informed about the possibility of a support person and a free legal aid counsel. Then the victim might be invited to the interrogation without knowledge about her or him being able to get an assistance or legal aid counsel to the first hearing. A criminal investigator explains the victim the rights, including the right for a support person and legal aid, and duties, before the actual interrogation. An investigator also asks for the victim's consent for sharing his or her contact information with the Victim Support Finland. From the police perspective a support person and a legal aid are necessary for the victim only since in a trial. An interviews representative from the Victim Support Finland, however, said that the presence of a support person and a legal aid counsel would likely help the victim get better through the interrogation. Often it is unclear before the interrogation whether the victim has a right for a legal aid counsel. The type of crime and the relationship between the victim and the perpetrator influence the possibility if the victim can receive a free legal aid counsel. Petty assault does not allow a free legal aid counsel for the victim, and a three-week relationship is not considered a close relationship.

Even if the crime is aggravated, or the perpetrator is not arrested for being a suspect the crime, it may take months before any active measures are carried out in the preliminary investigation. This means that no-one is being in contact with the victim or the perpetrator and tell them about available support services. Consequently, the violent situation may last and the victim and the perpetrator stay beyond the reach of help.

It is possible to mediate violence in close relationships on certain grounds. A successful mediation can in some circumstance enable a prosecutor to limit preliminary investigation so that charges are not considered. Finnish NGOs have criticized the police for victims experiencing pressure and a lack of alternatives when the police have suggested mediation as an alternative to criminal trial in domestic abuse case. There is often a backlog at many police stations in the criminal investigation. Therefore, petty assaults are sent to Mediation Office without a proper clearance or that the nuts and bults of mediation have been explained to the victim. Mediation is seen suitable only if the violence happens for the first time and the victim is clearly not in an oppressed situation. In order to clarify such conditions police needs to interrogate the parties, which is not always the case, or the victim is not heard face to face if the police talks to him and her only by phone.

It may take almost a year after the incident before preliminary investigation is complete and the case is litigated. If the violent relationship has stopped, it is typical that the victim tries to cancel the trial, for instance, because he or she does not want to be in touch with the ex-partner. Awaiting trial can be heavy both for the victim and the perpetrator.

**Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

Crime investigator always asks victim's consent for sending her contact information to Victim Protection Finland. Then Victim Protection calls the customer and tells him or her about a possibility to have a support person. The victim may not get the support person right away, but often the customer turns to Victim Support as the date of a trial approaches.

According to the law, the victim has a right for free legal aid counsel for instance, in sexual offences and domestic violence cases (excluding petty assault). The victim can obtain the legal aid by him or -herself or with the help of Victim Support.

Detectives also talk to Anchor team and may instruct the victim to approach and meet the social worker or the psychiatric nurse of the Anchor team. On customer's approval either one of these two professionals can also be present during the interrogation. The Anchor team can guide the customer to e.g. anti-violence work, refuge, or it can pass customer's information to his/her own social worker.

**In this process, what are the main obstacles and problems that victims face?**

Information about the possibility to obtain a legal aid counsel is often received only in the trial. In practice this means that the support person and the legal aid counsel can be obtained after interrogation, unless the victim insists that he or she wants those persons in the interrogation. If the victim wants an assistant and support person, the interrogation should be stopped and postponed. In reality this means that the victim accepts an interrogation without a support person and a legal aid counsel.

In this department, police is not aware of support services tailored specifically for the immigrants who have experienced violence in close relationships. Anti-violent workers (väkivaltatyöpari) have customers with various linguistic and ethnic

backgrounds, but they cannot necessarily get services in their mother tongues. If an interpreter is from the same original region the customer may not speak about his/her matters because she/he is afraid that the information may spread through his/her community. Police officers have difficulties to reach the customer at a personal level if an interpreter is required.

The duration of pretrial investigation can be rather long and one may have to wait a long time for the trial. If an offence is against a child, the investigation may take very long indeed. The reason is the hearing of a child and the resources at the Tampere University Hospital for assessing the reliability of the hearing are rather scarce. In some cases the police cannot move on with the preliminary investigation if the protection of child's interests requires measures from the University Hospital.

**What do you see, in the frontline response to DV, as "working" and "not working"?**

*Works:*
Response time of uniformed police (patrol) is at good level.

Anchor team is screening Emerge Center's reports and then tries to reach the victims of domestic violence. This is a unique arrangement in Finland and can be regarded as a local innovation and best practice. With resources available for a typical Anchor team, this type of activity is only possible is a small town like our case location number 1.

An individual criminal investigator is enthusiastic about developing the prevention and investigation of violence in close relationships in her/his unit. Her work is supported by the fact that she can concentrate and specialize in the investigation of violence in close relationships. Previously specialization was not possible because the investigation of domestic violence was spread to all investigators.

*Not working:*
Some uniformed police officers had a rather narrow view of the complexity of domestic violence. They seem not to fully understand the traumatizing influence of violence, nor did they know the other partner organizations working with domestic violence. If the patrol is in a situation where the victim refuses to talk and the situation remains unclear, the patrol may not report an offence. It is strongly felt that the victim has a great responsibility for explaining the situation and stopping violence. It was also believed that patrol's advice and discussion will stop violence. These police officers seem to be frustrated if a good and time-consuming discussion did not help to solve the situation.

There seems to be some gaps in some service processes. Firstly, cooperation between shelter services and child welfare and protection has room for improvement. Child welfare and protection should help the child already in the shelter, and the same familiar social worker should continue offering help and support also after the shelter period is over. Secondly, follow-up services and the guidance to customers to these services should be developed so that a solid stream of services accompanies the customer from the shelter to other services provided by the municipality.

**Overall, according to you, in this section, what is of key interest on your case?**

Cooperation is successful if the individuals are truly interested in violence in close relationships and understood well the phenomenon. In addition, cooperation is effective if the cooperating parties are located close to each other and knew each other by appearance. Cooperation was challenging, however, because it was not managed as part of organizational structures and processes, but successful cooperation was dependent on the individual worker's motivation and competence.

The co-operation exercised by the Anchor team is guided by well-functioning organizational structures and processes in addition to well-motivated staff. Within the police organization co-operation with the Anchor team was based on the responsible person: contacting the team was decided by individual police officers.

Good practices are often based on personal relations, which may lead into risks. Many interviewees talked about practices developed based on long work experience that could be useful, for instance, in interviewing and examining individuals, motivating to receive help, or exchanging information between various agencies. These practices were seldom brought forwards and consequently their wider usage in training and practice was not encouraged. The problem emerges especially when a well-motivated and competent individual moved into another position at work: knowledge, competence and motivation in addition to social networks would evaporate.

## Case location 2

### 1. Methodology

- Description is the same as for Case location 1 in Finland –

### 2. Overview

**Which actors are involved in the handling of domestic violence?**

We interviewed police officers from four types of units: uniformed police officers of a response unit, crime investigators of domestic violence unit, police officers working in a multi-agency Anchor team, and a police officer of a preventative policing unit.

Most often uniformed police officers of response units, who take care of all emergency tasks, are the first officers involved handling of domestic violence.

After a crime has been reported, the police carry out a preliminary investigation. During the preliminary investigation, the police investigate what has happened, who is a possible suspect and what injuries have occurred to the victims of crime. Detective senior constables and detective sergeants question the victim of crime, the suspect, witnesses and in some cases also various experts. Detective sergeants supervise the daily work. Detective chief inspectors and detective superintendents manage investigation units and decide about the use of coercive measures.

In Finland there are multi-agency teams ("Anchor teams") working in several police departments. Anchor teams consist of police officers, social workers and psychiatric nurses. The involvement of handling domestic violence depends on the particular police station.

Preventative policing unit is located organizationally in the response operations sector. The preventative policing unit includes a police officer, who is responsible especially for the co-operation with NGOs that support immigrant women and other vulnerable groups like LGBTQ people with refugee background.

Paramedics, nurses and doctors working in emergency room (ER), shelter professionals, social- and crisis services (including acute child welfare and protection) are involved in the social- and health care sector handling of frontline DV cases. In case location 2, sexual violence cases are handled in Sexual Assault Support Center if rape has happened in the last 30 days, which means that older cases are not treated there. In case location 1 rape cases are taken care in emergency room and municipal health center.

**What do they do? What is the nature of their involvement?**

***The work of senior constables and sergeants in the response operations unit***

Uniformed police officers working in the response operations units are responsible for maintaining public order and security by patrolling, handling emergency tasks given by Emergency Response Centre, providing advice and guidance, and preventing unlawful activity.

In a domestic violence case the basic procedure is as follows: interrupt the unlawful activity, calm down the situation, question the parties in different rooms, document injuries, inform the child welfare protection if there are children in the family, apprehend the suspect on the basis of Police Act or Coercive Measures Act depending the seriousness of the crime or the risk for reoccurrence, and file a crime report.

***The work of detective senior constables and detective sergeants in the investigation unit***

After a crime has been reported, the police carry out a preliminary investigation. Due to police resource shortages, the preliminary investigation may sometimes take months. During the preliminary investigation, the police investigate what has happened and what damages have occurred to the victims of crime. Detective senior constables and detective sergeants question the victim of crime, the suspect and witnesses. They also collect evidence such as doctor's statements, photos, and carry out technical investigations. They arrange translators if needed.

With the victim's consent the police can provide Victim Support Finland with a crime victim’s personal data. The police can also provide information on other forms of support offered to crime victims and on other assistance organizations. The domestic violence investigation unit in case location 2 works actively with various NGOs.

The record of the pre-trial investigation is prepared after the investigation is closed. The record will include the official interview records and collected evidence. The record of the pre-trial investigation will be submitted to the prosecutor for consideration of charges or for issuing a fine. Alternatively, the police may close a pre-trial investigation without submitting the case to the public prosecutor, if the investigation shows no offence has been committed.

**The work of Anchor teams**

The Anchor ('Ankkuri') model supports the wellbeing of children and adolescents and is geared towards the prevention of juvenile delinquency and crime, and violent radicalization and extremism. The Anchor model is also used to prevent domestic and intimate partner violence by intervening in incidents at the earliest possible stage and by referring the parties involved to relevant help services. (See https://ankkuritoiminta.fi/en/frontpage)

The Anchor model is based on multi-agency cooperation, which involves different public authorities working together at police stations. An Anchor team of case location 2 is consists of 4 police officers, 3 social workers and a psychiatric nurse. Social workers and the nurse are municipal employees. The staff cooperates closely as a team, each bringing to the team their own professional competence and the support and expertise of their own background organization.

Multidisciplinary cooperation makes it possible for professionals to serve the customer in a holistic manner based on a 'one-stop shop' principle. While the police officer from the investigation unit investigates the crime, the Anchor team's health care and social work professionals look into the overall circumstances of the customer and his/her family. The Anchor team's social worker and nurse assess the needs of the customer and refer him/her to further services. The benefits of this holistic approach and multi-agency co-operation are evident in challenging situations where the customer suffers from multiple problems like domestic violence, substance addiction and mental disorder.

***The preventative policing unit***

The police officer in preventative policing unit works to support integration and safety especially of immigrant women and to prevent harmful phenomena among cultural and religious communities. The nature of the work of the interviewee is to provide easy-access police services for people in vulnerable situations like for victims of honor related violence and LGBTQ people with refugee background. This human-centered preventive and supportive work includes close co-operation with NGOs, schools, Anchor team and domestic violence investigation unit.

***Social- and health care sector***

Paramedics sometimes work together with police officers in acute emergency situations. Doctors and nurses are involved handling domestic violence in ERs. When victim has child/children social workers are contacted by ER's professionals. If adult victim do not have children, she/he is only treated in ER and no social worker is contacted. It depends on an individual professional if a victim is informed about

available shelter services or given information about other support services in social and health care. In paramedics and ERs the most important thing is to treat the victim's and the perpetrator's physical injuries. Social- and crisis services concentrate ensuring that children in acute DV cases are safe. Professionals in paramedics and in ERs are obligated to contact child welfare and protection professionals if DV victim has children. According to our interviews this arrangement is working well. In addition, paramedics notify social workers about elder victims. The system seems to marginalize adult victims (working age victims) who do not have children as violence is considered "their own choice."

In shelter services involvement is more comprehensive than in ERs or social- and crisis services. Victims of DV get support, guidance and counselling from professionals at the shelter as well as assistance and information for dealing with practical arrangements. The shelter has staff available 24 hours a day and victims can go there either on their own initiative or on referral. Shelters try to make sure that victim can get long-time support if needed and victim is willing to receive support. The aid is provided by municipalities or NGO's. The shelter is meant to be a short-term refuge during a crisis but length of stay is always individual. On average one client spends 16 days in a shelter.

**What types of domestic violence are considered?**

Uniformed police offers deal almost only on the physical forms of domestic abuse or illegal threats. Psychological, economic, sexual, religious or cultural forms of violence are not the center of attention in their work. The other forms of violence are found out later in the crime investigation. Most uniformed police officers who in the field, told that they try to observe in house calls if there are indications of fear or subordination between the family members, especially when none of the parties wants to admit violence has occurred. Furthermore, police officers told, that in such situations they try to discuss much about the issues with the parties. If possible, they talk with the victim separately outside the apartment to find out if there are gaps in the stories, and if the parties have agreed to present fabricated stories to the police.

Crime investigators encounter more varied types of violence in close relationships than uniformed police officers. Investigators observe physical, psychological, economic, sexual, religious, and cultural violence. They also pay attention to other types of crimes that are typical in violence in close relationships, such as illegal threats, harassment, persecution, extortion and malicious damage.

From the perspective of the police officer working in the Anchor team violence in close relationships appears similar to what the crime investigators encounter. Anchor team emphasizes the services that the victims need, and the types of crime are not the center of action.

Preventative police officer's approach to domestic abuse relates to the community and culture of the victim and perpetrators, because the threat to the victim comes from the broader community. The protection of the victim is very difficult because family members, relatives and acquaintances may pose a threat to the victim. Violence in close relationship appears in the work of preventative police officer as physical or psychological violence, intimidation, restriction, forced marriage or child

abduction.

Social- and health sector professionals recognized multiple forms of violence: physical violence, psychological violence, sexual violence, honor related violence, economic abuse, children exposed to violence etc. In services where customers stayed longer time (like shelters) professionals had more time to notice different forms of violence that appeared together such as economic abuse and psychological violence. In ER, the interviewed doctor found it focal to use PAKE abuse and body map form to recognize different forms of physical and sexual violence. Using PAKE, a nurse and a doctor systematically ask about different forms of violence. They also ask details about the violence and the person who caused the injuries. Also information about victim's children is asked. By PAKE, different types of physical violence are revealed systematically but the focus is on the case that led to ER visit this time. They do not ask whether the violence occurred the first time or has it happened before. In shelter services MARAC procedure is used which will reveal all sorts of undergone violence.

**Do involved actors have different conceptions of DV, and which?**

Uniformed police officers working in the field had very similar conception of violence in close relationships. They saw that most often the factor behind violence is alcohol. Violence was also typified as physical violence that occurs between two equal adults. Interviewees experienced that so called regular addresses, with violence occurring weekly, violence is a part of way of life and the police intervention is worthless and unhelpful. One of the interviewees told that in certain regular addresses police officers can even forbid the victim to call anymore to the emergency number, because violence is recurring and the victim does not want to change the situation. Intoxication and the misuse of alcohol, drugs and narcotics are prevalent in in regular addresses

Some patrol police officers thought that the intervention by the police does not solve the problem of domestic abuse, because the perpetrator's fine is paid from the common funds of the family or household. Many interviewees were perplexed if the parties told to the police that this was the first violent situation in the household or family and that there was just one "slight smack." Often the victim doesn't want to report the violence, but the current legislation makes it mandatory to the police to record violence in close relationships. It was rather typical that uniformed police officers did not challenge the story about the violence occurring for the first time.

Crime investigators had much broader conception of violence in close relationships than uniformed police officers. The investigators understood how sensitivity is the encounter with the possibly traumatized victim and why victim has difficulty to leave the relationship. In addition, crime investigators had a strong motivation to encounter the victim and the suspect in a humane way, encourage both the victim and the perpetrator to ponder the reasons and impacts of violence and to motive them to accept support and help.

Anchor team members shared to a large extent crime investigators' conception of violence in close relationships. They understood the importance of multi-agency support and services to the victim and perpetrator as a means to end the violent life

conditions.

The preventative police officer focuses on the honor-related violence in her work. The protection and support of a victim is highlighted in such work, because the risk of violence comes from several people who could be family members, relatives or other member of the community. Consequently, the safety net of the victim can be non-existent, and she needs special support from different agencies and NGOs.

In social- and health care sector actors do not really have different conceptions of DV, but professionals see their role in the big picture differently. Most of the frontline professionals are doing their specific part of the totality of work, such as in ERs treating physical injuries or paramedics transporting the victim to ER, but follow-up treatment and support is often lacking.

**Describe the education/training on DV that different actors have or have access to.**

Uniformed police officers had had only very little training on violence in close relationships. In the basic train the typical situation of a house call was went through, but violence in close relationships as a social or psychological phenomenon was not covered. Most patrol officers had a very limited conception of violence in close relationships, yet most did not have a need for further education. One patrol officer wished to have more training on how to work with the immigrants.

Crime investigators had received further education and training for instance in hearing children and other training from several external organizers. Their own police organization had offered only a course on "children in pre-trial investigation". One NGO offers training relating to honor violence.

The members of Anchor team had received more training in violence in close relationships than other interviewees. Most training was offered by partner organizations. The police had not offered them any training in violence in close relationship.

In basic training social- and health care professionals didn’t have training on DV or it was voluntary. Some professionals had access on-the-job training, but it was also voluntary. In the EU project EPRAS, THL together with University of Jyväskylä and Police University College developed and implemented an e-learning program (Create trust – Stop the Violence) to improve social and health care and police professionals’ competencies in dealing with DV and awareness of shelter services. Apart from shelter professionals, other interviewed social and health care professionals had not yet completed the e-learning program. Interviewed health care professionals didn't have any training on DV.

**Which actors see DV as a priority? Which do not?**

Patrol officers did not prioritize violence in close relationships but handled tasks based on the urgency categories defined by the Emergency Call Center. The highest urgency class task involves an ongoing crime or a situation in which a suspect is fleeing the scene. Consequently, if violence in close relationship is under way or

there is an imminent threat of violence, the task will be classified as the highest priority or the most urgent task. In addition, to secure the arrival of health care and the starting of the care often requires the presence of the police. If the perpetrator has left the scene, the task is no longer regarded as the highest priority. Case-specific non-urgent family violence tasks can pass the other non-urgent tasks in the list.

The interviewed crime investigator work in the unit that is specialized in investigating violence in close relationships. The priority of the cases depends on the level of seriousness of the crime and the possible coercive means such as the apprehension of the suspect.

The Anchor team prioritizes violent cases that relate to families with underage children. It is utmost important to guide the family to various social services. A competing priority is also the crimes committed by the minors, which is the other area of responsibility of the Anchor team.

Shelter services see DV as a priority. Other social- and health care services deal only one part of the problem (cure wounds or ensure children are safe etc.), so DV is just one aspect of their work.

**Which actors work to make DV a more central concern?**

The preventative police officer has developed the prevention and detection of honor-related violence in cooperation with the commanding officers at the unit investigating violence in close relationships. They have gathered a working group on honor-related violence that comprises representatives from the following units: preventative policing, threat assessment, sexual crime investigation and the investigation of violence in close relations. Commanding Officers of the investigative unit of violence in close relationships had arranged training on honor-related violence and how to bring up the issues with the victim and the suspect to the members of their unit.

In every sector there are professionals who are eager to improve the situation and who stress the importance of the prevention of and intervention in DV. These are occasional workers whose actions come from their individual motivation, if DV isn't the organizations main concern.

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**

Uniformed police officers cooperate with social services, health care and the duty officer in Emergency Response Center. Social services receive information directly from the Emergency Response Center if children live in the task address. Social worker contacts the police patrol in the address of the incident in order to receive further information and comes to the scene if needs be. The cooperation with the social work helps the police especially if the patrol has to take the other parent to the police station and the other parent has to go to the hospital emergency room. The social worker looks after the children and the patrol is free to continue carrying out further tasks.

Field officers found the cooperation with the ambulance staff good although they couldn't tell much about the concrete examples of such cooperation. Police officers saw that a mutual understanding of goals between the two agencies is an asset. The victim covering the real course of events may agree to show the injuries to the crew of the ambulance. Then, the police officer next to ambulance has a chance to ask the victim about the cause of the injuries. Sometimes police officers receive tips from the ambulance crew e.g. on the mental problems of the customers that lead to unexpected violent behavior. Even though, police officers noticed the above described practices are problematic in the light of secrecy of personal information, the restricted exchange of information was regarded legitimate owing to occupational safety and the safe treatment of the customer.

Some uniformed police officers who knew the workings of the Anchor team, gave hints to the team about the potential customers that may benefit from the contact with the team. Yet, the practice of informing the Anchor team was not regular, but related to individual police officer's persona motivation and experience in the importance of information exchange.

If the victim agrees, crime investigators pass victim's information to the Victim Support. In addition, and again on parties' acceptance, the information of the victim and the perpetrator is also passed to the local Assistance Service for Domestic Violence, under the Federation of Mother and Child Homes and Shelters, which can offer various counselling, guidance and therapy conversation services and assistance to all parties of domestic violence. The newly recruited crime investigators also visit the local Assistance Service for Domestic Violence and get to know the staff and activities and thus can better market the services and assistance for customers. A local NGO has offered training on honor-related violence to the members of the investigative unit of violence in close relationships. In addition, an Arabic-speaking representative of that NGO has employed as an expert witness in an investigation of honor-related crime case.

Employees of the Anchor team guide the victim and the perpetrator to various welfare and support services available for the intoxicants and individuals with mental problems, and also to Assistance Service for Domestic Violence. The victims of honor-related violence are guided to the services of the above-mentioned local NGO. Another NGO provides special services to immigrant women victims without supporting social networks. If the customers agree the Anchor team exchanges information with social work and health care agencies. The exchange of information is easiest when the customer has children, because the cooperation can be justified by the child's interests without asking the customers to give their assent. On the other hand childless couples who do not want to receive assistance from the multi-agency Anchor team tend to fall through the service net. The multi-agency cooperation and the exchange of information between the police, social services and health care, which is the core of Anchor method, are based on an agreement between the police and the city (Note: municipalities have a duty to organize social services and health care to the citizens).

Shelter workers cooperated with the police and with municipality's social and health care services. ERs and paramedics informed child protection if a victim had children. Otherwise cooperation between professionals was rather sporadic. In case location 2

there wasn't multi-professional teams working in social and health care sector (for example MARAC), but in addition to Anchor team at the police station, there is a DV network working at an organizational level.

### 3. Steps of a DV case

**How are victims identified and detected? Are there active measures to maximize victim detection?**

If a house call is classified as a family violence (roughly equivalent to violence in close relationships) the patrol officers question the victim and the perpetrator in different rooms. After that the patrol officers exchange the parties, question them again, and compare the information they obtained. If the stories are consistent the officers are able to draw some kind of conclusion on the course of the events. If it seems that the parties are trying to hide real events, the officers use more time to talk to the parties. One of the interviewees told us that he tries to observe the behaviour of the parties and children. If he senses submission or avoiding, or otherwise has an intuition that something is wrong, he took more time to questioning the parties. Based on his experiences, the interviewee estimated that an agreed story or an act can be kept up about half an hour. After that the behaviour will change and it is possible to ask about what truly happened. If children were sleeping that could be regarded as a potential indication of a long-term violence, since the children were adapted to violence and not awaken by it.

The officers at the preventative policing unit works actively with immigrant women suffering from violence and in order to detect immigrant victims with minority sexual or gender identity. She is on duty at a special room in NGOs premises a day or half a day in two weeks. Thus the customers are able to meet a police officer anonymously in a safe environment and ask advice that relates to their life situation and criminal law. Many of the customers of this special NGO services cannot come to the police station because their family and relative exercise control. Thus it is only possible for them to meet and discuss with the police in a secret location. The police officer can also report a crime and give information about the progress of an ongoing criminal investigation. The interviewee may also meet customers who live under a threat of honor-related violence at a school welfare officers office at the school where the customer studies.

In ERs nurses and doctors use PAKE (Abuse and Body Map form) in all assault and abuse cases which help them systematically ask about different forms of violence and abuse. With PAKE protocol doctors and nurses can also document the injuries precisely. As the body map covers the whole body, it motivates professionals to go through all body areas and document possible injuries also in less frequently examined areas such as behind the ears etc. Documentation is made by camera but also by paper and pen. PAKE form is evidence and if police officers request it, doctor will write a statement about the injuries by means of PAKE.

Good practice that is used in all shelters is the risk assessment tool MARAC to determine how dangerous their client's situation is. Shelters should also draw up a safety plan for each client. Sometimes a client stays so short period in a shelter that there's no time to do risk assessments, but usually MARAC and safety plan is made.

The risk assessment and the safety plan help both the client and the staff understand the danger of violence.

**Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?**

The patrol officers report a crime if the case has clear indications of violence. The police officer may not report a crime if the case classified as family violence has unclear circumstances, the victim does not have visible injuries, or does not claim for punishment or compensation. A legal change enacted a mandatory police recording policy in the cases of violence in a close relationship in 2011. All assaults, including petty assaults in close relationships, became subject to public prosecution. In reality, if the victim does not want to talk about the events, the suspect denies the act, or there is no visible evidence or a witness, the case is not reported. Patrol officers assume that the crime report would be presented as a limited case to the prosecutor and therefore leads to a useless process that would unnecessarily keep investigators busy. Patrol officers were worried about the limited resources available in the investigation and so called "investigation backlog". Consequently, in unclear cases that seem not to have possibilities to move forward in the criminal process, were often not reported. This feeling was called "comradeship".

Patrol officers did not have instructions to use an interpreter in house call. It would be possible for the police to order an interpretation through a telephone, but this option was not used regularly. Police officers can also use an acquaintance of the parties if the parties actively offer such a person as an interpreter. Sometimes police officers use non-verbal language to show that violence and assault is not right.

If they notice violence in close relationships the police officers working in an Anchor team report a crime. However, they do not actively try to detect violence in close relationships. Other crimes detected in criminal investigation are also recorded as a crime in the police information system. The unit that investigates violence in close relationships highlighted a need to communicate to uniformed police officers that repeated violent cases should be reported to investigation because repetition could be grounds for arresting the suspect to avoid the extension of crime.

Preventative police officer encourages the customers under the threat of honor violence to report a crime, but the crime is not always reported. One reason is the unwillingness of the victim to say anything in the pre-trial investigation and there are not necessary any evidence of violence. The report would expose the victim's contact with the police to the perpetrators. The outcome would not be a conviction because there is no evidence, and that would also mean that the process of deportation of the perpetrator cannot be launched. Consequently, crime reports may worsen the circumstances for the victim and lead to a life threatening situation.

In case location 2 there is a Sexual Assault Support Center where reporting the rape to the police is not required for adult victims (over 18 years old), even though it is encouraged. In the Sexual Assault Support Center victim can file criminal complaints in the center if she/he wants. Then the police are called to the center.

In ERs professionals encourage victims to report offences to the police but it is not possible to file criminal complaint in the hospital. So the victim needs to go to the police station by her/himself. But in many cases the victim is taken to the hospital by police and then a report of an offence has already been done.

In shelters, victims receive information on legal services by the shelter professionals. Our interviews revealed one good practice: female police officers visited regularly in particular shelter so victims could discuss with police officers about their case and police officers could offer information and guidance for the victims. For migrant and other women from different cultures this practice can lower threshold to file criminal complaints. For shelter customers it was of course voluntary to meet police officers.

**Describe the process of filing a complaint. Are there active measures taken around this topic?**

The uniformed police officer records a crime if the patrol has been at the scene in a criminal matter. Another form of reporting a crime is e.g. when the victim arrives to the police station and reports a crime or reports a crime through e-form.

When the patrol records a crime at the crime scene they must enter detailed information about the circumstances of an offence, the description of an offence, parties involved and injuries, the content of the hearings and other possible matters such as the presence of children. If the report is given at the police station, for instance, by the victim, the duty officer asks the aforementioned facts from the person who is reporting an offence.

In all assault and abuse cases professionals in ERs ask victims whether they have already reported an offence to the police. This question belongs to the PAKE form. If not, victim is informed that she/he can do that, but typically it’s not possible to report an offence in the hospital area. Thus, victims need to do that afterwards at the police station.

In some shelters there are good measures taken around this topic. See the answer above.

**Describe what happens after victims have filed a complaint: which problems arise then?**

When an offence is recorded by the patrol, victim or some other person, the information about their right to a free support person or a legal aid counsel is not necessarily given to the victim. Then it is possible that the victim is invited to the interrogation without knowing that she could have a support person or a legal aid counsel already during the first interrogation. The detective tells the victim her rights, including a right to a support person or a legal aid counsel, and duties later on. The detective also asks the victim to give her consent to pass her contact information to the Victim Support Finland.

From the police perspective a support person and a legal aid counsel are only necessary to the victim at the trial, although the employee from the Victim Support Finland mentioned in the hearing that the presence of the support person or the legal

aid counsel might improve the victim's performance in the interrogation. Often, it is unclear before the interrogation whether the victim has a right to a free legal aid counsel before the trial. The type of crime and the relationship between the victim and the suspect influence on whether the victim is granted a free legal aid counsel or not . In the case of petty assault the victim is not given a legal aid counsel paid by the state. Similarly, a dating of three weeks is not considered as a close relationship, which is required for obtaining a free legal aid counsel.

It is also problematic if violence is not a felony or if the perpetrator is not arrested as a suspect for a crime, it may take months before the police actively engage in the pre-trial (criminal) investigation. This means that no-one informs the victim or the suspect about support services. The violent circumstance may continue and the parties are not guided to the assistance.

Violence in close relationships can be mediated on certain grounds in the Mediation Office. A successful mediation may in some circumstances enable the prosecutor to restrict the pre-trial investigation and the case does not enter into the consideration of charges. Finnish civic organizations have criticized the police of not treating victims properly. Victims have experienced that police have put pressure on victims and presented mediation as an only option. Criminal investigations have piled up in several police stations and therefore incidents of violence in close relationships that are regarded as minor have been sent to the Mediation Office without proper background checks, or that the victim has been thoroughly explained the facts of mediation. Mediation should be applied only if the abuse happens for the first time and the victim is clearly not in an oppressed situation. The exploration of the circumstances would require interrogations, which are not always conducted, or the victim is not questioned face to face if the police make the inquiries through the phone.

The slowness of pre-trial investigation can cause problem. Sometimes the completion of preliminary investigation and the hearing takes up to a year. If the relationship has been ended before the court proceedings it is common that the victim strongly desires to cancel the legal action because she does not want to encounter her ex-partner. Awaiting the trial for a long time can be tough both for the victim and the suspect.

Migrant women might not report offence for police if their residence permit is interrelated to marriage. That is a huge problem.

**Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

Detectives always ask the victim's consent for sending the victim's contact information to the Victim Support Finland and the Unit of Violence Work by the police. Victim Support calls and tells the victim about the possible to receive a support person. The victim may not accept the support person immediately, but often the customer turns again to the Victim Support as the litigation draws nearer. Victim's communication with the Victim Support Finland does not depend on the police. Even if the victim may have denied the occurrence of crime in the interrogation they may accept that her contact information is sent to the Victim Support.

According to law the victim is entitled to a free legal aid counsel in the case of sexual offences and violence in close relationships (excluding minor assaults). The victim can acquire the legal aid counsel by himself/herself or through the Victim Support Finland.

Detectives consult an Anchor team at the police department and may guide the victim to meet the social worker or the psychiatric nurse of the Anchor team. In addition, the Anchor team may guide to victim to the Unit of Violence Work, a refuge or pass the information to the victim's own social worker. On victim's consent the team can also pass his/her information to other associations, projects and NGOs that are specialized in providing services to various types of victims having different circumstances.

The police officer in the Preventative Units ponders the relevance of various multi-professional aspects that relate to customers who are living under a threat. She is constructing a support networks for the victim together with the Threat Investigation Team of the police, school welfare officer, and school health care, and a civic association specialized in honour related conflicts and violence. The Threat Investigation Team looks after the safety of the victim in acute and serious threat cases. Sometimes the victim's cooperation with the preventative policing can continue for several years. In an exemplary case and the civic association preventing honor related violence and the preventative policing met the victim's family and an imam several times before they could remedy the strained family situation that had already evolved into a planning of homicide.

**In this process, what are the main obstacles and problems that victims face?**

The information about a free support person and a legal aid counsel might be available only at the interrogation. This means in practice that a support person and a legal aid counsel can be obtained only after the interrogation, unless then victim has already asked if such persons are available in the interrogation. If the victim demands a support person, the interrogation must be suspended and postponed to a later date. In real circumstances the victim usually accepts the interrogation without a legal aid counsel or a support person.

Immigrants who have experienced violence in close relationships have quite a lot of services available in the case location 2 metropolitan area. However, if an interpreter is from the metropolitan area or from the same are in the country of origin, then the victim or the suspect does not usually want to talk about his or her matters because he or she is afraid that the information will spread throughout his or her community. Also police officers think it is difficult to reach the customer at the personal level when the interpreter is between. Police officers feel that the discussion is reserved.

It may take a relatively long time before the pre-trial investigation is finished and the criminal proceedings begin.

**What do you see, in the frontline response to DV, as "working" and "not working"?**

Working:

Response times of police patrols are good.

In the past, detectives used to investigate everything from domestic abuse to property and traffic offences. Now, during the past several years the department has had a unit specialized in the investigation of offences related to violence in close relationship (Unit of Violence in Close Relationships). The experiences of that have been good, because the specialization in violence in close relationships makes it easier to develop professional skills and maintain multi-professional cooperative relations with other service agencies. Turnover of staff has been high as a result of heavy work strain. Work counselling, better supervision, resilience training and additional occupational psychologist services have been introduced to prevent high turnover.

So called Competence Center is on call three days a week in the Unit of violence in close relationships. The Center consists of a psychologist and a social worker from the Child and Youth Forensic Psychiatry Unit. Detectives can hear the children in cooperation with the workers of the Competence Unity. Intensive cooperation reduces the workload of a crime investigator and improves the hearing of a child legally more reliable.

If DV victim had children, child welfare is always informed about the violence.

Not working:

A part of uniformed police officers have a limited view of the entirety and complexity of violence in close relationships. These officers may not understand the traumatizing effects of violence. In addition, they may not know all the partners with whom the police should cooperate with. Consequently, when the patrol encounters a situation in which the victim is not willing to speak about the events and the incident remains unclear the patrol may not necessarily record an offence. The probability of non-recording increases if there is a chance that it appears to the patrol that no offence has happen. These officers consider that the victim has a great responsibility for explaining the situation and stopping the violence.

In social and health care sector professionals working in frontline response are doing their own job but there is not always systematic, planned coordination between different actors and services. For example health care agencies are giving the necessary treatment in acute case but if customer doesn't have child/children social services is not part of the process. Sometimes health care professionals inform patients about shelter services, but not always. Either there is any follow up in health care (of course fractures etc. are followed but not the psychosocial part), and information about services patients might need after the acute situation is not given (NGO's material or information about municipalities services). Much work needs to be done to ensure that services are organized (written processes) and work as functional chains and ensure that victims receive the support needed. In Finland, the

Social Welfare Act (1301/2014) outlines that municipalities have to arrange social services also in situations of DV but these services are rarely specialized to DV.

There seems to be some gaps in some service processes. Firstly, cooperation between shelter services and child welfare and protection has room for improvement. Child welfare and protection should help the child already in the shelter, and the same familiar social worker should continue offering help and support also after the shelter period is over. Secondly, follow-up services and the guidance to customers to these services should be developed so that a solid stream of services accompanies the customer from the shelter to other services provided by the municipality.

**Overall, according to you, in this section, what is of key interest on your case?**

Cooperation is successful when the individuals have a genuine interest in violence in close relationships and they had a wide overall understanding of the phenomenon. Cooperation and collaboration were effective when the actors were physically located near to each other and knew their colleagues at least by appearance. The lack of management and permanent organizational structures of cooperation were considered as most problematic aspects. The successful cooperation was heavily dependent on the motivation and skills of individuals.

The cooperation within the Anchor team is guided by well-functioning structures and highly motivated personnel. Within the police organization, the cooperation between the Anchor team and the rest of the police depended on personal relations: contacting Anchor team was at the discretion of individual police officers.

The best practices are very often bounded on individual persons, which is problematic from the organizational perspective. Most interviews showed that the interviewee had developed a practice on the basis of his or her work experience that had been beneficial for instance when hearing or interviewing people, motivating to receive help or in exchanging information between agencies. These effective practices were not brought out in larger circles, and therefore they could not be utilized in training and education, nor was larger application of these practices encouraged. This problem was highlighted if these well-motivated and resourceful individuals moved into another unit or task: knowledge, skills, cooperative networks and effective practices would very likely disappear.

## 4. Respect of international standards on service provision (SP) by the police and other FLR

### Location 1

***Standards for all SPs***

| | Respected? Y/N/do not know | Comment (if any) |
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| There should be a help line covering DVs which is able to answer all incoming calls | Y | "Nollalinja" is a nationwide free-of-charge helpline for anyone who has experienced violence or a threat of violence in a close relationship. "Nollalinja" is also available for family members of victims of violence and for professionals and officials who require advice in their work with customers.<br><br>In acute cases victims or bystander can call emergency number 112. |
| There should be one specialist violence against women counselling service in every regional city. | Y and N | In both Case location 2 and Case location 1 there are NGO's specialist support services for adult victims of DV.<br><br>In the shelter victims of violence get support, guidance and counselling from professionals at the shelter as well as assistance and information for dealing with practical arrangements such as accommodation. The shelter is meant to be a short-term refuge during a crisis. Municipalities have an obligation to ensure all the other services that victims of DV need after a shelter stay.<br><br>These services vary between municipalities. |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | Y | On "Nollalinja" helpline customers can talk to professionals in Finnish, Swedish or English.<br><br>Almost all the shelters are fully accessible for people in wheelchairs in Finland, including shelters in Case location 1 and Case location 2. All the shelters in Finland use interpreter services in order to provide help for migrant victims. Interpreter services are also used in municipalities services (via phone and face to face).<br><br>The shelters cover geographically various parts of Finland and include also shelters for Swedish speaking as well as migrant women and children. If necessary, the shelters will pay customers' transportation costs from home to shelter.<br><br>Police uses interpreters. There is room for improvement in how to deal with individuals with various ethnic, religious and cultural backgrounds. |
| There should be a sufficient number of shelters available to victims of DV. | Y and N | In 2019, there are 28 shelters for victims of DV in Finland, and these can offer shelter for 202 families or clients that come alone. In Finland, the number of clients in the shelters during 2018 was 5 063, 2 697 of them adults and 2 358 children. 2 498 of the adult clients were female and 196 were male. Every day of the year the shelters had available family places across Finland but Finland has lots of sparsely populated areas with long distances where there |

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| | | is more challenging to access shelter service. |
| Service user has a right to be treated with respect and dignity at all<br>Times. Face-to-face contact should be within a safe, clean, and comfortable environment. | Do not know | Without knowing this for sure, we expect this is the case |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | Y | |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Do not know | |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons.<br>related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | Y and N | Without knowing this for sure, we expect that this is the case. |
| Services should be equitably distributed across geographic areas and population densities. | N | Finland has lots of sparsely populated areas with long distances where there is more challenging to access services. In 2016 THL started a pilot project in northern Finland to test if it was possible to provide "remote shelter services". It meant that in rural Kainuu region one family place was pointed out for victims of DV in connection to 24/7 crises center services. The professionals from the crises center could provide safety and protection for the clients in the remote shelter. The other part of this approach was the cooperation with the nearest existing shelter in the city of Oulu 200km away. The shelter in Oulu was responsible to provide technology-based interventions to support and help the victims of DV. The results from the project shows that this new form of shelter services is needed and that it is possible to support and help victims of DV by using technology-based interventions.<br><br>Municipalities are responsible for providing community care and services for those of its residents who have experienced DV. Access to services can vary between different municipalities despite the Social Welfare Act (1301/2014). |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Y | |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Y and N | This is not the case, for instance in hospital emergency room. |

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| Services should be provided free of charge. | Y and N | Services offered by NGO's are free of charge.<br><br>The Sexual Assault Support Center services in Case location 2 are totally free of charge. Also appointments of GP's are free of charge in Case location 2. In Case location 1 these services costs 41.20€ per visit. |
| Service providers should be mindful of the needs of children of service users. | | Professionals working in social and health care sector have a duty to notify the municipal body responsible for social services without delay and notwithstanding confidentiality provisions if, in the course of their work, they discover that there is a child for whom it is necessary to investigate the need for child welfare on account of the child's need for care, circumstances endangering the child's development, or the child's behavior. Municipal social workers help children and families in problem situations but they are not always specialized in DV situations.<br><br>Professionals working in shelters, hospitals and community health center in Finland must have a master´s or bachelor´s degree in social work or health care, which obligates them to follow specific laws and guidelines concerning professionals. These laws and guidelines provide a scaffold of protecting children and their rights in all social work and health care.<br><br>About half of the shelter customers are children (children usually stay in the shelter with their parent) and in shelter professionals have been trained to work with the children. In other services it varies. For example in Case location 2 there isn't worker who would be specialized working with children who have exposed to violence but there is a social worker who discusses about the violence with the child and the parents in the Anchor team. Long term specialist support services are still needed also for children. |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | Y/N | Professionals working in shelters, hospitals and community health center in Finland must have a master´s or bachelor´s degree in social work or health care.<br><br>Ongoing training about DV still lacks professionals in state agencies.<br><br>NGO's are used as trainers but it varies across services and municipalities. Volunteer working in shelter services are trained in short courses. |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | Do not know | |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | Y and N | Multi-agency "Anchor teams" working in Case location 2 police department's main police station consist of police officers, social workers and psychiatric nurse. While the police officer investigates the crime, the Anchor team's health care and social work professionals look into the overall circumstances of the client and his/her family. The Anchor team's social worker and nurse assess the needs of the client and her/his family and refer the client and the perpetrator to |

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| | | further services. There are no specialized services for children except child welfare and protection services (not specialized on DV). |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Y | |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Y | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users decision whether to make an official report to the police. | Y | This depends on service. In Case location 1, Multi Agency Risk Assessment Conference (MARAC), shelter services and in Sexual Assault Support Center in Case location 2, reporting the offence to the police is not required, even though it is encouraged. The client will be given information regarding NGO's services throughout the entire process, and, if they wish, they are assisted in starting the legal process. Other services can vary. |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | N | The Funding Centre for Social Welfare and Health Organizations (STEA) is a standalone state-aid authority operating in connection with the Ministry of Social Affairs and Health. STEA's funding can be granted to incorporated non-profit corporations and foundations for their work that promotes health and social welfare and which are registered within the Register of Associations or the Register of Foundations. Non-profit limited companies and cooperatives may also be eligible. The funding is not intended for use in statutory public services or business activities which prevents using funding on long-term support. Usually customers visit NGO services 1-15 times. If municipalities participate funding the services longer-term support is possible. |
| National and local governments should have funding streams for violence against women services. | N | See above.<br><br>Also the National Institute for Health and Welfare (THL) coordinates grants which municipalities can apply for health promotion projects (including DV projects).<br><br>In addition, some municipalities fund NGO's working in their area. There are no particular funding streams just for DV services. |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Y and N | This depends on the service. Be carried out in shelter services and Sexual Assault Support Center. |
| Services should develop guidelines for multi-agency co-operation. | N | |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | Y | THL will gather regularly data and feedback from the customers of shelter services and customers of Sexual Assault Center (Helsinki). |
| There should be clear protocols in place for data collection and information sharing between organisations. | Y | In Case location 1, Multi Agency Risk Assess Conference (MARAC) process will be started only with victim's consent. Victim can either seek help themselves or an official involved in the MARAC process, such as a police officer, can set the process in motion. Victim can give |

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| | | officials permission for sharing information regarding her/his situation. |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | Y | In Case location 2 area, the Sexual Assault Support Center provides clients a comprehensive service under one roof. The service entails forensic medical samples from the victim of the assault, comprehensive assessment of the situation, support for surviving the next few days, psychological support in recovering from a traumatic experience, and creating a plan for further treatment. The Sexual Assault Support Center serves all genders; women, men, transgender and intersex people, and other genders. The center is a support center for people over the age of 16 who have experienced sexual assault. Patients under the age of 16 are treated at the pediatric emergency clinics.<br><br>In the area of Case location 1 there isn't Sexual Assault Support Center so victims are treated at the emergency department of Central Hospital of the Hospital District. There is a chain of care in the area of Case location 1 which increases cooperation between primary and specialized healthcare, social services, NGO's and cooperation with other authorities, such as the police. |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | Y/N | In the area of Case location 2, a victim can choose at the Sexual Assault Center the forensic examiner's sex and all professionals are trained in evidence collection, documentation and writing medico-legal reports. In other areas the doctor on call will do the examination (not specialized on sexual violence). |

### *Standards for the police*

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | N | Most often the service users are informed about their rights and services they are entitled first time in the hearing. The consequence of this is that usually the victim has no support person or legal aid counsel with her/him in the hearing. |
| Police personnel should be trained on all aspects of DV. | N | Most of the uniformed police officers did not have training on DV as a social, psychological or economic phenomenon, or its consequences like the traumatization of victim, secondary victimization etc.<br>Some of the detective constables and detective sergeants had received some training organized by municipality or NGOs but opportunities to the attendance at the training were coincidental and depended on the motivation of the officer. |
| DV offences should be treated at least as seriously as other violent offences. | N | Some of the DV cases are transferred from the preliminary investigation process (police or prosecutor) to the mediation office without clarifying the on-going situation between the victim and perpetrator or without giving the victim enough information about the mediation process. |
| Victims should be seen as soon as possible by a specially trained officer | Y/N | Due to scarce resources of the investigation unit it is possible that the investigation unit is overloaded and it can take months before the case is brought forward and before the victim is seen by a crime inspector (detective constable or detective sergeant). In the case of an |

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| | | aggravated assault the victim is usually met as soon as possible by a crime inspector who works in the team of serious crimes. However, these police officers have not always got any training in DV but they have a long experience and expertise gained at the daily work. |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | | In the unit of response operations there are no specialized police officers for DV and for sexual violence. In the investigation unit there are specialized officers for DV and sexual violence. |
| Specialist Police units should be created in densely populated areas | Y | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Y | In most of the situations a crime report is a key to the services. For example in the situations where the police patrol does not file a report (explained e.g. as "verbal argumentation, an unclear situation, nobody has any claims") the victim or the perpetrator won't normally receive any contact from any services unless they've got children. Then the social workers of child welfare protection will contact the family. However, in case location 1 the multi-agency Anchor Team contacts also people whose case was not filed by uniformed police as the situation was explained to be "unclear". |
| Police should have powers to enter private property, arrest and remove a perpetrator. Restraining orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | N/Y | Police have powers to enter private property, arrest and remove the perpetrator.<br>An inside-the-family restraining order is most often first imposed as a temporary order by the police, which enters into force immediately. This is the case for example when the police removes a threatening person from home and takes him/her into custody and when the threat of a crime is evident also after releasing the person from custody.<br>Because an obligation to leave one's home involves stronger interference with the rights of a person than an ordinary restraining order, the prerequisites for imposing an inside-the-family restraining order is stricter than an ordinary restraining order. The order may be imposed only to prevent a crime on the life, health or liberty of a person or to avert a threat thereof, but not if the case involves crime on or harassment of peace. In addition, it is required that the likelihood of a crime referred to above would be greater if the order is not imposed. |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | N | The use of interpreter is not common at the response unit. Crime inspectors reserve an interpreter to the hearing.<br>Usually the victims are fully informed of the right to have a lawyer and a support person only in the beginning of the interrogation when there are no realistic chances for these persons to join the meeting unless the meeting is cancelled and rearranged later. |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Y | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | N | Most often the service users are informed about their rights and services they are entitled first time in the hearing. The consequence of this is that usually the victim has no support person or legal aid counsel with her/him in the hearing. |
| Police record systems should enable identification of cases of DV, and permit | Y/N | Police information system does not have an access to the database of courts. |

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| monitoring of interventions, repeat victimization and case outcomes | | |
| Police should have protocols on information sharing on DV with other agencies | Y | |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | Y | This is enabled by the teamwork of Anchor team and investigation unit and also by the MARAC meeting. |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained and reports made are kept confidential | N | Uniformed police officers do not file a crime report unless there is reasonable evidence or claims that a crime has been committed. Cases, where the situation is not clearly a criminal offence, is not reported as crime. |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | N | The response operations unit reacts to the DV call very fast. If the person reports police about the DV but the case is not considered acute or aggravated or high-risk, it can take months before the victim is contacted by a police officer. |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | Y/N | There is one police officer in case location 1 police station who works also in MARAC. The other police officers do not use any risk assessment tools. |
| Police should develop and implement strategies to eliminate or reduce victim risks | N | |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | do not know | Before the upgrade of police education up to bachelor level, there wasn't much training for earlier graduated police officers about meeting a victim sensitively or how to prevent secondary victimization. Thus for most police officers now working in the field, it depends on the individual police officer and if she/he is motivated and skilled to meet the needs of a victim. Now such aspects should be covered in training at Police University College, but there is not much time for this in the curriculum and it also depends on the individual teacher and his/her interests and emphasis. National Police Board has issued instructions on how to guide a victim of crime, which also includes a section on how to encounter and treat a victim of crime and a suspect of crime. These instructions cover some of the aspects listed in the left column, such as sensitivity, further traumatization and respect and the role of a support person. In principle commanding officers should take care that these instructions are implemented at work.<br>Some of the interviewed police officers understood the phenomenon of DV because they were exposed to DV as children or they had got training in DV or some other education. They emphasized the empathetic treatment of the victim. Some of the other interviewed police officers told about their frustration if the victim remains in a violent relationship. It is difficult to say are these feelings of frustration visible or not when the officer meets the victim. |

## Location 2

### *Standards for all SPs*

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Y | "Nollalinja" is a nationwide free-of-charge helpline for anyone who has experienced violence or a threat of violence in a close relationship. "Nollalinja" is also available for family members of victims of violence and for professionals and officials who require advice in their work with customers.<br><br>In acute cases victims or bystander can call emergency number 112. |
| There should be one specialist violence against women counselling service in every regional city. | Y and N | In both Case location 2 and Case location 1 there are NGO's specialist support services for adult victims of DV.<br><br>In the shelter victims of violence get support, guidance and counselling from professionals at the shelter as well as assistance and information for dealing with practical arrangements such as accommodation. The shelter is meant to be a short-term refuge during a crisis. Municipalities have an obligation to ensure all the other services that victims of DV need after a shelter stay.<br><br>These services vary between municipalities. |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | Y | On "Nollalinja" helpline customers can talk to professionals in Finnish, Swedish or English.<br><br>Almost all the shelters are fully accessible for people in wheelchairs in Finland, including shelters in Case location 1 and Case location 2. All the shelters in Finland use interpreter services in order to provide help for migrant victims. Interpreter services are also used in municipalities services (via phone and face to face).<br><br>The shelters cover geographically various parts of Finland and include also shelters for Swedish speaking as well as migrant women and children. If necessary, the shelters will pay customers' transportation costs from home to shelter.<br><br>Police uses interpreters. There is room for improvement in how to deal with individuals with various ethnic, religious and cultural backgrounds. |
| There should be a sufficient number of shelters available to victims of DV. | Y and N | In 2019, there are 28 shelters for victims of DV in Finland, and these can offer shelter for 202 families or clients that come alone. In Finland, the number of clients in the shelters during 2018 was 5 063, 2 697 of them adults and 2 358 children. 2 498 of the adult clients were female and 196 were male. Every day of the year the shelters had available family places across Finland but Finland has lots of sparsely populated areas with long distances where there is more challenging to access shelter service. |
| Service user has a right to be treated with respect and dignity at all | Do not know | Without knowing this for sure, we expect this is the case |

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| Times. Face-to-face contact should be within a safe, clean, and comfortable environment. | | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | Y | |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Do not know | |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons.<br>related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | Y and N | Without knowing this for sure, we expect that this is the case. |
| Services should be equitably distributed across geographic areas and population densities. | N | Finland has lots of sparsely populated areas with long distances where there is more challenging to access services. In 2016 THL started a pilot project in northern Finland to test if it was possible to provide "remote shelter services". It meant that in rural Kainuu region one family place was pointed out for victims of DV in connection to 24/7 crises center services. The professionals from the crises center could provide safety and protection for the clients in the remote shelter. The other part of this approach was the cooperation with the nearest existing shelter in the city of Oulu 200km away. The shelter in Oulu was responsible to provide technology-based interventions to support and help the victims of DV. The results from the project shows that this new form of shelter services is needed and that it is possible to support and help victims of DV by using technology-based interventions.<br><br>Municipalities are responsible for providing community care and services for those of its residents who have experienced DV. Access to services can vary between different municipalities despite the Social Welfare Act (1301/2014). |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Y | |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Y | |
| Services should be provided free of charge. | Y and N | Services offered by NGO's are free of charge.<br><br>The Sexual Assault Support Center services in |

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| | | Case location 2 are totally free of charge. Also appointments of GP's are free of charge in Case location 2. In Case location 1 these services costs 41.20€ per visit. |
| Service providers should be mindful of the needs of children of service users. | | Professionals working in social and health care sector have a duty to notify the municipal body responsible for social services without delay and notwithstanding confidentiality provisions if, in the course of their work, they discover that there is a child for whom it is necessary to investigate the need for child welfare on account of the child's need for care, circumstances endangering the child's development, or the child's behavior. Municipal social workers help children and families in problem situations but they are not always specialized in DV situations.<br><br>Professionals working in shelters, hospitals and community health center in Finland must have a master´s or bachelor´s degree in social work or health care, which obligates them to follow specific laws and guidelines concerning professionals. These laws and guidelines provide a scaffold of protecting children and their rights in all social work and health care.<br><br>About half of the shelter customers are children (children usually stay in the shelter with their parent) and in shelter professionals have been trained to work with the children. In other services it varies. For example in Case location 2 there isn't worker who would be specialized working with children who have exposed to violence but there is a social worker who discusses about the violence with the child and the parents in the Anchor team. Long term specialist support services are still needed also for children. |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | Y/N | Professionals working in shelters, hospitals and community health center in Finland must have a master´s or bachelor´s degree in social work or health care.<br><br>Ongoing training about DV still lacks professionals in state agencies.<br><br>NGO's are used as trainers but it varies across services and municipalities. Volunteer working in shelter services are trained in short courses. |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | Do not know | |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | Y and N | Multi-agency "Anchor teams" working in Case location 2 police department's main police station consist of police officers, social workers and psychiatric nurse. While the police officer investigates the crime, the Anchor team's health care and social work professionals look into the overall circumstances of the client and his/her family. The Anchor team's social worker and nurse assess the needs of the client and her/his family and refer the client and the perpetrator to further services. There are no specialized services for children except child welfare and protection services (not specialized on DV). |

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| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Y | |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Y | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users decision whether to make an official report to the police. | Y | This depends on service. In Case location 1. Multi Agency Risk Assessment Conference (MARAC), shelter services and in Sexual Assault Support Center in Case location 2, reporting the offence to the police is not required, even though it is encouraged. The client will be given information regarding NGO's services throughout the entire process, and, if they wish, they are assisted in starting the legal process. Other services can vary. |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | N | The Funding Centre for Social Welfare and Health Organizations (STEA) is a standalone state-aid authority operating in connection with the Ministry of Social Affairs and Health. STEA's funding can be granted to incorporated non-profit corporations and foundations for their work that promotes health and social welfare and which are registered within the Register of Associations or the Register of Foundations. Non-profit limited companies and cooperatives may also be eligible. The funding is not intended for use in statutory public services or business activities which prevents using funding on long-term support. Usually customers visit NGO services 1-15 times. If municipalities participate funding the services longer-term support is possible. |
| National and local governments should have funding streams for violence against women services. | N | See above.<br><br>Also the National Institute for Health and Welfare (THL) coordinates grants which municipalities can apply for health promotion projects (including DV projects).<br><br>In addition, some municipalities fund NGO's working in their area. There are no particular funding streams just for DV services. |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Y and N | This depends on the service. Be carried out in shelter services and Sexual Assault Support Center. |
| Services should develop guidelines for multi-agency co-operation. | N | |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | Y | THL will gather regularly data and feedback from the customers of shelter services and customers of Sexual Assault Center (Helsinki). |
| There should be clear protocols in place for data collection and information sharing between organisations. | Y | In Case location 1, Multi Agency Risk Assess Conference (MARAC) process will be started only with victim's consent. Victim can either seek help themselves or an official involved in the MARAC process, such as a police officer, can set the process in motion. Victim can give officials permission for sharing information regarding her/his situation. |
| Hospital emergency departments should | Y | In Case location 2 area, the Sexual Assault |

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| have protocols for handling sexual violence and staff training. | | Support Center provides clients a comprehensive service under one roof. The service entails forensic medical samples from the victim of the assault, comprehensive assessment of the situation, support for surviving the next few days, psychological support in recovering from a traumatic experience, and creating a plan for further treatment. The Sexual Assault Support Center serves all genders; women, men, transgender and intersex people, and other genders. The center is a support center for people over the age of 16 who have experienced sexual assault. Patients under the age of 16 are treated at the pediatric emergency clinics.<br><br>In the area of Case location 1 there isn't Sexual Assault Support Center so victims are treated at the emergency department of Central Hospital of the Hospital District. There is a chain of care in the area of Case location 1 which increases cooperation between primary and specialized healthcare, social services, NGO's and cooperation with other authorities, such as the police. |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | Y/N | In the area of Case location 2, a victim can choose at the Sexual Assault Center the forensic examiner's sex and all professionals are trained in evidence collection, documentation and writing medico-legal reports. In other areas the doctor on call will do the examination (not specialized on sexual violence). |

## *Standards for the police*

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | N | Most often the service users are informed about their rights and services they are entitled first time in the hearing. The consequence of this is that usually the victim has no support person or a legal aid counsel with her/him in the hearing. |
| Police personnel should be trained on all aspects of DV. | N | Most of the uniformed police officers had not training about DV as a phenomenon or its consequences like traumatization of victim etc. Some of the detective constables and detective sergeants had training organized by municipality or NGOs but opportunities to the attendance at the training were incidental and depended on the motivation of the officer. |
| DV offences should be treated at least as seriously as other violent offences. | N | Some of the DV cases are directed from the preliminary investigation process (police or prosecutor) to the Mediation Office without clarifying the still on-going situation between the victim and perpetrator or without giving the victim enough information about the mediation process. |
| Victims should be seen as soon as possible by a specially trained officer | Y/N | Due to resources of the investigation unit it is possible that the investigation unit is overloaded and it can take months before the case is brought forward and before the victim is seen by a crime investigator (detective constable or detective sergeant). In the case of an aggravated assault the victim is usually met as soon as possible by a crime investigator. However, these police officers do not always have any training in DV but they have a long experience and expertise gained at the daily |

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| | | work. |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | N/Y | In the unit of response operations (uniformed police) there are no specialized police officers for DV and for sexual violence. Police officers of response operations can consult the duty officer of the investigation unit in the case of sexual crimes and DV cases. In the investigation unit there are specialized officers for DV and sexual violence. |
| Specialist Police units should be created in densely populated areas | Y | There is a specialist unit investigating violence in close relationships at the case location 2 police department. |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Y | There are campaigns and public promotions by different agencies, the police, health care, social care, women's refuge services etc. The latest campaign was along Epras project between 2018 and 2019. |
| Police should have powers to enter private property, arrest and remove a perpetrator. Restraining orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | | Police have powers to enter private property, arrest and remove the perpetrator.<br>An inside-the-family restraining order is most often first imposed as a temporary order by the police (commanding officers that have powers to apply for a detention order), which enters into force immediately. This is the case for example when the police removes a threatening person from the home and takes him/her into custody and when the threat of a crime is evident also after releasing the person from custody.<br>Because an obligation to leave one's home involves stronger interference with the rights of a person than an ordinary restraining order, the prerequisites for imposing an inside-the-family restraining order are stricter than those of an ordinary restraining order. The order may be imposed only to prevent a crime on the life, health or liberty of a person or to avert a threat thereof, but not if the case involves crime on or harassment of peace. In addition, what is required is that the likelihood of a crime referred to above would be greater if the order is not imposed. |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | N | The use of interpreter is not common at the response unit. Crime investigators reserve an interpreter for the hearing.<br>Usually victims are fully informed of the right to have a lawyer (legal aid) and a support person only in the beginning of the interrogation when there are no realistic chances for these persons to join the meeting unless the meeting is cancelled and rearranged later. |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Y | This is a common protocol. |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | N | Usually victims are fully informed of the right to have a lawyer and a support person only in the beginning of the interrogation when there are no realistic chances for these persons to join the meeting unless the meeting is postponed and rearranged later. |
| Police record systems should enable | Y/N | Police information system can be search for |

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|---|---|---|
| identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | | information about records of crime and other police activities, but there is no electric link between this database and the information systems and databases used by prosecutor the courts. This makes monitoring hard, or even impossible. |
| Police should have protocols on information sharing on DV with other agencies | Y | This is regulated by the legislation. |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | N | The investigation unit of DV and Anchor team share information but they do not meet a client at the same time. |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained and reports made are kept confidential | N/Y | Uniformed police officers do not file a crime report unless there are reasonable claims that a crime has been committed. Cases, where the situation is not clearly enough a criminal offence, are not reported as crime. Information and reports are confidential. |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | N/Y | The response operations unit reacts to the DV call very fast. If the person reports police about the DV but the case is not considered acute or aggravated or high-risk, it can take months before the victim is contacted by a police officer. |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | N | |
| Police should develop and implement strategies to eliminate or reduce victim risks | N | |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | N/Y | Before the upgrade of police education up to bachelor level, there was not much training for the police officers about meeting a victim of domestic violence sensitively or how to prevent secondary victimization, or such training was unsystematic. Thus for most police officers now working in the field, these things depend on the individual police officer and if she/he is motivated and skilled to meet the needs of a victim. Now such aspects should be covered in training at Police University College, but there is not much time for this in the curriculum and it also depends on the individual teacher and his/her interests and emphasis. National Police Board has issued instructions on how to guide a victim of crime, which also includes a section on how to encounter and treat a victim of crime and a suspect of crime. These instructions cover some of the aspects listed in the left column, such as sensitivity, further traumatization and respect and the role of a support person. In principle commanding officers should take care that these instructions are implemented at work. |

## III. FRANCE

### Location 1 La Réunion (France)

La Réunion is an overseas department of France, located to the east of Madagascar in the Indian Ocean. La Réunion is an island with a population of 800,000. The population is made of the descendants of French settlers, the descendants of slaves from Madagascar and Africa, the descendants of indentured servants from India following the abolition of slavery, and French "expats", often working in the public sector. The main economic resource is tourism.

### 1. Methodology

#### How many interviews have been conducted? With whom?

A total of 39 interviews with 53 different people (8 interviews with 2 or more people, one re-interview), with:

- Police officers and gendarmes, from the highest echelons to frontline personnel)
- Social workers embedded in police stations
- NGOs, more or less structured, more or less activists
- Personnel from the "prefecture" (the agency representing the central state at the local level), including the delegate for women's rights
- Personnel from the departmental social services
- Prosecutors

#### How where they selected? How did you get access?

We got access through our partnership with the French gendarmerie (IMPRODOVA partner). The vast majority of the interviews were scheduled by a gendarme who has become an expert on domestic violence in the island. We got full and complete access to the gendarmes, good access to the police, were introduced to the most important and relevant NGOs, and so on. There is a wide consensus on the island that domestic violence is a problem – la Réunion has the highest rates of DV in France – and therefore our presence was seen as legitimate. We spent a bit more than two week doing intensive fieldwork (3 interviews per day and sometimes 4, with 4 interviewers). After the first week we were able to identify persons of interest we would like to interview, outside of the gendarmerie-scheduled interviews, and we contacted them.

#### Describe the interviews (length, tape-recorded or not)

Interviews lasted on average 2 hours, sometimes more and very rarely less. Because of our introduction by the Gendarmerie, we were taken seriously by all interlocutors, who had time for us. In accordance with the ethics protocol of our university, we didn't tape-record. We took notes, wrote-up notes after meetings, and typed-up the notes at night and in the following days.

**Describe limitations**

We are extremely satisfied with our research effort, but we wish we could have greater access to the medical profession and to public social services. We do not think that the introduction by the Gendarmerie prevented our interlocutors to speak candidly. Many of our interviewees were extremely candid, and the people from NGOs were vocal about problems with the police response.

## 2. Overview

**Which actors are involved in the handling of domestic violence? What do they do? What is the nature of their involvement?**

- Police officers & gendarmes: police officers are civilian personnel who focus on urban areas; gendarmes are military personnel who focus on the countryside. In the Réunion, the difference between the two types of jurisdiction is less obvious than in metropolitan France. Both police and gendarmes take reports from victims, realize investigations, arrest perpetrators and transfer them to prosecutors.
- Social workers embedded in police stations: they are former social workers from the department social services, with lots of experience, and have chosen to apply for the embedded position within police stations and gendarmeries. They work with victims, help them in their applications for social aid, and interact constantly with police officers.
- NGOs, more or less structured, more or less activists: there are 3 main NGOs which are highly professionalized, with a budget in the 500+k€, working with police and prosecutors; and a lot of smaller, more vocal (some say “oppositional”) NGOs which work with victims is “only” to listen to them.
- Préfecture’ delegate for women’s rights: the delegate’s formal function is to act against violence against women and in favor of professional equality between men and women; the delegate’s work is to convene other actors and to make them work together, for instance to establish partnerships between NGOs and police and prosecutors.
- Personnel from the departmental social services: they are the main providers of public social aid. They have a network of social workers who are trained to refer victims to social workers embedded in police stations.
- Prosecutors: prosecutors in the Réunion are very active when it comes to DV. In particular, they have institutionalized the practice of “instant audience” (“comparution immédiate”), that is, DV perpetrators are judged on a fast track (sometimes a matter of days), so as to speed up proceedings related to DV. Also, they are engaged in a initiative to treat perpetrators of DV with addictions.
- The medical profession: they play a key role in establishing the “reality” of violence by establishing medical certificates. They are perceived by some NGOs are lagging behind in the detection of DV (NGOs say that general practitioners must know about a lot of victims, as they know a lot about their patients’ lives and health, but very few detections originate with the report of a GP).

**What types of domestic violence are considered?**

In the Réunion like in everywhere else, there are victims of physical, sexual and psychological violence, as well as economic abuse. But it is much easier for victims of recent physical violence to be recognized as victims. NGOs are prompt to point out that DV victims' report are not taken at the police stations and gendarmerie, and additional probing shows that the real problem are the reports for sexual and psychological violence. That is, visible physical violence (bruises, injuries) or violence that is established by a medical certificate is (almost) always taken seriously by the officers, but not psychological and sexual violence. Gendarme commanders agree to that:

> Researcher*: "NGOs accuse you [*gendarmes*] of not taking the reports for other things than physical violence"*
> Gendarme commander*: "I agree with the NGOs. They all describe this, 'report not taken'. And the gendarme: 'yes but the facts are not established'. We need medical certificates, we need to see something. To take reports when the facts are only psychological, they [*officers*] are uneasy with that"*

For this reason (lack of hard evidence), women who come to the police station to report psychological violence or spousal rape may find police response lacking. With the increased presence of social workers embedded in police stations, victims are more likely to be heard.

**Do involved actors have different conceptions of DV, and which?**

The main contention point regarding definitions of DV at play among actors in the Réunion is between:

- Proponents of a "violence against women" understanding of domestic violence. This can be found among some NGOs (not all), especially the less structured, less organized, less professional, less integrated NGOs, as well as some state representatives. In the "violence against women" framework, domestic violence is caused by masculine domination, and DV is a sub-type of the more generic category of violence against women (with rape, female genital mutilation, honor killing). Proponents of the "violence against women" framework tend to be more vocal against police response to DV.
- People who do not necessarily adhere to a rigid theoretical conception but who tend to see DV as a subtype of violence within the family (alongside violence against children or seniors). Most professionals from law enforcement, as well as many NGOs, intuitively refer to DV as "family violence" and/or emphasize that the greatest problem with DV is how it negatively affects children (as opposed to women) and how it is caused by social problems and alcoholism (as opposed to masculine domination).
    - A subtype in this category may be represented by an NGO which understands domestic violence as a medical condition, where both victims and perpetrators have to be treated.

**Describe the education/training on DV that different actors have access to.**

Police officers and gendarmes have access to some trainings from their institution, but in limited supply. What we observe in the Réunion are actors with experience with domestic violence (NGOs, but also specialized police officers and social

workers) delivering more or less informal trainings to their colleagues.

**Which actors see DV as a priority? Which do not?**

Everyone wants to demonstrate that they take DV seriously and that they "do something" about DV. The highest levels of the police hierarchy at the Réunion received us almost overnight, the gendarmerie is an Improdova partner and was extremely cooperative and helpful, the social workers and the NGOs obviously were highly concerned about DV, the state agencies also ostensibly expressed their concern and were eager to communicate about their actions towards DV. The Réunion is one of the French departments with the highest rate of DV, and the problem is continuously in the news.
On the other side, we had scant access to the medical profession, but all other actors reported that the medical professions – especially general practitioners – were not as active as they could be.

**Which actors work to make DV a more central concern?**

Definitely:

- the local NGOs (the less structured, less organized, against "violence against women" type);
- the state's delegate for women's rights, who organized a general assembly of all partners in 2016-2017 and works to ensure that partnerships between NGOs and institutions (police, prosecutors) remain in place even in face of high personnel turnover;
- the fact that 2 or 3 times per year, a very gruesome killing happens (when we where conducting fieldwork: a triple infanticide, to get back at the ex-wife) which put DV in the news and forces everyone to keep focused on the issue.

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**

In general, there is a fairly-well working pattern of cooperation with task-sharing among different actors: once victims are identified / found / reveal themselves, and if they are willing, they will go to the police, will be oriented towards the embedded social worker, and from there will be oriented towards the social services or legal aid they need, while police and prosecutors work together well. This is the general pattern.
The actors that are out of this network are:

- the medical profession (but more research is needed as we couldn't interview some key medical professionals)
- the vocal NGOs (the one which bring little legal or psychological or medical expertise and focus on denouncing problems).

**3. Steps of a DV case**

**How are victims identified and detected? Are there active measures to maximize victim detection?**

This is the major problem at the Réunion. Police and gendarmes say that about 80%

of the women who report a crime in a police station are victims who were found after someone called 911 during an ongoing episode of violence, which led to a police intervention, where officers convinced the victim to come to the police station to report the incident. The remaining 20% are made of women who report a crime long after the episode happened (usually a chronic situation over years) and of women who want to report a recent incident, but without police involvement.

Police officers and gendarmes are well aware that this state of affairs in unsatisfactory, as they know the gap between the number of incidents evidenced by victimation surveys and the number of formal reports to the police. But they feel they have little means to make victims come to the police station to report a crime, apart from general information campaigns (TV spots, posters, etc.) and improving the reputation of how victims are welcomed when they enter police stations. The police, for instance, works to make the waiting room more welcoming, to reduce waiting time, to fast-track women who come for domestic violence.

Other actors claim to be the main purveyors of victims to police stations (NGOs, department social services). But they only play a role in the decision to report of those 20% of women who do not come to the station after a police intervention. Their role is therefore secondary (albeit crucially important for these women).

**Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?**

After interventions for DV, police officers are embedded social workers call the victims to motivate her to come to the police station to report the crime (if any). These call-backs are scheduled even if the incident doesn't lead to an arrest or a formal procedure.

**Describe the process of filing a complaint. Are there active measures taken around this topic?**

Victims must first pass a first filter at the reception, and then are oriented to both the embedded social worker (if she is present) and a police officer, who will follow a structured questionnaire thanks to the software used to take reports (described in WP1).

Embedded social workers help with reporting by structuring the report: sometimes victims "rehearse" their audition with the social worker, because they are in an emotional state which prevents them from providing all the relevant information; sometimes they need to be educated as to what constitutes a crime and what doesn't. The problem here is when the embedded social worker suggests to the victim to tell specific details which the social worker knows will trigger a desired juridical outcome (for instance in future conflicts about who will have the kids, who will keep the house). Police officers hate this type of interference, which can lead to conflict between the social worker and police officers.

The main question is whether victims report a crime to a random officer, or to a specialized one. Police and gendarmeries have created specialized units (on DV) to increase the level of professionalism and service to victims. The effects are clear:

specialized units are more competent, they understand better the victims, are more able to detect dynamics of risk, and so on. The problem is that to field specialized units, there must be a critical mass of personnel in a given police station or gendarmerie.

**Describe what happens after victims have filed a complaint: which problems arise then?**

According to NGOs, victims feel frustrated after the report for two reasons. First, they may perceive the court proceedings and the punishment as excessively lenient (not all reports go to court, a lot of cases in court are "punished" with formal warnings). Second, the penal procedure usually becomes less important than the civil procedure: divorce, children custody, etc. Lengthy legal battles are hugely frustrating for the victim; in spite of the help she can get from expert NGOs.

**Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

Victims will receive two types of help:

- from public sources: they will be referred to social workers, receive monetary assistance if needed, get assigned housing, etc. This is all part of how the French welfare state operates, with a strong focus on protecting children (and therefore helping mothers).
- From private sources (NGOs): in the Réunion, victims will get most of their assistance from two principal NGOs, one that helps victims deemed at higher risk of re-victimization; this NGO works with both perpetrators and victims, and employs skilled psychologists. The other NGO is a legal aid service, which will help women with their penal and civil proceedings.

**In this process, what are the main obstacles and problems that victims face?**

Once a victim is identified as such by any relevant actor (social services, police, expert NGOs, etc.), the victim is "taken care of": he/she will be motivated to report the incident to the police, where she will receive expert help from the embedded social worker, and will be referred to all the competent NGOs she needs. There is general consensus that finding housing is not a huge concern. The problem that victim will face is after reporting, when the procedure shifts from the penal component (getting a punishment for the perpetrator) to the civil component (divorcing, children custody, etc.). Many victims feel betrayed by the rights that that their abusive partner enjoy.

**What do you see, in the frontline response to DV, as "working" and "not working"?**

In the Réunion, what doesn't work is victim detection.

In the Réunion, what works is the general state of cooperation between diverse actors: social services, police agencies, expert NGOs, prosecutors. There is a clear sense that DV is a real problem and a clear motivation from all the parties to work together to improve the situation. This results for instance in police officers and NGO personnel working together, learning from each other, in ways that plausibly improve

the service offered by the police (and gendarmerie).

**Overall, according to you, in this section, what is of key interest on your case?**

- The key problem is to get victims to go to police stations;
- Specialized units – critical to allow for professionalization of police officers; specialized officers may also find that working on DV can be interesting and rewarding, something they may experience by working with NGOs which provide them with types of expertise and intellectual tools that police officers find useful and stimulating;
- Embedded social workers (keeping in mind that sometimes their relationship with police officers is not good).

## 4. Respect of international standards on service provision (SP) by the police and other FLR

### *Standards for all SPs*

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Y | |
| There should be one specialist violence against women counselling service in every regional city. | Y | |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | Y | But this is made more difficult with Creole language |
| There should be a sufficient number of shelters available to victims of DV. | Y | |
| Service user has a right to be treated with respect and dignity at all<br>Times. Face-to-face contact should be<br>within a safe, clean, and comfortable<br>environment. | Y | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | Y | |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Y | |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons.<br>related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | Y | |
| Services should be equitably distributed across geographic areas and population densities. | | Obviously it is better to be in the big city where everything is, but given Réunion is small and densely populated, spatial |

| | | |
|---|---|---|
| | | equity is fairly well respected. |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Y | |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Y | |
| Services should be provided free of charge. | Y | |
| Service providers should be mindful of the needs of children of service users. | Y | |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | | Depends on NGOs. In more structured ones, Yes; in less structured ones, no. |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | Y | |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | Y | |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Y | |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Y | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users decision whether to make an official report to the police. | Y | |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | Y | |
| National and local governments should have funding streams for violence against women services. | Y | |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Y | |
| Services should develop guidelines for multi-agency co-operation. | Y | |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | | Depends NGOs; the least structured ones do not collect data |
| There should be clear protocols in place for data collection and information sharing between organizations. | Y | But only for high-impact DV |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | Y | |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | ? | |

## Standards for the police

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | Y | |
| Police personnel should be trained on all aspects of DV. | | Depends on whether there are specialized units |
| DV offences should be treated at least as seriously as other violent offences. | Y | |
| Victims should be seen as soon as possible by a specially trained officer | | Depends on whether there are specialized units |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | | Depends on whether there are specialized units |
| Specialist Police units should be created in densely populated areas | Y | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Y | |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | Y | |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | Y | |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Y | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | Y | |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | N | |
| Police should have protocols on information sharing on DV with other agencies | Y | For high impact DV |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | Y | |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained and reports made are kept confidential | Y | |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | Y | |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | N | |
| Police should develop and implement strategies to eliminate or reduce victim risks | N | These plans are developed by the state's local representative (prefecture) |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | | Depends on whether there are specialized units |

## Location 2 - Loire-Atlantiques Nantes

The Loire-Atlantique is a department located in the West of France, with a population of about 1,4 million inhabitants.

### 1. Methodology

**How many interviews have been conducted? With whom?**

A total of 9 interviews with:

- Police officers (1) and gendarmes (3) who are specialized in handling DV cases at the departmental level.
- Social workers embedded in police stations (2)
- The main victim support NGO in Nantes (1)
- The main women's rights promotion association in Loire-Atlantique – CIDFF (1)
- The delegate for women's rights of the departmental "prefecture" (the agency representing the central state at the local level) (1)

**How where they selected? How did you get access?**

We got access through our partnership with the French gendarmerie (IMPRODOVA partner) and the French police (through our contacts in the national senior officers' training school of the police). Interviews were scheduled in January and July by the CNRS team. DV is actually considered as a political stake and a policy priority in Loire-Atlantique, therefore our interlocutors regarded as normal to be interviewed by researchers.

**Describe the interviews (length, tape-recorded or not)**

Interviews lasted on average 2 hours, sometimes more and very rarely less. Because of our introduction by the gendarmerie and the police, we were taken seriously by all interlocutors, who had time for us. In accordance with the ethics protocol of our university, we didn't tape-record. We took notes, wrote-up notes after meetings, and typed-up the notes at night and in the following days.

**Describe limitations**

Our fieldwork effort was focused on La Réunion, so it was impossible to conduct a extensive study in Loire-Atlantique. We focused our study on a good practice which was developed by the gendarmerie: a departmental unit which is responsible for calling the victim the next day after a DV situation is identified (most often through an emergency call). This practice will be presented in detail in the D2.4.

## 2. Overview

### Which actors are involved in the handling of domestic violence? What do they do? What is the nature of their involvement?

Same thing than in La Réunion, apart from the presence of a local branch of the main French NGO for promoting women's rights (CIDFF). In this regard, La Réunion is an exception because there is no CIDFF on the island, which appears problematic in terms of legal support to victims of DV (local small NGOs are less capable in providing legal advice to victims).

Another difference is that the departmental delegate for women's rights work under the direct supervision of a regional delegate for women's rights (since the Loire-Atlantic is a regional prefecture). As a result, she has less autonomy and less resources than her colleagues who work in departmental prefectures, and consequently is less central and has less influence in the network of stakeholders than the delegate for women's rights in La Réunion. In Loire-Atlantique, this network is less integrated, more fragmented, and key actors are the Department Council and the municipality of Nantes, in sharp contrast to La Réunion where these actors were among the least involved.

The 4 specialized social workers within the police and the gendarmerie are financed by the Department Council.
Ordinary social workers of the Department Council help victims to prepare their separation from the perpetrator.

The Department Council subsidizes many specialized NGOs. It is responsible for a departmental observatory of violence against women (which is more a tool for institutional communication than a tool to survey the state of DVs in the department). It is responsible for the protection of children who are exposed to family violence. It takes initiatives to improve the training of its 4800 personnel regarding DV. It created a departmental committee to coordinate the activities of the different stakeholders, which is effectively attended by all the local actors.

The prosecutor' office pursues initiatives to prevent re-offending, manages the phone devices for women who are at serious risk, implement the European tools for individual evaluation of victims (EVVI), and works with the police and the gendarmerie to improve the reporting of DV situations to the prosecutor 'office when the victim does not fill a complaint.

The police have established a victim support unit staffed with 1 social worker, 1 psychologist and 2 specialized investigators (it looks very much like the Austrian victim support unit described in the Austrian country report).

The gendarmerie has initiated the departmental unit responsible for recalling the victims, and offers prevention activities targeting middle-school students through its unit for prevention of juvenile delinquency.

The CIDFF (main legal aid NGO) organizes focus groups of stakeholders to promote better knowledge of one another, and to facilitate the elaboration of common

strategies.

**What types of domestic violence are considered?**

The number of women victim of DV in Loire-Atlantique is around 4600 each year. The number of cases of children's exposure to domestic violence and emotional maltreatment is around 3000. The Loire-Atlantique is third-placed among French departments for the number of emergency call to the help line covering DVs (3919). In 2016, 5 women have been killed by their intimate partner.

As in the case of La Réunion, non-specialized police officers tend to consider mainly physical abuses whereas specialized officers have a broader understanding of DVs and generally attempt to establish the full range of offences that were committed by the perpetrator in each DV situation, including harassment, psychological violence, sexual violence, financial violence, and so on.
Looking on the larger scale of the whole network of stakeholders, all types of DV are taken into consideration and are managed by one or another actor, even specific DV situations (LGBT, immigrants, addiction situation…).

**Do involved actors have different conceptions of DV, and which?**

The same thing than in La Réunion.

**Describe the education/training on DV that different actors have access to.**

The same thing than in La Réunion.

The main victim support NGO (France Victimes 44) has invested heavily in training gendarmerie officers, since this NGO is the major partner of the gendarmerie departmental unit responsible for recalling DV victims.

**Which actors see DV as a priority? Which do not?**

DV is a priority for all actors. The Department Council (the local government at departmental level) and the municipality of Nantes are particularly involved in the elaboration and implementation of policy initiatives against DV (which is not the case in La Réunion). There is a rivalry between the different local and national authorities (Nantes municipality, Nantes Metropolitan Council, Department Council, prefecture, big public interest NGOs) to appear as the most dedicated and proactive actor. This is not to say that actors have conflicting relationships or refuse to cooperate. Rather, it means that there has been inflation in separate initiatives and competition to occupy media space.

The level of involvement of the hospital doctors seems to be higher than in La Réunion (there are a lot of hospital units providing special attention to DV victims), but the difficulty of raising awareness among family physicians is the same.

**Which actors work to make DV a more central concern?**

See above.

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**

As in La Réunion, the network of specialized actors works in a quite coherent and integrated manner despite the rivalries stated above. As long as a victim comes into contact with a specialized actor, whether it is police investigator (in a family protection unit), medical doctor (in a hospital victimology unit) or social worker (within the police or a within a NGO), there is a very good chance that she will receive correct advice, proper orientation and appropriate support. There is a clear divisions of tasks between police investigators, social workers within the police, specialized hospital units, legal aid NGO, social aid NGO, women's rights promotion NGO and public welfare administrations. However, the respective roles of the Department Council, the municipality of Nantes and the departmental and regional delegates for women's rights are not well established. Each of these institutions pretend to be the main coordinator of the network of stakeholders.

The actors that are out of this network are the non-specialized and non-professionalized ones: small vocal NGOs, general practitioners of the medical profession.

## 3. Steps of a DV case

**How are victims identified and detected? Are there active measures to maximize victim detection?**

Same thing than in La Réunion.

The departmental unit of the gendarmerie which is responsible for recalling the victims is one measure to maximize victim detection.
Medical doctors, social workers, lawyers and schools seem to be more prone to orient DV victims towards specialized first responder (specialized units of the police or gendarmerie and of hospitals, NGOs) than in La Réunion.

**Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?**

Same thing than in La Réunion.
NGOs systematically explain to the victim how to fill a complaint, help them to be aware of the different types of abuses they have suffered and to gather evidence, and support them through the process, but do not pressure their users to fill a complaint, because NGOs know that judicial proceedings can have negative consequences for the victim.

**Describe the process of filing a complaint. Are there active measures taken around this topic?**

Same thing than in La Réunion

**Describe what happens after victims have filed a complaint: which problems arise then?**

Same thing than in La Réunion.

**Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

Same thing than in La Réunion.

Help from private sources is more structured and less fragmented than in La Réunion: there are only 3 main NGOs that provide assistance to victims – France Victimes 44 provides legal aid to help victims tackling criminal proceedings ; Solidarité Femmes 44 provides shelter as well as social and psychological support, CIDFF provides legal aid to help victims tackling civil proceedings (divorce…), and small NGOs provide help to specific groups (LGBT, immigrants…).

**In this process, what are the main obstacles and problems that victims face?**

Same thing than in La Réunion

**What do you see, in the frontline response to DV, as "working" and "not working"?**

The victim support unit of the police has developed its own network of partnerships with individual social workers working in other organizations. This alternative network is not sufficiently coordinated with the main one.

Restraining orders are seldom demanded by victims and seldom used by judges or prosecutors. The application form is too complicated for victims, who need the help of a NGO to fill it correctly.

Due to the profusion of initiatives, victim risks to be bounced between different institutions and NGOs depending the nature of the advice they need at different steps. To remedy this problem, actors actually are in the process of creating a one-stop-shop reception center in Nantes where all stakeholders will be present.

Actors want to improve the quality of support delivered to disabled persons.

One actor said that too many victims still receive poor reception at police or gendarmerie station ("30-40% of them are not satisfied") – but it admitted that specialized units do good job in this respect – the problem comes from non-specialized officers who feel no empathy for victims.

Actors are not capable to monitor the situation of DVs in the department, they do not

initiate studies or surveys that could help them to get a better knowledge of that phenomenon. They do not assess the impact of their activities.

**Overall, according to you, in this section, what is of key interest on your case?**

The victim support unit of the police.
The departmental unit of the gendarmerie which is responsible for recalling victims.
The one-stop-shop reception center in Nantes (should be opened in September 2019).

## 4. Respect of international standards on service provision (SP) by the police and other FLR

### *Standards for all SPs*

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Y | |
| There should be one specialist violence against women counselling service in every regional city. | Y | |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | Y | With some variability depending on locations |
| There should be a sufficient number of shelters available to victims of DV. | Y | |
| Service user has a right to be treated with respect and dignity at all Times. Face-to-face contact should be within a safe, clean, and comfortable environment. | Y | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | Y | |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Y | |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons.<br>related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | Y | |
| Services should be equitably distributed across geographic areas and population densities. | Y | Nevertheless it is better to be in the big city where everything is, than in remote rural areas. |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Y | |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Y | |

| | | |
|---|---|---|
| Services should be provided free of charge. | Y | |
| Service providers should be mindful of the needs of children of service users. | Y | |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | Y | Loire<br>-Atlantique NGOs are very professional |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | Y | |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | | It depends from the NGO |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Y | |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Y | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users decision whether to make an official report to the police. | Y | |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | Y | |
| National and local governments should have funding streams for violence against women services. | Y | |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Y | |
| Services should develop guidelines for multi-agency co-operation. | N | |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | Y | |
| There should be clear protocols in place for data collection and information sharing between organisations. | N | |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | Y | |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | Y | |

## Standards for the police

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | Y | |
| Police personnel should be trained on all aspects of DV. | | Depends on whether there are specialized units |
| DV offences should be treated at least as seriously as other violent offences. | Y | |
| Victims should be seen as soon as possible by a specially trained officer | | Depends on whether there are specialized units |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | Y | |

| | | |
|---|---|---|
| Specialist Police units should be created in densely populated areas | Y | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Y | |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | Y | |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | Y | |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Y | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | Y | |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | Y | |
| Police should have protocols on information sharing on DV with other agencies | Y | |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | N | |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained and reports made are kept confidential | Y | |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | Y | |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | N | |
| Police should develop and implement strategies to eliminate or reduce victim risks | N | The strategies are focused on victim support and maximizing punition of the perpetrator, but not on reducing DV in society. |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | | Depends on whether there are specialized units |

# IV. GERMANY

## Location 1: Freiburg

### 1. Methodology

**How many interviews have been conducted? With whom?**
Altogether, ten interviews have been conducted: police chief (1 interview), domestic violence police specialist (2 interviews), patrol officers (3 interviews), forensic specialist in DV cases (1 interview), NGO (3 interviews).

**How where they selected? How did you get access?**
Access to interview partners was received by existing connections to police chiefs from former research cooperations, from contacts from the German Police University, from previous EU research, and via snowball-effect (NGO). The first NGO was contacted by calling the institution identified via online research.

**Describe the interviews (length, tape-recorded or not)**
Interviews on average took one hour. All interviews were audio-recorded.

**Describe limitations**
Not applicable.

### 2. Overview

**Which actors are involved in the handling of domestic violence?**

Police patrol officers who initially attend the emergency call, carry out the first response measures like restraining order, removal of perpetrator from residence, information to youth authority and referring to NGOs.
The following interview partners are involved in the handling of domestic violence:

- Patrol law enforcement in one or two teams, occasionally K-9 units and rarely backup (4).
- DV investigation and management specialists (2)
- Forensic scientist (1)
- Social worker, Psychologist (NGO, Women's Shelter)

**What do they do? What is the nature of their involvement?**

The police respond to emergency calls, and, if necessary remove the abuser. Moreover, they conduct further investigation and legal measures. Especially DV investigation and management specialists protect victim and children, remove or admonish the perpetrator, inform the Youth Authority, and provide contact to counselling services

**What types of domestic violence are considered?**

All, domestic Violence is the generic term used for assault on partners and family members. In the report there is no specification other than in criminal law terms.

**Do involved actors have different conceptions of DV, and which?**

No.

**Describe the education/training on DV that different actors have or have access to.**

Professional education B.A. at college level (police and investigators), university level undergraduate and graduate (NGOs), medical doctorate/specialist

**Which actors see DV as a priority? Which do not?**

Law enforcement specialists (2)

**Which actors work to make DV a more central concern?**

As above.

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**

Mainly a good inter-agency cooperation is reported. Sometimes police complain that information flow is one-sided.

**3. Steps of a DV case**

**How are victims identified and detected? Are there active measures to maximize victim detection?**

Usually, the victim is detected by police emergency calls. Pro-active mechanisms are not mentioned.

**Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?**

Yes, but no extra measures are reported.

**Describe the process of filing a complaint. Are there active measures taken around this topic?**

Patrol officers have to write a report, and in case of offences, charge the offender. Victims are asked whether they wat to register a criminal complaint. This is often withdrawn the next day or later.

**Describe what happens after victims have filed a complaint: which problems arise then?**

Police transfer the paperwork to the state attorney's office and inform youth authority, in case children are involved.

**Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

They can only register complaints in cases where they are authorized by victims.

**In this process, what are the main obstacles and problems that victims face?**

Among the main obstacles are psychological phenomena like shame, regret, felt responsibility for the abusing partner, or the feeling that they have to save the partner. Other main obstacles are economic issues and childcare issues.

**What do you see, in the frontline response to DV, as "working" and "not working"?**

Law enforcement in cooperation with local city and NGO networks.

**Overall, according to you, in this section, what is of key interest on your case?**

Generally, human factor issues appear as crucial, this is true for all responders, and city political decision makers. For police, the leadership support.

**Location 2: Münster**, **Germany**

**1. Methodology**

**How many interviews have been conducted? With whom?**

Overall sixteen interviews have been conducted. We interviewed four physicians, eight social workers and four police officers.

Two physicians are working at a hospital, one at a trauma outpatient ambulance and one as emergency physician. One is securing evidence as forensic physician and we also interviewed a member of a medical umbrella association providing an overview about the medical profession.

Seven of the eight social workers interviewed are working at counselling centers; one of them is responsible for victim protection shelters. Only one counselling center was specialized on domestic violence, the others were focusing on women, children or sexualized violence in general. We also interviewed someone who works with perpetrators. One interview partner is organizing the social work in the city, being part of the city administration.

We had the permission of the federal government to interview four police officers:

three patrolmen and one clerk.

**How were they selected? How did you get access?**

Based on our previous findings in work package 1 where we identified different frontline responders working in non-governmental institutions we contacted all of the counselling centers in Münster via E-Mail and telephone. We provided information about our project and informed them about our field work explaining why we would like to interview them. We contacted 14 of them, two never answered our request and two rejected our request because they do not deal with DV in their everyday work, one did because of lack of time and one gave no explanation.

As we did not collect specific information about the medical profession in Münster before we used here another approach: we contacted all four hospitals in the city, used personal contacts and did web-based research of physicians that are part of working groups in Münster. We also contacted the emergency service. Of the 115 physicians we contacted most ignored our request while we were able to win three physicians for our field research. In order to get an idea about why it is so hard to conduct interviews with the medical profession we contacted a medical umbrella organization to gain more general input about the current situation related to DV in the medical profession.

We also sent a request to the public relations department of the local police who forwarded our request to the ministry of interior of the federal state North-Rhine Westphalia. They granted us four interviews with police officers.

**Describe the interviews (length, tape-recorded or not)**

The interviews took between 40 and 75 minutes depending on the amount of time the interviewee granted us and the time it took to answer all the applicable questions.

All except of two interviews were tape-recorded. One because it was a telephone interview and one because the interviewee did not feel comfortable. In these cases, the interviewer took notes.

All interviews took place at the workplace of the interviewee.

**Describe limitations**

While we were very successful interviewing all relevant NGOs that are part of the network in Münster it was very hard to interview physicians. Even though we used personal relations we were only able to conduct four interviews. We were neither able to interview a gynecologist nor a general practitioner, so our results only allow limited generality regarding the medical profession. In contrast, although only four interviews with the police were granted, we got a very good overview about the situation as all our interview partners were very well prepared and deal with domestic violence almost every day.

We had no problems discussing any subjects. Everyone was very open and shared a lot of information with us.

## 2. Overview

### Which actors are involved in the handling of domestic violence?

The starting point of a DV case depends on where the victim tries to get help first: an NGO, the police or a physician. Based on our interviews this results in different procedures with a different amount of involvement by other actors.

The following scenarios are based on the information we extracted from the interviews:

### Scenario 1: Emergency Call - Police as the first contact point

The victim, children of the victim or neighbours send an emergency call and patrol officers come to the residence. We were told that in many cases neighbours call the police and not the victims themselves. Patrol officers take necessary steps (banning the perpetrator, filing a complaint). When the victim is injured and medical care is needed, patrol officers execute first aid measures and call an ambulance. It could also be possible that the victim called an ambulance and the emergency call center contacted the police so that both arrived at the same time. Information about NGOs is provided by patrol officers: they always have information like flyers with them. The victim then decides if he/she wants the police to contact an NGO in order to live in a victim shelter for example or if he/she wants to contact them on her/his own. Sometimes the police bring the victim directly to a victim protection shelter because he/she does not want to stay at home no matter if the perpetrator is banned or not. In severe cases the victim is taken to a hospital. Based on our information, it very much depends on different circumstances if any further steps (contact to NGOs etc.) as soon as a physician is responsible for the victim are taken.

### Scenario 2: Complaint filed by the victim without an emergency call – Police as the first contact point

Another possibility that was only very briefly described by the police is that a victim comes to a police station and files a complaint. In this case the victim is often accompanied by relatives or friends. In the next step, the police try to find the perpetrator and ban him for 10 days so that the victim can go back home. Information about NGOs are also offered in this case. The medical profession is not involved in this scenario.

### Scenario 3: The victim seeks help from a counselling center – NGO as the first contact point

The victim contacts one of the various counselling centers in the city via telephone, by making an appointment or going to the open consultation hour. Depending on the concept and the array of treatments as well as the needs of the victim, the victim is supported by an organization from one appointment up to five years. During this course of time the police might be involved when the victim decides to report the matter. The NGO and the police do not cooperate directly with one another. The medical profession is not involved in this scenario.

**Scenario 4: The victim is heavily injured by the perpetrator and needs to be seen by a physician – Medical profession as the first contact point**

The victim goes to an emergency ambulance in order to let injuries be treated by a physician. From what we know it depends very much on the personal resources, the daytime and the knowledge of the physician if the victim gets any further information: it might happen that the physician provides further information about counselling centers or trauma ambulances. But as all data underlie medical confidentiality the physician is not able to share any information with other organizations. The only exception is endangerment of self or others. That is why the physicians we talked to said that the situation is different when they have the suspicion that a child is victim of DV. When the explanation of the parents how the child got injured is not credible the physicians call the police.

**Scenario 5: Securing of evidence by a forensic physician – Medical profession as the first contact point**

In Münster, the victim has the possibility to let evidence of domestic violence be secured by a physician without filing a complaint. This anonymous securing of evidence is another first contact point for victims. Only when the victim files a complaint, the police will contact the forensic institute and the evidence can be used in a criminal proceeding. Injuries will not be treated by the forensic physician, so the victim has to go to a regular ambulance when there is a need for treatment.

NGOs told us that victims also contact general practitioners as a first contact point that send them to counselling centers but we were not able to conduct any interview with a physician that provided information about that scenario.

**What do they do? What is the nature of their involvement?**

Additional to the description above, the role and the nature of the involvement of different frontline responders is described best by their goals in a case of DV.

The police's aim is guaranteeing safety for the victim and initiating criminal proceeding against the perpetrator. They try to safeguard the situation when arriving at the residence. Two persons always try to handle the situation, one talks to the victim in order to get all relevant information and the other one is responsible for the perpetrator and by that for the safety of all present people. They are assessing the risk and if the perpetrator needs to be banned from the residence. If this is the case they perpetrator is banned for 10 days. If the victim is injured they take care of him or her as well as described above. The patrol officers' job is done when they filled in all relevant information in two documents that are necessary for the further proceeding. The case is then further processed by a clerk. They invite all involved people – victim, perpetrator, witnesses – to protocol their statements.

NGOs we talked with said that their overall goal is to protect the victim from any further harm. They often work with victims that never called the police or filed a complaint and all of them said that it is not the objective of their work to involve the police. They are satisfied with their work when they supported the victim in making a decision if he/she wants to leave their partner for example or when they found a

place in a victim protection shelter. Most of the NGOs are offering counselling for reaching their goal.

The medical profession aims to treat injuries and this is their (one and only) goal and because of various reasons (personal resources, lack of knowledge etc.) that is why – to what we know – their work with the victim ends as soon as this goal is reached. It somehow seems to be a personal decision if a physician takes any further steps as no standardized steps or guidelines exist. The work of forensic physicians is somewhat different as described above.

**What types of domestic violence are considered?**

All of the people we talked to are aware that different forms of domestic violence exist although they are only involved when specific forms of DV (mostly physical violence) occur. All of them named physical, psychological, sexualized and economic violence as well as stalking. In their everyday life they have to deal with gender-based violence, (ex-) partner-violence, violence against spouses and elderly. Violence by children against their parents was also mentioned. Regarding violence against elderly one form of violence that was added by the interviewees was neglect as one form of domestic violence that needs to be tackled.

As mentioned above, physical violence is the form of violence that leads to the most involvement by frontline responders (especially Police and medical profession). Frontline responders told us that they often experience different forms of violence at one time and that some forms like psychological violence have a long-term history in a relationship even before violence gets physical. Counselling centers are on the other hand also often contact points for early stages of violence as their range of topics is wider.

**Do involved actors have different conceptions of DV, and which?**

All involved actors had the same conception of DV although they know that physical violence has a different status for the police and the medical profession while the focus of counselling centers is different.

**Describe the education/training on DV that different actors have or have access to.**

Although we do not have any in-depth information about specific trainings, no group claimed a lack of trainings or training materials.

For the police, dealing with domestic violence is part of the basic training where they learn to deal with those cases in scenario-based trainings. When they start working in the field, they always have a tutor by their side who is experienced in dealing with DV cases and who provides information that are hard to train. For patrol officers, no advanced training possibilities were mentioned. For clerks, there are training possibilities, but we were told that it is very hard for them to participate because of lacking personal resources: they do not get the permission to attend these trainings. They may have the opportunity to participate in a training every ten years.

In NGOs, where most of the staff are pedagogues and social workers, the situation is quite different: the experience and knowledge employees gained during their basic training at a university or technical school is varying between the people. Some knew a lot about DV even before starting to work while others had of “learning by doing” and advanced trainings. The range of advanced trainings they have access to was described as very wide and satisfactory.

Regarding the medical profession one can say for sure that they learned about DV against children in their basic courses, and gynecologists about DV against women as well in their basic courses. Forensic physicians are even more specialized about that topic.

All in all, we were told that DV is a topic that physicians do not have to deal with very often and that is why they do not go to trainings offered. Even if they might learn about how do detect and deal with DV in a more specialized way they would not be able to practice it because of insufficient personal resources and a lack of time. We were not able to get a very good overview about the trainings they have access to: we only know about the basic courses and about trainings that are offered by the medical chamber.

**Which actors see DV as a priority? Which do not?**

As stated before, the medical profession does not see DV as a priority. Their priority is to treat injuries and diseases and as they said it does not matter to them how or by whom a victim got injured.

Regarding the police one has to say that the clerks are responsible for DV and sexualized violence against children at the same time and that they prioritize sexualized violence against children in their everyday work. Patrol Officer on the other hand say that DV is an incidence that is of higher priority because at that very moment somebody’s life might be at risk.

Some NGOs main focus is on domestic violence which makes them see DV as a priority. Other NGOs focus on women or children for example: they do not prioritize any form of violence and handle every case the same. One NGO told us that – although they do not focus on DV – the try to give women that experienced violence a prompter response.

**Which actors work to make DV a more central concern?**

We gained no information from the interviews indicating that the police or the medical profession work on making DV a more central concern.

The medical umbrella organization that we interviewed told us about different projects for physicians that focus on violence against children. They also tried to establish a system that allows every physician in different hospitals to get information about previous DV incidents regarding a child which was stopped by the government because of data protection.

NGOs are very engaged in any form of raising public awareness for that topic with

different campaigns, including flyer, poster and public events to destigmatize that topic. They also designed trainings for the police and the medical profession to share their knowledge about DV. Regarding the medical profession, a training was designed and the date was set for April and then it got cancelled two days in advance because not enough physicians wanted to participate.

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**

The situation in Münster is perceived as very good by different frontline responders. The Working Group Protecting Against Violence Act (*"Arbeitskreis Gewaltschutzgesetz"*) exists in Münster and multiple NGOs, the police and a couple of physicians participate in that working group in order to establish a good interconnectivity, informal communication and personal relations with other people that deal with DV in Münster. The cooperation – where it is necessary – is described as very good and the main factor seems to be the personal relationship between one another. No conflicts were reported although they have different objectives.

The problem that physicians participate very rarely and that the prosecution is not part of the working group was mentioned. Prosecutors and judges said that they do not want to be part of it because they do not want to lose their objectivity. Physicians reported a lack of time as a reason why they do not participate more often.

**3. Steps of a DV case**

**How are victims identified and detected? Are there active measures to maximize victim detection?**

The connection between different FLR and the victim is always initiated by a victim. The only exception is when neighbours or other people call the police when they get aware of DV.

Active measures like campaigns and flyer try to destigmatize DV and to give victims information about what rights they have and what contact points exist, hoping that this will raise the number of victims that seek help.

We do not know about any other active measures to maximize victim detection.

**Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?**

NGOs do not explicitly encourage victims to file complaints. NGOs explain all the possibilities they have and filing a complaint is one of them.

We have no information about how physicians deal with this.

When the police arrive at a crime scene of DV they file a complaint against the perpetrator when a crime took place. But – as described above – the victim and the perpetrator have to make a statement days after the incident and we were told that victims often back away from filing a complaint at that point. The police are not

allowed to recommend anything to the victim.

No active measures to maximize complaints were mentioned.

**Describe the process of filing a complaint. Are there active measures taken around this topic?**

As described above: When the police arrive at a crime scene of DV they file a complaint against the perpetrator when a crime took place. But – as described above – the victim and the perpetrator have to make a statement days after the incident and we were told that victims often back away from filing a complaint at that point. The police are not allowed to recommend anything to the victim.

No active measures were mentioned.

**Describe what happens after victims have filed a complaint: which problems arise then?**

Two problems were mentioned regarding this: victims backing away and a lack of evidence.

Everyone we talked to mentioned that one has to deal with victims that are very inconsistent regarding complaints. Many back off some days after the incident happened or downplay the violence what eliminates the legal basis for prosecution.

Even when women decide that they want to file a complaint and stick to their decision through the whole process another problem arises: lack of evidence. The forensic institute is able to secure evidence in a way that stands up in court but only very few victims go there after they were injured. Physicians in general do not document injuries necessarily in a way that is valid for legal purposes and sometimes no evidence is secured at all. So sometimes perpetrators are not punished because in the end it is only one person's word against another's. Regarding stalking this also is an important aspect.

**Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

Independently of whether a victim filed a complaint, a victim has access to the support network. They can go to victim protection centers or get help at a counselling center. There are also many federal and national support services like the helpline.

**In this process, what are the main obstacles and problems that victims face?**

As we did not talk to the victims we have no information about what their main obstacles and problems seem to be. The only problem mentioned by FLR was that especially women often have to face that they do not have the financial security to find a new home because of high rents. Nothing else was mentioned explicitly by the FLR and we could only hypothesize about other obstacles.

**What do you see, in the frontline response to DV, as "working" and "not working"?**

The network and the possibilities different FLR have (if they use them) are good and adequate and that is also what they told us.

One big problem in every area is a lack of time and insufficient personal resources and that is a point FLR cannot change on their own.

When children are victims of DV another big problem is that the perpetrator as a parent has to allow that the child talks to a counselling center or the police: some FLR stated that they have the feeling that the rights of the perpetrator as a parent are more important than the rights of the victimized child. The medical profession also mentioned trouble with data protection and that it frustrates in the everyday work that data protection seems to be more important than the wellbeing of a child.

All the trainings that are offered are on a free basis: it should be more compulsory especially regarding the medical community.

**Overall, according to you, in this section, what is of key interest on your case?**

We have the impression that there is a wide range of knowledge and competency in Münster regarding DV: that a good network exists, trainings are offered and everyone who wants help gets help.

In every interview it was addressed that a process often stops or help is offered but not accepted because victims had doubts about what to do. At some points FLR also stated that they think it sometimes is quite a waste of time to help victims of DV while other people also need their help and – in contrast – also accept their help.

## Location 3: Berlin

### 1. Methodology

**How many interviews have been conducted? With whom?**
In total, we conducted 18 interviews (8 police officers, 5 social professionals, 5 health professionals).

**How did you get access? How were they selected?**
The Criminal Police of Berlin (LKA Präv2) provided access to all interview partners in Berlin, most of them being part of the police DV network. The selection was based on the following criteria:

- Actors understand domestic violence as one of their priorities or even the only priority
- Actors represent a good cross-section within their field
  - police: different hierarchical levels and professional experience, various fields
  - social and medical field: different professions, organizations with different foci/of different size

**Describe the interviews (length, tape-recorded or not)**

Without any exception all interviews were tape-recorded. The average duration of interviews is 1 hour 30 minutes (minimum: 52 minutes, maximum 132 minutes).

**Describe limitations**

The only limitations were the time constraints of the participants. Taking this into consideration, the duration of participation was announced to be 1.5hrs, including the introduction and the signing of the declaration of consent. Being aware that not all questions could be covered within that time-frame, additional interviews were conducted. Whenever possible, the set of questions was distributed over more than one person representing a specific background of experiences.

## 2. Overview

**Which actors are involved in the handling of domestic violence? What do they do? What is the nature of their involvement?**
Please see tables above.

**What types of domestic violence are considered?**
The whole range of facets in which DV occurs is being considered by the interviewed actors.

**Do involved actors have different conceptions of DV, and which?**
Every single interviewee used the expression 'Domestic Violence', being aware of the Berlin definition of DV, which had been created in 2001 and has not been changed since then. The definition refers to partnership violence in general, without age restriction. Thus, it can also affect partnership violence among young people; lately this concept has attracted more attention.

The definition is as follows:
*Domestic violence (regardless of the crime scene – even without joint domicile) refers to violent crimes between persons*

- *in a partnership relationship,*
  - *which currently exists,*
  - *which is in dissolution,*
  - *which is dissolved or*
- *who are relatives of each other, as far as it does not concern offenses against children.*

*In cases of doubt, domestic violence shall be assumed when assessing the individual case.*
*Domestic violence (including observed acts of violence) poses a threat to the wellbeing of the child.*

The wish for the implementation of a uniform definition had been expressed by the police, aiming at enabling emergency forces to clearly categorise this form of violence, to compile meaningful statistics and to be able to describe and approach the phenomenon as such. The definition was then formulated by parts of the Senate

in cooperation with the police.

Since 2012, with the implementation of the Istanbul Convention, the dilemma aroused that the Berlin definition of DV does not correspond to the one of the EU. The EU definition refers to intra-family violence, which can contain all kinds of violent crimes and not just DV. The cases are now counted (nationwide) according to the EU definition.

The Berlin definition is nevertheless taken into account insofar as the police statistics of Berlin and the Federal Government additionally count violence in partnership. However, the presentation of homicides or other more specific forms of violence becomes more difficult.

**Describe the education/training on DV that different actors have or have access to.**
1. Police Berlin: Professional education/training at the Police Academy (operative service) and Berlin School of Economics and Law (upper or higher police service in Berlin). Additional trainings/workshops/presentations/visits at NGOs, which specialized units organize for themselves.

2. Medical field: DV is introduced only once for about 2 hours at university. Practitioners specialized on DV attended additional training and are well-connected with NGOs (who provide trainings) and the Police Berlin (who advises when needed).
3. NGOs: Practitioners are highly specialized, benefitted from trainings of their own organization or the ones of other NGOs, have supervision and case discussions within their organization and in some cases additionally by external supervisors.

**Which actors see DV as a priority? Which do not?**
1. Police Berlin: Except for one patrol officer and a case controller in the main commissionariat, all officers have received special DV trainings and consider DV as one of their priorities, in some cases due to their specialized unit/position as their only priority.

2. Medical field: The interviewed physicians treat/document any kind of trauma/violence, but have specific knowledge on DV. The NGO providing coordination services in this field (training, round table) deals with DV and sexualized violence only.

3. NGOs: Two of the three NGOs included in this study provide their services exclusively to female cases of DV. The third NGO provides services to victims of any kind of violence; the practitioners have specific knowledge on DV, counseling both, female and male victims.

**Which actors work to make DV a more central concern?**
There is a new dynamic on the political level: With the establishment of the "Round Table on Health Care for Domestic and Sexualized Violence" in 01/2019, Berlin is the first federal state in Germany to begin implementing the WHO Guidelines on Domestic and Sexual Violence in Health Care and Health Policy.

Most recent news is that additional financial resources will be made available by the Senate to increase the number of women's shelters. (Currently, only 30-40% of women asking for protected shelter in cases of DV can be provided with a place. The necessary amount of places, as calculated according to the Istanbul Convention, is by far not fulfilled in Berlin.)

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**
Berlin has very good networks, favoured by the conurbation and the fact that the city of Berlin is at the same time a federal state. The actors of the different professions in the field of DV know of each other and in many cases know each other personally, for the most part through committee work and cooperations. Differences in financial support may create a competitive situation; the non-participation of NGOs in certain committees may also harbour potential for conflict; however, this is hardly expressed openly (in two cases only: 461, 466).

Overview of some cooperations:

- Police Berlin - "Weisser Ring" (the only nationwide victim support organisation in Germany, independent from state funding, committed to help victims of crime; not included in the sample): A historically grown close cooperation with the current intention to conclude a cooperation agreement; police can ask for payment of travel expances of victims, prepaid cards for mobiles etc.
- Police Berlin - NGO A (see best practice study): There are grown work processes, which are also included in the "Quality Standards of dealing with DV" of PB. One standard procedure is the "proactive approach": Female victims of DV are asked whether they wish to be counseled by NGO A; if so, PB sends a fax to NGO A and a counselor offers ambulant counseling as early as possible.
- NGO A - other NGOs and all women's shelters in Berlin: NGO A coordinates the NGO A hotline; NGO A counselors do hotline duty Mo-Fr from 8-9am and 6-11pm as well as weekends and public holidays; 9am-6pm on weekdays another NGO (5 alltogether) steps in. The NGO A hotline has the most recent information on the availability of places in all protected shelters of Berlin.
- Outpatient Clinic for the Protection against Violence (for court proof documentation of injuries – "NGO B" (providing specialised counseling to female/male victims of DV, and of any other experience of violence): Counselors of the NGO do inhouse counseling after the documentation if victims wish so; also legal support is provided inhouse once a week.

### 3. Steps of a DV case

**How are victims identified and detected?**

By emergency calls

**Are there active measures to maximize victim detection?**

1) Police Berlin: Not mentioned

2) Medical field: There is NGO B which provides trainings in the medical field (to

hospitals, pharmacies, gynaecologists, pharmacists etc.). The trainings include information and practical exercises on how to sensitively respond to conspicuous wounds or other abnormalities in order to give potential victims the space to talk about DV.

3) NGOs: NGOs give trainings for all professions on how to sensitively address DV. NGO A provides for example schools with information/workshops for parents, teachers and pupils; pupils also have the opportunity to talk about their personal experiences during a consultation hour that NGO A provides at the schools at the end of the programme.

**Are victims encouraged to file criminal complaints?**

1) Police Berlin: If the crime is evident, police officers cannot but file the criminal complaint due to the "Legalitätsprinzip" (the principle that the prosecution must seek an indictment for all crimes). However, police also provides counseling on many levels (from the police departments up to headquarters): And as long as no concrete information on the crime are provided, police also accounts for the fact that filing a complaint may not always be the best or the only situation for a victim to deal with DV. If it becomes evident that a victim is highly at risk and cannot escape danger by any other means, filing a complaint will be highly recommended. But, PB is aware of the fact that compliance is needed and that it will be difficult to protect a person that is not willing to comply. One officer stated that if he feels the victim needs more support to go through the process of filing a complaint, he talks on the phone with familiy members about this (with the victim's permission) to get them on board with the victim.

2) Medical field and NGOs: Victims are not being encouraged to file a complaint, but will be well informed about their possibilities. Unless it is evident that the person is at high risk.

**Are there active measures to maximize complaints?**

No further measures mentioned

**Describe the process of filing a complaint.**

The following information is a rough summary of the checklist included in the "Quality standards in cases of DV" of PB. This set of standards is available in the police intranet, thus available for any police officer in Berlin. Besides the checklist, it contains much more detailed information on all measures, the legal basis and forms needed in cases of DV.

- Having forms and resources ready for use
- Behaviour on site: Separating the parties; careful handling of victims and children
- Crime scene work, preservation of evidence: graphic/photographic evidence; documentation of the injuries of the victim; asking who the attending physician is; documentation of the site and the persons' behavior
- Measures concerning the suspected person: Risk prognosis for the examination of the need of "Wegweisung" (asking the suspected person to leave), "Betretungsverbot" (prohibition of entering the home) and "Kontaktverbot"

(prohibition of contact) according to §29 a ASOG; checking whether it is necessary to create a "Gefährdungslagebild" (an operational description of the situation focusing at the risk of the victim)

- Measures concerning the victim: Examination of police security and protection measures; fax to Youth Authorities if children are involved; giving verbal and/or written information on NGOs/supporting institutions and, if agreed on, establishment of contact through the proactive approach; information on the "Gewaltschutzgesetz" (law for protection against violence)
- Support possibilities for the suspected person: giving verbal and/or written information and, if agreed on, establishment of contact
- Police case management: filing the complaint, case management in Poliks (police case management system); hearing of the victim and other witnesses; investigations in connection with doctors; hearing of the suspect; final report; reporting of facts touching on the topics of homosexuality and transsexuality

**Describe what happens after victims have filed a complaint: which problems arise then?**

- Victims often withdraw their complaint later.
- The pro-active approach sometimes leads to nowhere: Victims who agreed to the pro-active approach and thus to receive counseling from NGO A do either not even pick up the phone or do not make an appointment. There are two hypotheses as to why this may occur (one by a police officer, one by a counselor): 1) Maybe victims need to be asked more precisely as to whether they can use their phone at all without the perpetrator controlling the victim, investigating how and when they can be reached unguardedly. 2) Maybe victims agree to the pro-active approach only because they are under shock and/or because they are intimidated in face of a police officer as an authority, not daring to admit they do not want counseling.
- If the victim left the home, it may occur that important medication, documents, belongings were left behind: In urgent/some cases PB provides protection and accompanies the victims. However, this approach is not a general approach; it appears whether it is applied differs between directorates and persons. There are different (legal) considerations involved in taking the decision for this approach.
- The perpetrator keeps on stalking/threatening the victim: There are many legal measures to protect victims at high risk if the victim wants to be protected. In situations that increase the risk, such as the day of going to court for example, PB will accompany the victim.

**Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

Both, medical services and NGOs most definitely file complaints once childrens' wellbeing is at risk. However, firstly, they encourage the victim to file the complaint in order not to loose the victim's trust.

**Describe victims' support networks, whether or not they have gone to court.**

Counsellors do accompany victims if these wish so.

**In this process, what are the main obstacles and problems that victims face?**

One of the main issues are:

- Victims are often ambivalent to definitely leave the perpetrator. Returning to their violent relationship is likely to put them at a higher risk of an escalation of DV.
- Some victims have problems admitting to themselves that they are endangered and refrain from accepting adequate protection.
- Victims who are not financially well off have a long and difficult way to escape DV due to the lack of places in protected shelters in Berlin and the lack of affordable rental housing.
- It is more difficult to receive support at an advanced stage (housing, therapy etc.) while the frontline response network is very dense.
- It is still difficult to keep the new address of a victim a secret in the long run: At many stages in many institutions (insurance, job center etc.) the address is needed in the documents. This is being attended by PB and NGOs, trying to establish understanding in administrative bodies and other institutions.

**What do you see, in the frontline response to DV, as "working" and "not working"?**

- The cooperation and the (frontline response) networks work well.
- The frontline response and support networks work especially well if children are involved. However, when searching protected shelter, it may be more difficult when children are involved; the situation gets also more complicated if sons are too old to stay at a women's shelter.

From a police perspective the following challenges need to be addressed:

- The long duration it may take if patrol officers need to organize protected shelter: it can take hours that the patrol is being blocked in such cases.
- Barrier-free access is still difficult: PB works on better solutions for deaf and learning impaired victims, in cooperation with NGOs.

From a counsellor's perspective one of the dilemmas is that due to the lack of places in protected shelters and affordable rental housing their counselling approach has changed: They cannot recommend to escape from DV if there is no place to escape to.

From a physician's perspective working in the field of trauma-therapy it is being questioned if victims receive the necessary therapeutically support if counsellors of NGOs work with them in support groups/quasi-therapeutical settings. Overall, there is an extreme lack of therapists in Berlin, making it very difficult for victims and any persons in need of therapy to receive treatment.

**Overall, according to you, in this section, what is of key interest on your case?**

- Cooperation network, NGOs working as coordinators, the large variety of NGOs with different foci
- DV network and specific training of officers within PB
- Lack of protected shelters and its consequences for police and social work

## 4. Respect of international standards on service provision (SP) by the police and other FLR

## Location 1: Freiburg

### *Standards for all SPs*

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | yes | 24/7 only police |
| There should be one specialist violence against women counselling service in every regional city. | yes | |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | Yes, | with some restrictions |
| There should be a sufficient number of shelters available to victims of DV. | yes | But there are waiting list problems |
| Service user has a right to be treated with respect and dignity at all Times. Face-to-face contact should be within a safe, clean, and comfortable environment. | yes | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | yes | |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | yes | |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons. related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | yes | |
| Services should be equitably distributed across geographic areas and population densities. | | Can't really say whether ´this is the case |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | In principle yes | In practice there are restrictions |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | ./. | |
| Services should be provided free of charge. | yes | |
| Service providers should be mindful of the needs of children of service users. | yes | |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | yes | |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | yes | |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | yes | |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | yes | |

| | | |
|---|---|---|
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | yes | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users decision whether to make an official report to the police. | yes | |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | yes | |
| National and local governments should have funding streams for violence against women services. | yes | But limited |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | yes | |
| Services should develop guidelines for multi-agency co-operation. | | In theory |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | yes | |
| There should be clear protocols in place for data collection and information sharing between organisations. | yes | |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | yes | |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | yes | |

## *Standards for the police*

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | yes | |
| Police personnel should be trained on all aspects of DV. | Partly yes | |
| DV offences should be treated at least as seriously as other violent offences. | yes | |
| Victims should be seen as soon as possible by a specially trained officer | no | |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | yes | |
| Specialist Police units should be created in densely populated areas | yes | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Partly yes | |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | yes | Ruled by the Violence Protection Law |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | yes | |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | yes | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | yes | |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | yes | |
| Police should have protocols on information sharing on DV with other | yes | |

| | | |
|---|---|---|
| agencies | | |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | yes | |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained and reports made are kept confidential | yes | |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | yes | |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | Partly yes | Formalized risk assessment not everywhere |
| Police should develop and implement strategies to eliminate or reduce victim risks | yes | |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | yes | |

## Location 2: Münster

### *Standards for all SPs*

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Yes | |
| There should be one specialist violence against women counselling service in every regional city. | Yes | |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | Yes | Sometimes they work with translators but they told us that they always find a way to help victims |
| There should be a sufficient number of shelters available to victims of DV. | No | Regarding national standards the number is very good but sometimes they have problems to find a place for woman. And there is no possibility for men to stay somewhere in a shelter. |
| Service user has a right to be treated with respect and dignity at all<br>Times. Face-to-face contact should be<br>within a safe, clean, and comfortable environment. | Yes | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | Yes | |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Yes | |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons.<br>related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | Yes | But as mentioned above sometime victims do not accept help. |
| Services should be equitably distributed across geographic areas and population densities. | | We do not know and can only make statements about the city of Münster. |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Yes | Not every service but one at least (like the police or the helpline or hospitals) |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Yes | |
| Services should be provided free of charge. | Yes | |
| Service providers should be mindful of the needs of children of service users. | Yes | This gets more and more attention. |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | | We have no information about the employment contracts but everyone had some kind of trainings regarding DV. |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, | Yes | |

| | | |
|---|---|---|
| medical staff, and police officers. | | |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | Yes | |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | | We do not know if this takes place. |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Yes | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users decision whether to make an official report to the police. | Yes | |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | Yes | |
| National and local governments should have funding streams for violence against women services. | Yes | |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Yes | |
| Services should develop guidelines for multi-agency co-operation. | No | Although multi-agency cooperation is a past of their work there are no guidelines regarding this. |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | | We do not have information about that regarding every SP but in general data is collected. We have no information about analyses. |
| There should be clear protocols in place for data collection and information sharing between organisations. | | We do not know about this except for the medical profession where data is not shared. The police share information with NGOs when the victim allows them to do so but even then it is only the name and the phone number. |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | No | |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | Yes | |

## *Standards for the police*

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | Yes | |
| Police personnel should be trained on all aspects of DV. | Yes | |
| DV offences should be treated at least as seriously as other violent offences. | Yes | |
| Victims should be seen as soon as possible by a specially trained officer | No | There are no specially trained officers or they did not tell us in the interviews. |

| | | |
|---|---|---|
| There should be at least one specialized officer per police unit, for DV and for sexual violence | No | There are no specially trained officers or they did not tell us in the interviews. |
| Specialist Police units should be created in densely populated areas | No | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Yes | |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | Yes | |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | Yes | |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Yes | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | Yes | |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | Yes | |
| Police should have protocols on information sharing on DV with other agencies | | We do not know about that. |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | | We do not know if this happens. |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained and reports made are kept confidential | Yes | |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | Yes | |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | No | Risk assessment in general is made (written down by the patrol officer) |
| Police should develop and implement strategies to eliminate or reduce victim risks | No | Only the restraining order or taking them to a victim protection shelter. |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | Yes | But they also told us that it depends on the time they have to stay at one incident. |

## Location 3: Berlin

### *Standards for all SPs*

| | Respected? Y/N/do not know | Comment |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Y | |
| There should be one specialist violence against women counseling service in every regional city. | Y | |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | Y | |
| There should be a sufficient number of shelters available to victims of DV. | N | |
| Service user has a right to be treated with respect and dignity at all Times. Face-to-face contact should be within a safe, clean, and comfortable environment. | Y | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | Y | |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Y | |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | Y | social inclusion- here it get difficult, see protected shelters and housing |
| Services should be equitably distributed across geographic areas and population densities. | Y | |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Y | |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Partly Y | not yet barrier-free services |
| Services should be provided free of charge. | Y | |
| Service providers should be mindful of the needs of children of service users. | Y | |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | Y | |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | Y | |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | Y | |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Y | |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Y | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is | Y | |

| | | |
|---|---|---|
| undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users decision whether to make an official report to the police. | | |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | Y | long-term support more limited |
| National and local governments should have funding streams for violence against women services. | Y | |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Y | |
| Services should develop guidelines for multi-agency co-operation. | Y | |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | Y | |
| There should be clear protocols in place for data collection and information sharing between organisations. | Y | |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | Y | |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | Y | |

## *Standards for the police*

| | Respected? Y/N / do not know |
|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | Y |
| Police personnel should be trained on all aspects of DV. | Y |
| DV offences should be treated at least as seriously as other violent offences. | Y |
| Victims should be seen as soon as possible by a specially trained officer. | Y |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | Y |
| Specialist Police units should be created in densely populated areas | Y |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Y |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | Y |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | Y |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Y |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | Y |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | Y |
| Police should have protocols on information sharing on DV with other agencies | Y |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | Y |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained and reports made are kept confidential | Y |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | Y |

| | |
|---|---|
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | Y |
| Police should develop and implement strategies to eliminate or reduce victim risks | Y |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | Y |

# V. HUNGARY

## Location 1

### 1. Methodology

#### How many interviews have been conducted? With whom?

Our team conducted altogether sixteen interviews at case location 1. From the local police station, we contacted the Head of the Investigation Department, the colleagues of the Violent Crimes Unit and the Crime Prevention Advisor.

In addition to the professional staff (such as social workers, family assistants and psychologists), even the directors of social institutions (Crisis Center, Temporary Home for Families, Secret Shelter, (hereinafter: shelters) and Children's Home of the Child Protection Service) also shared their experiences and ideas with us. Furthermore, we conducted an interview with a doctor (gynaecologist and obstetrician) working in the local hospital.

#### How were they selected? How did you get access?

Firstly, we got in contact with the National Headquarters of the Hungarian Police and requested a permission to carry out interviews at the local police station. Fortunately, we obtained an authorization within a few weeks. After consultations with our team, interviewees were selected and the interviews themselves were organized by a contact person assigned by the local police chief.

At the same time, we informed the heads of various social and health institutions at our case location about the background, aims and the methodology of the IMPRODOVA program and asked them to support our field work. All of the institutions would have liked to take part in the research program and granted us permission to conduct interviews with their colleagues.

#### Describe the interviews (length, tape-recorded or not)

All of the interviews were tape-recorded. The minimum length of the interviews was around twenty minutes, while the longest conversation took more than three and a half hours. The average length of the interviews was around forty-five minutes.

#### Describe limitations

We were looking for experts and practitioners with knowledge and experience about DV. However, some of our interviewees (typically family assistants) did not understand our approach, concepts, or even specific questions of our interview guideline (especially about professional standards, protocols and risk assessment tools). These interviewees often considered the conversation as an opportunity for ventilation, sharing with us their feelings and emotions without giving feedback about characteristics of DV and the institutional response on it.

Our impression is that we should have paid more attention to the actors of the Child Protection Perceiving and Reporting System (e.g. social workers in schools, colleagues of the Guardian's Office etc.), the court and the prosecution.

## 2. Overview

### Which actors are involved in the handling of domestic violence?

In case location I, all of the actors that were previously mentioned (police, social and health sector) have a crucial role in handling domestic violence. In addition, further institutions of the Child Protection Perceiving and Reporting System (especially the Family Support and Child Welfare Services and the Guardianship Office) should be mentioned as important actors giving organizational response to DV.

### What do they do? What is the nature of their involvement?

When violence between family members is reported (through the telephone helpline 112 or through the "Phone witness" number, which is also free and ensures anonymity), police officers arrive at the venue within 20 minutes. If it is necessary, the abuser is arrested (short-term) by the police officer and custody or restraining is initiated. In addition, police officers 1) can initiate the temporary relocation of endangered children to temporary homes, 2) provide information to the victims. Furthermore, our interviewees considered crime prevention – which can be implemented through presentations, campaigns and various programs – as a primarily task of the police.

As it was mentioned earlier, within the framework of the IMPRODOVA field work we contacted the local shelters and the Children's Home of the Child Protection Service.[5] Staff members at these institutions have various responsibilities, including the reception of victims, carrying out needs assessment, handling official procedures related to victims, searching for necessary services, providing psychological care and support, counselling, tutoring and development of children, distributing donations (food, clothes, etc.). The primarily aim of these processes is to build mutual trust, promote independent and autonomous living and support the victims in leaving their abusive relationships.

Victims of domestic violence often contact the healthcare system first, typically for the treatment of their injuries or in order to take medical records. Healthcare staff are obliged to report to the child protection services, the guardianships office and the police in case of detecting domestic violence affecting minors.

[5] Children living with their families can be placed in the temporary home for children in case they were temporarily left without care or supervision or would be left without these in lack of accommodation and whose maintenance is endangered due to the life management difficulties of the family. Persons in crisis situation due to domestic violence can be accommodated in crisis centres and secret shelter homes: victims and persons living in the same household. The crisis centre provides even halfway house services as a supplementary activity in order to help the social reintegration of the victim for no more than five years where the accommodation and help needed in life management is provided for the abused family leaving the shelter home.

Staff at the Child Protection Perceiving and Reporting System (even medical professionals, such as health visitors, doctors, nurses) report to the child welfare services (and initiate official proceedings in case of abuse or gross negligence of the child, or in any other case of severe endangering) in order to prevent and stop the endangerment of the child. Obligations of the Child Welfare Services include recording reports, exploring the problems of endangered children and searching for solutions are.

**What types of domestic violence are considered?**

The police officers we interviewed emphasized that several types of DV (namely physical, psychological, sexual and financial) are considered, despite the fact that usually physical violence is reported (as opposed to psychological and sexual violence).

Social sector professionals gave more detailed descriptions about the types of DV (only one interviewee within the sector was unable to provide a clear definition). Beside the above-mentioned forms of DV, neglect, verbal violence, pathological jealousy, control, the parental manipulation of children, restriction of personal freedom, direct threat on the victim's life and financial dependency were also mentioned.

Healthcare practitioners are able to recognise the signs of physical violence only, given the lack of time that can be devoted to each client and the fact that victims usually do not talk about their abusive relationships in such contexts).

**Do involved actors have different conceptions of DV, and which?**

Professionals working at the local shelters and the Children's Home of the Child Protection Services have contact every day with victims and experience about the process, the characteristics and the consequences of DV. Therefore, they were able to provide more detailed definitions of DV (compared to the police officers or the health practitioners).

**Describe the education/training on DV that different actors have or have access to.**

Our interviewees at the local police station took part in a training program about restraining order (one of them even supported the program as a trainer). The training introduced 1) the psychological dimensions of DV, 2) the legal environment and regulations regarding DV, 3) the circumstances that should be taken into consideration when restraining order is applied by the police officers. Some of our interviewees underlined that their basic training (at the police secondary school) and their specialized training (at the Faculty of Law Enforcement) also included information on DV (while discussing psychological dimensions, technics of interrogation etc.).

A worker at the Crisis Centre underlined that her colleagues at the organization had access to various education programs (trainings, annual conferences and workshops) on DV. However, family assistants indicated that only a training about

restorative techniques was available for them. Professionals at the Temporary Home for Families took part in education programs on supportive communication, psychodrama, conferences and trainings about DV held by the National Crisis Telephone Information Service. In addition, compulsory training for childminding staff should be mentioned.
The education of the healthcare professionals does not focus at all on DV.

**Which actors see DV as a priority? Which do not?**

Professionals working in the social sector consider prevention, fast and effective institutional response, as well as support for the victims priorities (more so than the police officers or healthcare practitioners). However, it is important to underline that all the actors that we contacted during the field work see DV as a priority.

The police officers we interviewed underlined that they handle DV according to the severity of the problem and they react as soon as the violence is reported.

**Which actors work to make DV a more central concern?**

All of the actors fulfil their tasks and duties in connection with DV but we could not see efforts to make DV a more central concern.

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**

Some of our interviewees at the local police criticized health visitors and doctors for usually not reporting DV incidents. The official working hours of the social institutions should also be mentioned as a barrier to effective cooperation. Staff members at the Guardianship Office and the Family Support and Child Welfare Services have nine-to-five jobs so they cannot offer services around the clock. Therefore, measures aiming at the temporary relocation of endangered minors, which should be initiated outside working hours by police officers can be delayed.

Despite these difficulties, police officers generally assessed inter-agency partnerships as excellent – especially between the schools, the Guardianship Office, the Family Support and Child Welfare Services and the police (but not really with health institutions). Case discussions, regular meetings and personal contact support effective cooperation.

Our interviewees from the social sector explained that police officers react in time and arrive on the spot to take the measures they consider necessary. In addition, they organize training on crime prevention for the social sector. Some of our interviewees have direct contact with the local police station and call their number (and not 112) in case of emergency. Nevertheless, social sector professionals generally criticised the work of the police. As they underlined, police officers often do not have well-founded information about DV and have stereotypes about offenders and victims, the latter being easy to blame due to their inability to step out of abusive relationships and whose credibility are often discredited. Although, police obviously aim at providing practical information about DV and there are several efforts to

sensitize police officers in protecting victims from violence. However, "*this information does not really flow down to the lower level."* As one of the family assistants described, one of his clients was convinced by a police officer not to apply for restraining order as initiating such a process requires (too much) administration and time. Somebody else emphasized that police react only if injuries of physical violence can be observed on the spot.
Case managers have a crucial role in documenting DV, supporting the victims, coordinating the work of various agencies, monitoring the process, follow-up the implementation of the action plans etc. Serious damages can be caused if the work of the case managers is not effective.

Some of our interviewees criticized the lack of interpersonal communication between the FLRs of various sectors that is replaced by (too much) administrative work and official forms.

School is an actor of the Child Protection Perceiving and Reporting System. Thereby, it is mandatory for the staff to report abuse of children (even if only suspicion arises). However, as some of our interviewees stated, the local education institutions usually do not fulfil these obligations; primarily as they are not able to identify domestic violence. In addition, schools often do not prefer the enrolment of young victims enrolled in shelters or Children's Home of the Child Protection Service (as they just temporary residents of these institutions and as they may have "*behaviour problems*").
Despite these difficulties, most of the FLRs considered the inter-agency cooperation excellent. There are personal connections and interactions between the local institutions, monthly professional meetings and workshops are held.

### 3. Steps of a DV case

#### How are victims identified and detected? Are there active measures to maximize victim detection?

When violence between family members is reported, police officers are obliged to go to the location concerned. They conduct a hearing with the victim and the offender separately. (According to one of our interviewees, the victim and the offender are often taken to the police station where officers have the necessary competences and sufficient information about DV, which may not be the case with patrol officers.) There are several ways of detecting crisis situation and violence: a quarrel is reported, visible injuries caused by physical violence, the emotional state of the victim (e.g. he/she is stressed out or shows upset behaviour), the victim reports multiple aggressive incidents etc. If victim(s) can be detected, police officers have to take certain measures; including not only by separating the offender (by restraining order) and not only providing information for the victims (e.g. about the opportunities to ensure their safety) but, if necessary, even by the relocation of endangered victims in shelters. All in all, there are active measures to maximize victim detection – but the effectiveness of these measures largely depends on the competences, skills and experiences of the responding police officers.

Victims can contact institutions of healthcare. However, during our field work we found that healthcare practitioners do not report DV – only in case of very serious

injuries (when it is obligatory to report to the police).

Victims are often identified by OKIT (the organisation that aims to help victims of domestic violence and human trafficking through a helpline, which is available non-stop free of charge, throughout the country). Staff members at OKIT are responsible for risk assessment, (in case of emergency) calling the police and coordinating the placement of victims in protected accommodation, e.g. in the Temporary Home for Families in case location I.
Victims can be identified not only by the police but even by the organisations of the Child Protection Perceiving and Reporting System that is operated, organized and coordinated by the Child Welfare Services that initiate official proceedings in case of abuse or gross negligence of the child or any other example of severe endangering.

**Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?**

Police officers always inform victims about the way criminal complaint can be filed, the legal consequences of a criminal complaint and the criminal procedure itself. All in all, victims are not really encouraged to file criminal complaint but all of the relevant information is provided. Family assistants at shelters also assist victims in case they would like to file criminal complaints.

**Describe the process of filing a complaint. Are there active measures taken around this topic?**

Only police officers gave us information about the process of filing a complaint. In case of DV, criminal complaint can be filed 1) upon request from the victim[6], 2) by the police officer (ex officio) in certain cases[7]. Police officers underlined that if the victim does not file a criminal complaint and if the police officers themselves cannot initiate it ex officio, then "*there won't be evidence about DV so charges will not stand up."* According to most of the interviewees at the local police station, even if victims initiate a criminal complaint, they often withdraw their testimonies and the criminal procedure cannot be fulfilled (except if a medical record or any other evidence about the injuries is available).

**Describe what happens after victims have filed a complaint: which problems arise then?**

Only the police officers whom we interviewed gave us information about the process of filing a complaint. They complained about the lack of cooperation between the victims and the police. As one of them described, "*They* (the victims) *contact us and we file a complaint upon their request. But later on, their cooperative attitude often disappears as they are afraid of being abused by the offender. Or they are afraid of losing the family member who is abusive but earns the money. Or they just hope that*

[6] However, charges will stand up **only if** regularity of DV can be approved.
[7] There is **no opportunity** to file a criminal complaint ex officio if DV is committed. Instead, several other proceedings can be initiated; for example, if minors are also present during the abuse a complaint can be filed as minors were endangered. Another example: if serious battery is committed police officers also have to file a complaint ex officio.

*the behaviour of the offender will change. Or they are afraid of the reactions of the family members, friends and relatives. There could be several reasons why they cancel their testimony. And if there is no testimony, no witness, no video footage, we cannot do anything."* We found that some of the police officers are frustrated because of the cancellation of the criminal procedure by the victims themselves. As a result, negative attitudes towards the victims are formed and reinforced.

**Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

Our interviewees agreed that DV is a kind of taboo in our society; even if people have found out about an abusive relationship in their environment, they do not talk about it, let alone reporting it to the police.

**In this process, what are the main obstacles and problems that victims face?**

Beside the above-mentioned factor (see the question: "Describe what happens after victims have filed a complaint: which problems arise then?"), some additional ones should be mentioned:

- although police officers (and practitioners of the Child Protection Perceiving and Reporting System) may be aware of DV in a family, they cannot act if evidence is not available. The very same problem may arise during criminal procedures on psychological abuse; victims cannot be protected if there are no evidences pointing toward the offender's guilt.
- male victims of DV may not be taken serious by police officers.
- it can be extremely difficult to report DV to the police if victims
    - are shamed of being abused.
    - are afraid of the offender's reactions.
    - would not like to file a criminal complaint against their closest relatives.
    - live in traumatic bonding.
    - would not like to meet the offender again (during the criminal procedure).
    - do not recognize that they are involved in abusive relationships given the hidden character of psychological abuse and/or their socialization.
- minor victims
    - are often afraid of losing their homes and parents, so they do not turn in their abusive fathers/mothers to the police.
    - cannot escape from their abusive family members if, in addition to the offender-parent, the other parent (who is also often a victim himself/herself) also refuses to testify. In such a case, the police cannot initiate an investigation and reveal whether the criminal act of child abuse or endangerment was committed.
    - may be relocated to victim support institutions (e.g. Children's Home of the Child Protection Service) that are not able to ensure their safety. In this case, victims often escape from these institutions and get back to their original home and (abusive) relationships within a few weeks/months.
- victims must pay for their medical records if they would like to have medical evidence about their injuries (preparing such a record is free of charge only if the police initiates medical examination).
- sometimes there are parallel proceedings at the court, initiated based on different claims (e.g. one related to visitation rights, while another one related to abuse),

involving the very same parties. However, the court handles the related cases separately, which can be burdensome for the victims.
- offenders can return to their families if the court passes a suspended sentence only.
- if the offender is a local, powerful actor (especially in the countryside and/or in small settlements), then the reaction of the victim support organisations/service providers may be delayed, postponed or even cancelled.

  Due to hierarchical and power issues, problems with data protection may arise as well. As one of our interviewees put it: "*Sometimes the father is able to acquire information about the report related to DV and its details, as he has power and good relationships at the local level. He knows the local police officer and asks him to provide information from the Robocop*[8]*. That is clearly against the law."*
- it can be difficult to get into a Temporary Home for Families due to the long waiting lists.
- FLRs may not report DV as they may be simply afraid of the consequences; especially if the offender is aggressive and/or has criminal record.

**What do you see, in the frontline response to DV, as "working" and "not working"?**

First of all, some "working" practices, approaches and processes should be mentioned. Police officers always arrive on location in case of an emergency call and they follow the protocol in case there is any sign of DV. We also like the approach that female (or male) complainants have to be interrogated by female (or male) police officers.

There seems to be a good inter-agency cooperation – although there are some examples of a lack of effective cooperation (more details are available under the question: "Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing").

Enthusiastic, committed professionals and practitioners work at the local shelters and the Children's Home of the Child Protection Service. We encountered some innovative initiatives (e.g. a board game for victims supporting their skill-development in the field of autonomy and independence, support network for new mothers, trainings and summer camps for children, etc.) that will be mentioned in Task 2.4 later on.

Some areas that are "not working" should also be introduced.

Restraining order[9] is applicable in case of violence between family members. As some of the police officers whom we interviewed underlined, restraining order is only

[8] The system of integrated management and case process of the police.

[9] It can be applied if the legal requirements for arrest stand up (for example if the person cannot be indicted with committing a criminal offence). The temporary restraining orders made on the spot may extend to 72 hours at most. Preventive restraining orders are made by the court of justice in civil lawsuit proceedings, which may last 30 days at most. Restraining orders in criminal proceedings may only be issued if criminal proceedings are in progress due to an offence punishable by imprisonment.

a short-term solution, without any follow-up (e.g. the victim and the offender are reconciled within 72 hours but neither the court, nor the police have information about the way the relationship evolves later on).

Heads of departments, leaders of the social institutions and the local police station are well-trained in this respect and are aware of the characteristics of DV. However, police officers patrolling the streets (especially young officers without relevant experience) may not be prepared well enough to address DV. Although they receive information about the phenomenon during their basic and specialised training but the identification of abusive relationships (and especially forms of DV, which do not cause visible injuries) may cause difficulties – especially if the policer officers themselves have been victims of DV. Similar problems may arise in case of the practitioners of the social sector.

Administrative overload ("*an essential amount of time is devoted to filling in pointless forms")* and high workload seem to be crucial problems for the professionals and practitioners of all the sectors under investigation. As a result, there is less time and energy for professional work, which affects negatively not only the support provided for the victims but even staff members' professional development in the workplace. As one of our interviewees put it: "*There are several important and very interesting trainings but they are just pain in our ass. If any of us takes part in these programs, it causes extra workload due to the substitution."* Burnout among practitioners, a lack of young professionals and an absence of supervision, along with fluctuation are also core problems. Mutual trust between the staff and the victims can hardly develop at shelters and the Children's Home of the Child Protection Service if the fluctuation among the staff is high.

We observed that some of the police officers and family assistants can easily jump to blame the victims of DV. They do not know the mechanism and effects of DV and do not understand why victims do not call for help and leave the abusive relationships for years.

Victims may be in a precarious situation after leaving shelters due to their low income and the lack of affordable accommodation.

**Overall, according to you, in this section, what is of key interest on your case?**

The education programs that police officers complete display crucial deficiencies as the amount of time dedicated to DV throughout the training is insufficient and, even more importantly, students cannot gain practical work experience as part of their training. As a result, police officers patrolling the street may not be able to identify various forms of DV.

Institutions in the social and healthcare sector face serious organisational problems (fluctuation, burnout, lack of young professionals, administrative overload and high workload, etc.), which have a negative impact on the quality of the professional work.

Committed and enthusiastic people work at the local shelters and the Children's Home of the Child Protection Service, where victim-support services (e.g. providing help in managing psychological injuries of abuse, giving legal advice to protect the

interests of victims, helping the social reintegration of victims of DV etc.) works well. However, a lack of access to training programs and poor professional competences may result in victim-blaming and sexist attitudes (that are represented by some of the police officers as well).

Inter-agency cooperation works well. However, the lack of direct communication between staff at different institutions and the absence of professional relationships between them can hinder effective cooperation and victim-support. (This issue will be discussed in detail in Task 2.4.)

## Location 2

### 1. Methodology

**How many interviews have been conducted? With whom?**

Our team conducted altogether sixteen interviews at case location II. From the local police station, we contacted the Head of the Investigation Department, and conducted interviews with three people from the investigation department: the head of the department and two other investigators.

The institutional network of shelters that provide protected accommodation for DV victims has three different types of institutions country-wide: Crisis Centres, Secret shelters and Temporary Homes for Families (hereafter: Shelter). Temporary Homes for families also host families facing other hardships, such as housing problems and poverty. But some of their inhabitants are also DV victims. These three forms of institutions are usually run together, under the same institutional management, and typically in the same building - such as in case location II the shelter includes three different kinds of institutions (hereinafter: Shelter). We interviewed the directors of the Shelter institutions and professional staff (social workers, family assistants and a psychologist). The head of the Child Protection Service and some employees of the service (case manager, family care worker) also shared their experiences with us. From the health sector we interviewed one local health visitor who assists families who live in the Shelters, and a local GP, who is also a head of the network of GP's in location 2.

**How where they selected? How did you get access?**

Firstly, we got in contact with the National Headquarters of the Hungarian Police and requested a permission to carry out interviews at the local police station. Fortunately, we obtained an authorization within a few weeks. After consultations with our team, interviewees were selected and the interviews themselves were organized by a contact person assigned by the local police chief.

At the same time, we informed the heads of various social and health institutions at our case location about the background, aims and the methodology of the IMPRODOVA program and asked them to support our field work. All of the institutions would have liked to take part in the research program and granted us permission to conduct interviews with their colleagues.

**Describe the interviews (length, tape-recorded or not)**

All of the interviews were tape-recorded. The minimum length of the interviews was around half an hour, while the longest conversation took more than three and a half hours. The average length of the interviews was around an hour.

**Describe limitations**

We were looking for experts and practitioners with knowledge and experience about DV. However, some of our interviewees (typically family assistants working in Shelters) did not understand our approach, concepts, or even specific questions of our interview guideline (especially about professional standards, protocols and risk assessment tools). These interviewees often considered the conversation as an opportunity for ventilation, sharing with us their feelings and emotions without giving feedback about characteristics of DV and the institutional response on it.

Our impression is that we should have paid more attention to the actors of the Child Protection Perceiving and Reporting System (e.g. social workers in schools, colleagues of the Guardian's Office etc.), the court and the prosecution.

A further limitation of the interviewing was that some of the interview questions were not sector-specific enough, and it was hard to find a balance between gaining relevant, in-depth information from each sector and information that will feed in the template.

**2. Overview**

**Which actors are involved in the handling of domestic violence?**

In case location II, police and some institutions of the Child Protection Perceiving and Reporting System (especially the Family Support and Child Welfare Services and the Guardianship Office) have a crucial role in handling domestic violence. Furthermore, the Shelters should be mentioned as important actors giving organizational response to DV.

Only the health sector is an exception. Although they are also members of the Child Protection Perceiving and Reporting System, and they are obliged to report to the child protection services, the guardianships office and the police if they detect DV affecting minors, in the view of the representatives of the GP that we interviewed the doctors very rarely take responsibility for recognizing and reporting DV cases. They act only if a medical report is asked from the police or from the victim or the injuries are so serious that they have to act ex officio – even in those cases the GP's typically send the case to a specialist and leave the task of reporting to the specialist. It seems that their attitude is rather passive and they take an active role in reporting DV if they cannot avoid it.

Health visitors are more active than doctors in location II, but – as our interviewee expressed – the threshold of reporting and the reaction to the signs of DV depends on the individual attitude of each health visitors.

**What do they do? What is the nature of their involvement?**

When violence between family members is reported (through the telephone helpline 112 or through the "Phone witness" number, which is also free and ensures anonymity), police officers arrive at the venue within 20 minutes. If it is necessary, a restraining order is initiated against the perpetrator. In addition, police officers 1) can initiate the temporary relocation of endangered children to temporary homes, 2) provide information to the victims.

As it was mentioned earlier, within the framework of the IMPRODOVA field work, in case location II we contacted the institutional network of Shelters (an institution ran by the Hungarian Interchurch Aid' - an association of different churches[10]) and the Child Welfare Services. Staff members at these institutions have various responsibilities, including the reception of victims, carrying out needs assessment, handling official procedures related to victims, searching for necessary services, providing psychological care and support, counselling, tutoring and development of children, distributing donations (food, clothes, etc.). The primarily aim of these processes is to build mutual trust, promote independent and autonomous living and support the victims in leaving their abusive relationships.

Members of the Child Protection Perceiving and Reporting System (mostly school and kindergarten teachers) report to the child welfare services (and initiate official proceedings in case of abuse or gross negligence of the child, or in any other case of severe endangering) in order to prevent and stop the endangerment of the child. Obligations of the Child Welfare Services include recording reports, exploring the problems of endangered children and searching for solutions are.

**What types of domestic violence are considered?**

The workers of the Shelter meet with several forms of violence, including physical, sexual, emotional, psychological. They consider negligence as well as a form of violence. One pedagogue at a primary school that hosts children living in the shelters emphasizes that physical and psychological violence usually goes along. She specifies the different forms of psychological violence, such as verbal violence and coercion, as forms of violence that are more typical to occur independently in middle- and upper class families based on her experience, which view is reinforced by the representatives of the police. She also emphasizes that children are mostly affected by emotional violence, indirectly via facing other forms of violence targeting their family members.

Child protection experts highlight hat each case is difficult on its own. There are no simple and more complicated situations. Those cases are more difficult from the point of a front line response that are more difficult to recognize and are more likely to remain in latency. These are psychological and sexual violence.

Victims are less likely to talk about psychological violence, since in many cases they do not even acknowledge those forms of violence. According to the experience of the

[10] Networks of shelters are typically run by Churches or NGO's in Hungary

practitioners, sexual violence is the one of which the victims are the most reluctant to talk about.

One police investigator reinforces that sexual violence is the least likely to get to the horizon of the police - having met all together two sexual violence cases in the last years of practice. Another investigator mentions that the most prevalent form of sexual violence, which comes to the surface are pedophile crimes done by adults.

Workers of the Child Welfare Services consider psychological violence oftentimes more serious than physical violence. They make a difference between those forms of violence that direct only to the mother by the father and those that consider children as well. They also mention forced prostitution as a form of violence, in which often the pimps and the women are living in the same family.

**Do involved actors have different conceptions of DV, and which?**

Only the representatives of the police, investigation department emphasize regularity as important criteria when defining DV. It is mainly due to the fact that from the point of the procedure, to initiate a criminal procedure based on Domestic Violence as a criminal offense (Act C of 2012 on the Criminal Code, Article 212(A)), regularity is a basic criterion. They also highlight that regularity is a subjective category, and the definition of regularity it is not regulated precisely in the Criminal Code – which they consider as a problem.

While Workers of the Child Welfare Services, the Shelter and the school describe the psychological mechanisms behind victimization and the difficulty to break with the spiral of being a victim of violence, policemen do not seem to have such detailed background knowledge about the mechanisms of DV. One police investigator even expresses difficulties to understand why women do not break the circle of violence: "*It is very difficult for me to handle how someone, who has been hit two or three times, can go back for a fourth".*

A family care worker from the Child Welfare Service explains that typically victims have past experiences with DV from their childhood. Since violence becomes part of their normality, they do not acknowledge some forms of violence. On the other hand she emphasizes that the offenders' socialization takes place within similar family patterns, which they repeat in their own partner relationships.

Workers of the shelters describe the mechanism of breaking with the circle of violence in details. They say that women tend to get out of the circle of violence when gradually more and more forms of violence appear in a relationship, and the perpetrator hits the children as well.

Shelter workers make a difference between two different types of violence: one they call as 'aggression' and the offender as 'aggressor' - meaning those families where an aggressive communication style is dominant, and the victim also has aggressive reactions. They consider this type of violence less unequal than the other, which they call as 'abuse' and the offender as 'abuser', the latter based on a very unequal relationship between the victim and the offender. In case of an abuse the victim is passive and inferior to the offender. It is more difficult to identify abuse and abusers, since their violent actions are more sophisticated and hidden. As one worker of the

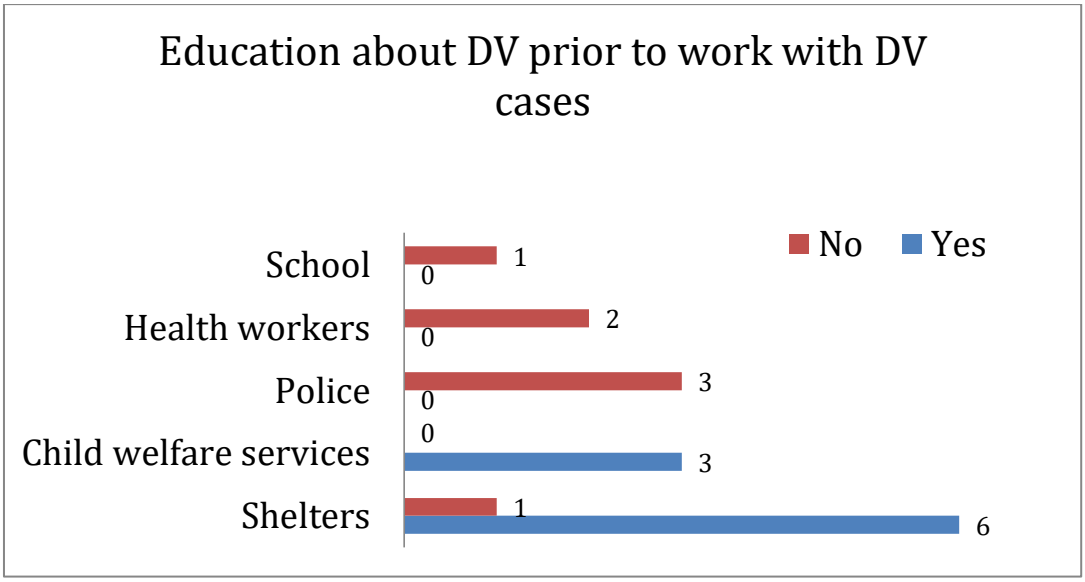
shelter explains: *"Aggression is very clear even for a patrol doing a police measure, since the aggressive man is shouting. While abusers are strategic. Many times they convince patrols and even DV-aware social workers about their innocence."*

One pedagogue mentions that the main factor, which keeps the victims in the circle of violence is the lack of experience in how to run their lives, take responsibilities and make decisions alone. Secret shelter workers mention the phenomena of psychological dependence and affection towards the aggressor, which is often a survival strategy for women who cannot leave the violent relationship.

**Describe the education/training on DV that different actors have or have access to**

**Education prior to work with DV**

Concerning our interviewees, we see a diverse picture of their DV-related educational background. The next table shows the answers for the question, whether they were trained about DV before they started to deal with DV cases:




Family assistants and other workers of the Shelter and of the Child Welfare Services, most of them have an educational background of social work or social pedagogy. They reported that the university curriculum contained basic information on DV, but they haven't gained comprehensive knowledge of DV during their university studies. A few of them went to postgrad trainings or courses to deepen their knowledge about DV. Most of them learned the specific knowledge via learning through experience on the field. Police officers hardly learned anything about DV during their college training. Doctors, health visitors and school teachers gained only sporadic information on DV as part of their education.

**Further trainings provided to the professionals working with DV**

Shelter workers have the widest education and training opportunities according to the interviews. The Ministry of Human Resources offers training for the whole child protection system regularly. NGO's such as NANE Women's Right Association also offer trainings about DV but those are not free of charge; the Shelter buys their trainings occasionally. A woker at the shelter mentions that since such specific trainings are not available for the other members of the Child Protection, Perceiving and Reporting System (such as teachers, health visitors and workers of the Child Welfare Services) they often invite these professionals to join their trainings.

A further learning platform mentioned by the Shelter workers are professional exchanges among the Shelters – which take place either in forms of institution visits or 1-2 day long workshops. Those are considered to be the most useful opportunities to learn from field experiences and acquire good practices. There is a yearly event of OKIT (a 0-24 telephone helpline for DV victims), for all the shelters, which includes experience exchange moduls that are very useful.

Police also reports that there are 1-2 day long compulsory trainings for the police officers, organized by the Hungarian National Police headquarters, that are available for county police officers. They do not mention any that directly concerns DV, but they mention: training for empathy, training for communication, training connected to the children's interviewing techniques. They emphasize that these trainings are usually not specific enough, do not relate to their daily work, and they do not have time to attend more useful trainings besides the compulsory ones.

**Which actors see DV as a priority? Which do not?**

Professionals working in the social sector consider prevention, fast and effective institutional response, as well as support for the victims priorities (more so than the police officers or healthcare practitioners). Lack of financial and human resources hinder the work of the whole social sector, but – in light of the interviews of case location II – shelter workers are more motivated and proactive to address the difficulties and improve the system. We faced more symptoms of burn out and hopeless attitude within the Child Welfare Services. The police officers we interviewed also consider DV as a focal issue, and phrase many problems related to the legal framework and practice of the prosecution and courts not treating DV as serious as other violent offences.

**Which actors work to make DV a more central concern?**

All of the actors fulfil their tasks and duties in connection with DV, except the health sector. We we have seen efforts to improve the frontline response to DV only in the work of the Shelter.

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**

Police officers generally assessed inter-agency partnerships as excellent – especially between the Guardianship Office, the Family Support and Child Welfare Services and

the police. Case discussions, regular meetings and personal contacts support effective cooperation. Investigators emphasize that they take part on the yearly regional meeting of the Family Support and Child Welfare Services, where they discuss their experiences, focusing on the problems, reflecting on the laws and protocols as well. Members of the Child Protection Perceiving and Reporting System file police complaints. Most often the Family Support and Child Welfare Services report DV, but it happened already that they got a report from a doctor. Schools very rarely report cases directly (usually schools, kindergardens and doctors report cases to the Child Welfare Services and they connect the police directly.)

Shelters also consider cooperation with the police very good. They have the phone number of local police units, and call them directly if police intervention is necessary (e.g.: a violent offender appears in the shelter unexpectedly).

Shelters complain about the Family Support and Child Welfare Services who *"do not understand the power of cooperation, and the necessity of information sharing".* According to a person working at the shelter, they often act as authorities instead of supporting services. They see the need for an attitude change, which could be available through trainings.

Shelters also highlighted the difficulties with local schools and kindergardens. They usually do not prefer to host children enrolled in Shelters- although schooling is a legal obligation for the shelters. Only a few elementary schools – such as the one we interviewed – are ready to take the extra burden to host the Shelter children (their legal status is called 'guest students'), who usually have learning and behaviour difficulties and are only temporary residents. The rest of the schools see them as an unnecessary burden on their overloaded system. Administrative and bureaucratic uncertainties (e.g. that many schools are not aware of 'guest student status' – and their related administrative and organizational protocols) are further gaps that do not support cooperation between schools and shelters.

Some of our interviewees criticized the lack of interpersonal communication between the FLRs of various sectors that is replaced by (too much) administrative work and official forms.

## 3. Steps of a DV case

### How are victims identified and detected? Are there active measures to maximize victim detection?

#### *Victims identified by the police*

DV victims are detected by the police either based on the report of the victim or based on the report of an other individual or institutional body, such as the Family Support and Child Welfare Service. The patrol making the procedural act interviews both the victim and the perpetrator separately, preferably on the spot and makes a report to the chief officer. Based on the report the chief officer makes the assessment of the situation and decides whether it contains enough information that refers to a crime. If yes, then he orders the investigation. (About the further police measures after filing a complaint, see subchapter: "Describe what happens after victims have

filed a complaint: which problems arise then?") To conclude, all in all there are active measures for the detection of victims by the police - according to the opinion of the police. Most problems occur later on during the investigation process (described later), which results in the fact that DV is a criminal offence, in which charge by the prosecution takes place very rarely.

### *Victims identified by Child Welfare Institutions*

Shelters are run mostly by non-governmental bodies, such as churches or assocations. Furthermore, there are Children's Homes run by the Child Protection Service. There is a central organization, OKIT, a 0-24 phone help line available free of charge, which is responsible for the division of cases among the shelters. OKIT is the institution, which makes victim identification and the first step of risk assessment via a detailed questionnaire. They organize police notification – in case of an emergency situation, they ask the victim if a police action is needed for him or her to escape – and the placement of victims in the network of shelters, such as the Crisis Centre and Secret shelter. OKIT gets calls mainly directly from the victims, and from the **Child Welfare Services**. Shelters have secret locations and there are several measures to keep the secrecy. E.g.: the victims are not told about the final location where they are placed, but they get a continuous guidance on their way. The continuous phone contact not only serves the purpose of secrecy, but also ensures that the victims gets to the location safely, avoiding that the perpetrator traces them. OKIT phone service has a phone number that the victims can call for free even from street phone cells- this is a measure, which supports a wider outreach towards the victims.

OKIT has a quite strict filtering mechanism of the cases based on a set of criteria, measuring if a real crisis situation is happening - due to the limited capacity of the shelters. Although, the leader of the Shelter in Location II. has a different attitude. While OKIT filters strictly the cases that are delivered to the shelters, some other clients are mediated to the Shelters via members of the Child Protection Perceiving and Reporting System, or directly from the Child Welfare Services. In these cases the Shelter follow a less strict policy. They try to give a shelter to everyone who claims that she is a DV victim. *"We accept that if someone identifies herself as a DV victim, then she is. We have to find a place for her. There are no objective measures of victimhood. Women in different social situations, and with emotional backgrounds bear different amount of burden. Our task is to help everybody, who asks for help."* Although ex officio the different forms of shelters can accept clients based on certain criteria, the practice is that if there is a free space in any of their homes (secret shelter, crisis centre or Temporary Family Home) they try to place the victim who is asking for help, regardless if she fits the formal, regulatory reception criteria of each types of institutions.

If the Child Welfare Service detects a victim, either directly as part of its own interventions or through other actors of the Child Protection Perceiving and Reporting System, its official measures depend on the seriousness of the situation. In case of a crisis situation they notify the previously mentioned OKIT phone services to search for a shelter for the victim(s), if the DV situation is less serious (e.g.: there is no physical violence involved and the regularity of the violence is not proved), or there is only a suspicion but not direct proof of the violence, then the typical measure to take

is a *case conference* – which includes all members of the Child Protection Perceiving and Reporting System that are concerned in the case and are in contact with the family (e.g.:Family Support and Child Welfare Services and Guardianship Office, police, school, paediatrician, health visitor) that are in contact with the victim(s). The function of the case conference in these situations is to map the circumstances and to assess the potential risk.

A problem identified in relation to victim detection is that the Child Welfare Services do not have a unified protocol regarding the assessment of victimhood and related risks, neither a protocol on the measures as reactions to certain types of violence. More practitioners highlighted that measures to take vary on a large scale country-wide depending on the competencies and attitudes of the responding Child Welfare Service.

E.g.: in location II. enhancement from the family happens in all cases where physical violence is present. Moreover, enhancement is also initiated if the level of poverty risks childrens' lives (e.g.: they are deprived of food and basic housing conditions, such as electricity). But the representative of the Child Welfare Service mentions that e.g. in another, more disadvantaged region of the country – with greater numbers of DV cases – the service do not enhance children from the family automatically in case of physical violence, but initiate less strict measures.

***Victim identified by other institutions – members of the Child Protection Perceiving and Reporting System***

Based on a standardized protocol, regulated by governmental and ministerial decrees, members of the Child Protection Perceiving and Reporting System (kindergardens, schools, family doctors, health visitors, nurses, etc.) shall report any forms of DV that they detect in order to prevent and stop the endangerment of the child to the child welfare services . According to the experiences of the workers in the Shelter and workers of the Child Welfare Services, the members of the network often do not make a report in case of a suspicion of DV or if only emotional abuse has been proven. The main reason for not reporting, according to the interviewees is that they are afraid of the consequences. This a problem especially prevalent in small towns and villages. Although reporting is anonymous, where local communities are small, keeping anonymity it is not a realistic endeavour. A few violent criminal acts against workers of Child Welfare Services[11] reinforced that protection against possible threats and violent actions of the offender are insufficient, and it might fuelled the fears of those social workers, teachers and medical professionals who face DV while working with families and children.

According to statistical data, provided by the government, in year 2015 regarding all children-related risk situations which resulted in 'endangered' status of the children, ordered by the Child Protection Perceiving and Reporting System, only 3% included a DV report (all the rest of the reports were justified by 'environmental' – and 'financial' reasons)[12].

[11] E.g.: a murder of a family support worker in her office, in which the first instance judgement, life imprisonment was sentenced in 2019 June.
[12] KSH, 2017. (Hungarian Central Statistical Office)

Our interview with a member of the network of GP's in Location II. reinforces the experience of the Child Welfare Services about the low reporting rates. She reported that there was only one case throughout her 30 years of practice when she reported a DV case to the Child Welfare Services. As a reason she highlighted that all family doctors have experiences of threats and violent actions against them. They try to avoid confrontation with the families. The protocol and practice is different in case of serious physical injuries. But in those cases they delegate the patient to the hospital and the specialists have the responsibility to report the case to the police.

**Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?**

Due to certain characteristics of the victims, such as fear, dependency and the dynamics of violence usually victims are either reluctant to file a complaint against the offender, or they are likely to cancel their testimonies and withdraw their complaints already in the investigation phase. The long and bureaucratic nature of the investigation process discourages the victims further to maintain their testimonies.

The Shelter has a clear professional standpoint about filing criminal complaints. They try to inform DV victims about the criminal procedure, including all the difficulties and possible obstacles that they might face during the procedure, and also the probable outcomes of the procedure. They think that this is a fair process, and if the victim finally files a complaint that will be a more aware and well-grounded decision: *"As part of the action plan that we set up when the victim arrives to the institution we target the question of filing a criminal complaint. If they haven't filed a complaint yet, we usually tell the process of filing a complaint, and that such a procedure will be circa 1,5 year long."* - At the end, based on their informal statistics, around 40% of all victims that arrives to the shelter files a DV complaint.

Shelter workers mention that based on their experiences sometimes the police officers discourage the victims to file a complaint about DV: *"it happened before that a victim went to the police to file a complaint in DV, and they sent her away, saying that they think she will change her mind later and will not keep her testimony.(….) It happened not once that the police officers told the victims to think it over one more time and come back if they are still convinced that they want to file a complaint."* – Most likely police officers are influenced by their negative experiences of victims cancelling charges and not keeping testimonies.

**Describe the process of filing a complaint. Are there active measures taken around this topic?**

Information on filing a complaint came to us from two resources: from the police (1.) and from the Shelter (2).

(1.)The police described the difference between two different types of complaints. One is if the DV involves serious injuries, meaning that the offender committed an aggravated battery (Article 164 (3)), than the police is obliged to file a criminal complaint ex officio. If the DV involves less serious physical injuries,

or no physical injuries at all than it is upon the request of the victim to file a criminal complaint. What makes it more difficult for the victim to make a complaint – according to the police officers – is that **regularity** is a premise in the law for the recognition of DV as a crime.

*"Any person who, on a regular basis: a) seriously violates human dignity or is engaged in any degrading and violent conduct, b) misappropriates or conceals any assets from conjugal or common property, and thus causing serious deprivation, against the parent of his/her child, or against a family member, former spouse or domestic partner living in the same household or dwelling at the time of commission or previously, against his/her conservator, person under conservatorship, guardian or person under guardianship is guilty of a misdemeanor punishable by imprisonment not exceeding two years, insofar as the act did not result in a more serious criminal offense."* (Criminal Code, Article 212/A (1))

As the police officers reported, in many cases it is very difficult to prove regularity, since the victims usually do not have evidences (e.g.: medical reports, photos, etc.) from the previous violent actions of the offender. Moreover, it is even more difficult to prove other, psychological and emotional forms of violence. In those cases where the only evidences for the DV are the statement of the victim and the statements of witnesses, usually the offender claims the opposite with witnesses on his side, and it is hard to make a charge.

2. Some shelter workers highlighted the problem that there is a lack of a unified approach within the Hungarian Police concerning DV complaints. The attitude and competence of the police to handle DV complaints varies on a very wide scale.

Two cases were explained to illustrate the ineffective practice of filing complaints at the police. It is important to mention that – due to the fact that families are placed in shelters away from their homes – in both cases the Police Department responsible for the misconduct was not the Police Department of the City of Location II.

A family assistant explained a case of one of the clients, who ended up in the shelter. A woman and her child were held almost in captivity by her husband. She did not have a phone, and she could hardly get in contact with anyone to ask for help. She asked for the help of the police via the free telephone helpline several times, but they said they cannot help until there is no evidence of a regular abuse. Most likely the police officer meant that they cannot file a complaint ex officio if there was no serious physical abuse happening. It is unclear whether the police officer informed her that she can file a complaint or tried to convince her not to, due to the lack of evidence. The police haven't reported the case to the Family Support and Child Welfare Services. Finally she managed to get in contact with the Services who found a place in a shelter and managed to take her away from the offender.

Another, even more extreme case which ended up in a murder due to dysfunctional operation of handling DV complaints by the police was mentioned by a worker of the shelter. A mother was placed in the shelter with 3 children. She reported to the workers of the shelter that the fourth child who stayed with the father is in danger. The father blows out cigarette butts on his chest, and beats him up regularly. The

police initiated an investigation in this case, but the medical reports could not prove without a doubt that the injuries were caused by beating. Nevertheless, based on the decision of the Family Support and Child Welfare Services and Guardianship Office the child was replaced to a Children's Home of the Child Protection Service. The police was not convinced based on the evidence available to file an official complaint. The mother filed a complaint, but the evidence was not enough for a charge by the prosecution. Due to the lack of a charge against the father, the father was able to see the child regularly via forms of home visits by the child. On one of those visits the father killed the child.

**Describe what happens after victims have filed a complaint: which problems arise then?**

After filing a complaint, the police decides based on a set of criteria, whether an investigation based on a DV case or as any other criminal case (e.g: battery, abuse of a minor, etc.) has to be initiated.

The following criteria has to be considered: - regularity;- physical injuries; - emotional status of the victim(w); - whether minors are concerned.; - were there previous measures taken by the police or by the Child Welfare Services in relation to the violence.

If the petrol or the chief officer detects a direct risk situation based on the information he/she collects, he/she might orders a temporary (72 hour) restraining order (meaning that the offender cannot get in contact with the victim). One aspect of the police protocol, which maximizes victim detection and efficiency is that in the phase of 'mapping the case', after an on the spot interview most likely the chief officer is also interviewing the parties at the police station. So two police measures are executed one after the other by different level of police officers to collect background information about the case. A further element, which assists victim detection – mentioned by the officers – is that police patrols always work in pairs, and both of them contribute to write the report or to make urgent decisions in crisis situations about police measures.

72 hour restraining order is an insufficient measure that does not fulfil its aim. An investigator thinks that the offenders do not take this measure serious, and the system lacks sufficient monitoring whether the offender complies with the rule.

The most prevalent problem after filing a complaint is, that the collection of evidence is very difficult. Regularity is hardly provable, due to the fact that a) there is usually no evidence about the previous violent actions; b) physical abuse is accompanied by other forms of abuse (psychological abuse, constraint, etc.), which forms of violence usually happen in privacy, and there are no witnesses to rely on. Or the only witnesses are the usually minor children – whose involvement into the investigation is a very delicate issue, due to their peculiar vulnerability. Even if the minors are involved into the investigation, usually their testimonies are not enough as independent evidence - because of their dependent situation in the family.

Police list the types of evidences that they find as strong:

- steady, maintained testimony of the victim
- medical report
- photos of the injury
- expert opinion (e.g.: psychologist)
- testimonies of other actors

According to the experience of police officers at case location II, the typical scenario in their police department is that in most cases, where a complaint is filed, the police initiates and executes an investigation - they do not filter out hardly any of the cases without an investigation. However, in many of those cases, where the police thinks that the evidence collected is enough for a DV charge, the prosecutor does not make a prosecution. This practice is confirmed by the statistics from the police department in case location II: there were altogether 4 DV crime cases investigated in 2018, 3 of them were based on a police report, one of them was based on a citizen's report. None of them resulted in a criminal charge by the prosecution.

In case of an injury, which is considered as 'light' – meaning that *"the injury or illness caused by battery takes less than eight days to heal"* (Criminal Code, Article 164(2)) the victim has 30 days to initiate a procedure. If the violent act has happened earlier, there is no legal base for prosecution.

According to the police there is no unified, country-wide practice in the evaluation of DV evidence by the prosecution. The same amount of evidence has different adjudication in each county. What would be enough for a charge in one county is not enough in another. Police reported of a similarly wide range of judgment practices in the county courts. Police officers raised the need for a more unified approach, supported by more binding rules and a less broad individual freedom when measuring evidences:

*„Prosecutors evaluate the evidence freely. While in the prosecution service of location II endangering of a minor or DV are hardly get to prosecution, in another city of this county the prosecution charges based on the same evidence. The difference is greatly visible. "* – the investigator tells an example for that. There was a case where the local prosecution was concerned, a medical report served as evidence for physical violence three times within half a year, the prosecution dropped the case with the reasoning that regularity cannot be verified. While in the other city of the same county a strong witness testimony from the women's side was enough for the prosecutor to charge.

Some aspects of the system of medical reporting support the criminal procedure others hinder. A supporting factor is that in case an injury is documented in a medical report, the police can file a claim to the health service and get an automatic access for the report free of charge any time later. A hindering factor that goes against victims' readiness to ask for a medical report from a doctor is that in case the victim asks for such a report it is not free of charge (it costs 3500 HUF/ 12 EUR). Medical reports are initiated by the police ex officio only in case of a serious physical injury, which implies the crime of aggravated battery.

The price of medical reporting especially puts indigent victims to a detrimental situation who may not able to pay the fee of a medical report. Many times victims of

DV are also in financial dependence of the offender, and paying for a medical report might cause difficulties to them. A further hindering factor of making a medical report – according to the experience of the police – is that except for serious physical injuries, medical reports demand the active adjustment of the victim: *"If the victim comes to the police station to file a complaint, and they do not have a very serious physical injury, the first thing we tell them is to go to the doctor and initiate a medical report. We tell them that they have 30 days for that, after the violence has happened. That is the phase where many women change their minds"*.- They also have the possibility to make a medical report and not to file a complaint, but have a record that the violent act has happened. But in case they do not want to file a complaint they rarely take that chance.

Police officers describe that it is very difficult to make an investigation in a DV case, which ends up in a criminal charge. Thereby they consider those scenarios easier, if there is a suspicion that other crimes are also committed besides DV, such as simple battery, aggravated battery or harassment: "even if we know that the crime is domestic violence, we tend to build the investigation on a different crime category if the violent acts concern mixed crime categories, because it will be more likely that a prosecution will be actuated.

A further condition, which has a great impact on the evolution of a case is that most victims who are ready to file a complaint are the ones who already escaped to a shelter. In their case, the investigation is a remote-investigation: the complaint is filed in the city of the shelter but most of the investigation has to be executed in the residence of the family. This results in a complicated, over-bureaucratized procedure, in which the victims have to travel great distances and go back to the place where the offender stays for participating in procedural acts, such as court hearings. This is a crucial factor that often discourages victims during the procedure and is an obstacle that stands against the victim's cooperation.

**Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

According to the experience of the family care worker, working in the Shelter about 50% of the women who get to the shelter files a complaint. They are afraid of the pressure of the family. They do not want to take all the complications that a criminal case implies, especially if there is a remote investigation and they have to travel back and force to their hometown, where the offender lives for the procedural acts (explained under the subchapter: "**Describe what happens after victims have filed a complaint: which problems arise then?").**

While we get the information from the case manager of the Child Welfare Service that around 20% of all women manage to get out of their victim status, meaning that regardless the complaint and the outcome of a criminal procedure they do not go back to the perpetrator, they find a job and build a new home for theirselves out of DV. They also emphasize that 9 out of 10 women go back to offender for the first time – which they evaluate as failure of their work. A typical scenario is that even many of those who manage to get out of the DV situation leave three or four times temporarily once they are able to make a final decision on leaving the relationship.

**In this process, what are the main obstacles and problems that victims face?**

Condition of the children in the procedure:
    - are often afraid of losing their homes and parents, so they do not turn in their abusive fathers/mothers to the police.
    - cannot escape from their abusive family members if, in addition to the offender-parent, the other parent (who is also often a victim himself/herself) also refuses to testify. In such a case, the police cannot initiate an investigation and reveal whether the criminal act of child abuse or endangerment was committed.
    - may be relocated to victim support institutions (e.g. Children's Home of the Child Protection Service) that are not able to ensure their safety. In this case, victims often escape from these institutions and get back to their original home and (abusive) relationships within a few weeks/months.
- bureaucratic and long criminal procedures re-victimize the victim
- Members of the Child Protection Perceiving and Reporting System are afraid of reporting – if there are no supporters of the victims from their families, in many cases they cannot rely on the support of the institutional actors (e.g.: school, doctor, health visitor)
- it can be extremely difficult to report DV to the police if victims
    - are ashamed of being abused.
    - are afraid of the offender's reactions
    - would not like to file a criminal complaint against their closest relatives
    - live in a vicious circle of violent relationship
    - do not recognize that they are involved in abusive relationships given the hidden character of psychological abuse and/or their socialization.
- sometimes there are parallel proceedings at the court, initiated based on different claims (e.g. one related to visitation rights, while another one related to abuse), involving the very same parties. However, the court handles the related cases separately, which can be burdensome for the victims.
- offenders can return to their families if the court passes a suspended sentence only.
- sentences are rarely proportionate to the violent acts and to the impacts of violence
- if the offender is a local, powerful actor (especially in the countryside and/or in small settlements), then the reaction of the victim support organisations/service providers may be delayed, postponed or even cancelled

**What do you see, in the frontline response to DV, as "working" and "not working"?**

There is a well-specialized, continuously developed system of shelter institutions according to the needs of the victims. But once the victim who went through the whole procedure of leaving the perpetrator, moving to a shelter, filing a complaint, participating a criminal procedure, etc. after she exceeded the maximum time limit that a family can spend in the system of shelters (months), there is no smooth, gradual integration to the society. Women have to make a living on their own, without any extra social aid or social housing.

The legislative framework and legal practice is insufficient – DV is not treated as serious as other violent crimes.

The set of measures for protecting of victims and social workers assisting victims from the perpetrators are insufficient.

There are good practices available in all sectors of the frontline response, but they are not unified and institutionalized country-wide.

Sector-specific, practical education on DV assisting the daily work and answering practical questions of the frontline responders are missing.

## 4. Respect of international standards on service provision (SP) by the police and other FLR

### Location 1

***Standards for all SPs***

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Yes | Not specifically at case location but nationwide. |
| There should be one specialist violence against women counselling service in every regional city. | Yes | |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | No | |
| There should be a sufficient number of shelters available to victims of DV. | No | |
| Service user has a right to be treated with respect and dignity at all times. Face-to-face contact should be within a safe, clean, and comfortable environment. | Yes | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | Yes | Although, some of our interviewees declared: data protection was not always ensured, data leaks (about the services user) have already been realized by police officers (from Robocop). However, it is rather an exception than a practice.<br>In addition, some of our interviewees were not aware of data that should be handled confidentially (e.g. doctors). |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Yes | Although, some of the police officers and family assistants can easily jump to blame the victims of DV (but it is not typical). |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons. related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social | Yes | |

| | | |
|---|---|---|
| inclusion. | | |
| Services should be equitably distributed across geographic areas and population densities. | Yes | |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Yes | |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Yes | |
| Services should be provided free of charge. | Yes | Although, victims must pay for their medical records if they would like to have medical evidence about their injuries (preparing such a record is free of charge only if the police initiates medical examination). |
| Service providers should be mindful of the needs of children of service users. | Yes | |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | No | |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | Yes | Except health sector. |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | No | Except shelters and Child Welfare Services. |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Yes | |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Yes | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users decision whether to make an official report to the police. | do not know | |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | No | They are autonomous and non-profit but some problems arise regarding sustainability and long-term support. |
| National and local governments should have funding streams for violence against women services. | Yes | |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Yes, in case of shelters. | |
| Services should develop guidelines for multi- | Yes | Depending on local |

| | | |
|---|---|---|
| agency co-operation. | | capacities/attitudes/approach. |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | No | |
| There should be clear protocols in place for data collection and information sharing between organisations. | Yes | But the official process does not ensure effective information sharing. |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | No | |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | do not know | |

## Location 2

### *Standards for all SPs*

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls. | Yes | Not specifically at case location but nationwide. |
| There should be one specialist violence against women counselling service in every regional city. | Yes | |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | No | |
| There should be a sufficient number of shelters available to victims of DV. | No | |
| Service user has a right to be treated with respect and dignity at all times. Face-to-face contact should be<br>within a safe, clean, and comfortable environment. | Yes | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | Yes | Although, some of our interviewees declared: data protection was not always ensured, data leaks (about the services user) have already been realized by police officers (from Robocop). However, it is rather an exception than a practice.<br>In addition, some of our interviewees were not aware of data that should be handled confidentially (e.g. doctors). |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Yes | Although, some of the police officers and family assistants can easily jump to blame the victims of DV (but it is not typical). |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons.<br>related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social | Yes | |

| | | |
|---|---|---|
| inclusion. | | |
| Services should be equitably distributed across geographic areas and population densities. | Yes | |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Yes | |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Yes | |
| Services should be provided free of charge. | Yes | Although, victims must pay for their medical records if they would like to have medical evidence about their injuries (preparing such a record is free of charge only if the police initiates medical examination). |
| Service providers should be mindful of the needs of children of service users. | Yes | |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | No | |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | Yes | Except health sector. |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | No | Except shelters and Child Welfare Services. |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Yes | |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Yes | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users decision whether to make an official report to the police. | do not know | |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | No | They are autonomous and non-profit but some problems arise regarding sustainability and long-term support. |
| National and local governments should have funding streams for violence against women services. | Yes | |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Yes, in case of shelters. | |
| Services should develop guidelines for multi- | Yes | Depending on local |

| | | |
|---|---|---|
| agency co-operation. | | capacities/attitudes/approach. |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | No | |
| There should be clear protocols in place for data collection and information sharing between organisations. | Yes | But the official process does not ensure effective information sharing. |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | No | |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | do not know | |

## Standards for the police

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | Yes | There is an information sheet about the rights of the person, which is read out loud by the police officer at the beginning of any procedural act. According to a police order, the victim should be informed about available victim support services |
| Police personnel should be trained on all aspects of DV | NO | |
| DV offences should be treated at least as seriously as other violent offences. | Yes | Yes only, if DV concerns a serious crime, including physical injuries. |
| Victims should be seen as soon as possible by a specially trained officer | NO | |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | Yes | |
| Specialist Police units should be created in densely populated areas | NO | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | NO/Yes | There are some very good, local initiatives aiming at crime prevention, building mutual trust and relationship with the local community.<br><br>There are no country-wide, unified protocols and practices encouraging reporting and providing information about DV to the community.<br><br>Police telephone helpline is available free of charge, 0-24. In case of a report, police has an obligation to arrive and take a measure if necessary. |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from | Yes | |

| | | |
|---|---|---|
| the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | | |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | Yes | |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Yes | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | No information | |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | No | |
| Police should have protocols on information sharing on DV with other agencies | Yes | |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | Yes | |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained and reports made are kept confidential | Yes | |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | Yes | |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | No | |
| Police should develop and implement strategies to eliminate or reduce victim risks | No | No specific strategies targeting the reduction of DV victims risks |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | Yes | |

# VI. PORTUGAL

## 1. METHODOLOGY

The Portuguese team chose to select two locations inspired on the criteria suggested in the Guidelines: Sampling of case locations for field research (see D2.1 Field study design). As previously mentioned, we knew that the year 2018 would bring important changes that should be taken into account in the sampling criteria. These 2018 data were only made available on April, 4th, and the strategy to identify the fieldwork was only designed afterwards, with obvious implications for the start of field work, such as obtaining official permissions, scheduling interviews, travel times, later transcription (a very time consuming task) and codification, etc.

Considering the existing 20 regions for statistical analysis, there was a decrease in the volume of DV cases reported in 11 of these regions. In the remaining regions, the number of cases increased considerably (annual rate of change equal or superior to 2%), and this was the case in 7 regions - or remained practically unchanged (this was the case in only 2 regions).

Thus, the proposed criterion combined two main indicators: incidence rates of DV per 1000 inhabitants and the rate of change (%) from 2015 to 2018. This cross-section (which corresponds to different regional profiles) identified the following regions:

Table 1 – Design for sample purposes

| DATA FROM 2018 | | RATE OF INCIDENCE (per 1000 inhabitants) | | |
|---|---|---|---|---|
| 2015-2018 variation | | HIGH | AVERAGE | LOW |
| ANNUAL RATE OF VARIATION (%) | HIGH | **Setúbal Portalegre** | | |
| | AVERAGE | | **Porto Coimbra** | |
| | LOW | | | **Santarém Oeste** |

The identification, in each of the opposing clusters (high-high and low-low) of two regions is justified by the possibility that constraints may exist in one of the regions, creating the necessity of using a second alternative.

Moreover, we do not have a process for assessing whether in any of these four selected regions there are any “best practices” that could be accumulated during the investigation phase. If they do not exist, we have a plan B that involves selecting those “best practices” where we know they exist, for granted. And this was, in fact, the case of the Porto region, in which we discovered the existence of a pilot experiment, involving a broad partnership, which we considered very important to analyse (see details below). In these conditions, we opted for a more in-depth approach to two regions: Oeste (West) and Porto, which are quite different from each other, from a sociological point of view, and above all from the point of view of the dynamics of domestic violence reported to the authorities.

However, not wanting to miss the opportunity to know a reality that is quite contrasting with the previous ones, especially in terms of the evolution and incidence rate of domestic violence, but mainly as a complement to information in the health

area, we also selected the Setúbal region. In this region, 5 interviews were conducted, of which 4 were from the Health area and one from the Justice area. In some way, these interviews served to complete the collection of information in the Health area, which was considered to be underrepresented in the set of information collected. We also conducted another interview with a member of the Police, from another region not belonging to any of the regions indicated above.

It is also worth to mention that we may have some bias in the collection. As we will see in this document, it is quite striving to reach and speak with some professionals and technicians. Besides, they do not usually speak to each other. As a result, interviewees were signalled when and where it was possible to mobilise particular acquaintances. For instance, as formal answers were delayed or even absent, police DV structures were contacted to provide for such connections and facilitate the meetings. However, we must say that this methodological bias reflects what happens in reality; it actually illustrates the real.

In total, 26 interviews were conducted between the last week of April and the end of May. All the interviews were recorded, with an average duration of 66 minutes in Porto and 38 minutes in the Oeste. In Setúbal, the average duration was 41 minutes.

The interviews were always scheduled in advance, as they were overwhelmingly carried out in the interviewees' workplace, and in addition to the necessary authorization, it was also essential to ensure the availability of the interviewees themselves. The receptivity to the request was always quite good, but the scheduling difficulties were not easy to overcome.

A draft script initially provided by the consortium IMPRODOVA (see IMPRODOVA WP2 – Sampling and Interview themes and questions – Draft) supported the Portuguese interview’s script adopted.

In the first one, located around 70 km from Lisbon, is related to the West Region (NUTS III), which comprehend a medium scale town (Caldas da Rainha) and other urban agglomerates like Peniche, Cadaval, Bombarral, Lourinhã, among others.

Figure 1 – location of the regional spots considered for the interviews


The second one relates to Porto's metropolitan area, and more specifically the city of Porto.

These two case studies represent twenty (20) interviews: ten (10) from the Oeste, and ten (10) from Porto.

We have an additional of six (6) interviews not directly related with any of the previous case locations but were considered necessary because of the specific functions the interviewees develop in the area of Health care.

## 2. Overview

The Portuguese team undertook the task of designing the content analysis framework. This model contemplates two major dimensions: the actor, and his agency. The results are promising. Unfortunately, they have no place in this overview and it will be mobilised on the next template.

### 2.1. The two studies case at a glance

**Study Case 1: OESTE REGION**

The Oeste region occupies 2.200 km$^2$, which represent 2% of the national territory. It is composed by the municipalities Alcobaça. Alenquer, Arruda de Vinhos, Nazaré, Caldas da Rainha, Óbidos, Lourinhã, Bombarral, Cadaval, Torres Vedras, and Sobral de Monte Agraço, which determine a total of about 350.000 inhabitants.

Figure 2 – Oeste Region map


The population density for the urban areas were superior a 250 residents/km$^2$ in NUTS III. Taking into account the latest statistics presented by INE (2018; National Institute of Statistics), it can be stated that the Oeste region includes some median urban areas such as Caldas da Rainha (201.8/Km$^2$), Sobral de Monte Agraço (199.8/KM$^2$), and Torres Vedras (192.8/KM$^2$).

The social and territorial context determines the association to a more rural environment, even though in demographic and socio-economic terms is more likely to be influenced by the proximity to the Lisbon Metropolitan Area.

The evolution of population has presented negative values, and according to the latest statistics, only four municipalities presented a weak positive evolution, with a range of 0.2% for Lourinhã, to 1.1% for Sobral de Monte Agraço. This conveys an increase in the aging index, presenting high values which in 2017, namely Cadaval, representing the unbalance between residents with age. It is a fact that demographic aging is higher in rural areas (212.7 elderly for each 100 youngsters). The demographic pyramid also shows the aging process occurred in the last decades and the decrease of the young effectives in younger ages.

In terms of educational attainment, 85% achieves the high school grade; however this achievement is inferior to the other regions and national level. This scenario is expanded for the higher education, as the region presents only 9.2% of graduate, the lowest value, when comparing to national and other regions values.

Analysing the per capita in purchasing power standards (PPS) reveals that in global the Oeste region has inferior's values when compared to national values, and that only in Sobral de Monte Agraço the means is higher than Portugal. However, the values for all the municipalities are higher than 71%. This numbers are followed by the purchasing power percentage (PPP) of the Oeste region is only of 3%, being Torres Vedras the municipality with a higher score (0.712%), followed by Caldas da Rainha (0.490%) and Alcobaça (0.459%).

The particular Oeste features in terms of institutional actors, their organisations, victims and resources mobilised, suggests the possibility to understand this region as a natural area. And so, the ecological approach (Bronfenbrenner, 1979) to DV seemed an adequate one. It is that homeostatic character of that community that we tried to grasp. For instance, and generically speaking, this allowed us to acknowledge that the basis of the victims' support is interrelationship (Mendras, 1995).

**Case study 2: PORTO area**

Porto is inserted in the Porto Metropolitan Area and for that reason should be understood in this context.

The population density of the Porto Metropolitan area is 842.4 /km2, to which contributes mainly the locations of Porto (5,180.7/Km$^2$) followed by Matosinhos (2,783.6/Km$^2$).


*Figure 2.* Porto Area Map

The majority of the cities presented a positive annual growth rate of population is negative, although the range of the rate varies between 0.1% (Póvoa do Varzim, Vila do Conde, Trofa, for instance), and 0,6% (Maia, and São João da Madeira). The growth rate of the major City, Porto is only of 0.2%.

Following the patterns of other regions and the matrix of Portugal, the aging index reveals high levels for the global, 148, and partial. Porto, for instance with his 221.6 is almost the double (1.5) greater than the total. In other cases, the value is even lower

that the total of Portugal, presenting only a ratio of 94.9, which is considered a good reference, because there is only 94.9 elderly for every 100 youngster.

90% of the population conclude the mandatory schooling. The university education also represents a good percentage of the total, with 18% of graduates.

In terms of PPS indicator only Espinho (104.58), Maia (113.16), Matosinhos (123.68), Porto (161.43) e São João da Madeira (136.12) present values higher than the total for the country (100) and the global of PMA (104.02). On the opposite side, Arouca has the lowest level, meaning that the concentration of purchasing power is very weak, when considering the spatial distribution of the residents.
For the North, the contribution of the Porto Metropolitan Area is huge with 17.5%, with a concentration in Porto (3.35%), Vila Nova de Gaia (2.901%) and Matosinhos (2.075%).

The approach to DV within the city is a more formal one, in the sense, that the context is much more urban, and the infrastructures available for the responses are more consolidated, but on the other hand, aspects as anonymity, isolation, urban poverty and segregation, social exclusion, characterise Porto as a spot of urban life (Wirth, 1938).

## 2.2. Limitations felt

One of the major limitations in collecting data was the availability of the interviewees, initially signalled. We also found some difficulties in discussing some subjects, mainly because of the lack of experience. Furthermore, the bureaucracy involved in the process of the formal request to the GNR interviewees enabled us to include such information in this report.

We must stress that the interview guide we used was the original one. So, there are some issues that weren't sufficiently addressed.

Furthermore, regarding the cooperation issue, we found some difficulties in getting a clear picture of the cooperation partners, namely avoiding making an exhaustive list to describe the specific relations they have. Most of them drafted an overview about their organisation´s cooperation by including almost all partners with no exception, using a politically correct discourse. This probably may result from the lack of experience of working together and has to do with a typical Portuguese characteristic in terms of its culture and sociology. Historically, it can be said that Portuguese people have some reluctance in collaborative work, and in recognising the others' success. So, in our minds, DV has to be thought as a cultural imbedded phenomenon, and organisations, experts and leaders should acknowledge that and act in a community-based perspective.
Therefore, it seems essential to educate towards collaborative work, for instance by using collaborative methodologies (e.g. simulation, role-playing, vignettes, focus group, brain-storming, follow-up, or walk-throughs).

The other problem one may pose is the point of view from which the interviewees answered our questions. Who has, in fact, the ownership of the procedure, risk, and

coordination? Again, it seems everybody is working according with his/her respective organisations, or their own beliefs regarding DV. In fact, the outcomes of the very recent Final Report from the Multidisciplinary Technical Commission for Improving the Prevention and Fight of DV (CTM; June 28, 2019) suggests:

- To develop the conditions to create a single DV database, enabling a global and integrated vision of the phenomena;
- To redefine the action protocol to speed up the whole process after the crime report, assuring the effective coordination of all entities involved;
- To create a Support Emergency Network (Rede de Urgência de Intervenção) permanently available, involving all judiciary authorities, LEAs, as the victims' support structures;
- To revise the DV tools, specifically: the Standard Complaint Report for DV in Police Forces; the documentation case and the victims' status; and, the Risk Assessment Sheet for DV (VD 2L; revaluation);
- To enhance the efforts regarding the education and training delivered to the professionals.

On the other hand, DV and its regulations are quite new in Portugal, maybe the reason why there is still some unclear approach. As written in the Country Report (T 1.1), the juridical regime applicable to the prevention of DV, and the protection and assistance of DV victims was established (Law no. 112/2009, 16 September; Law no. 19/2013, 21 February).

**Which actors are involved in the handling of domestic violence?**

Police services, courts, health system, NGO's, and support services to DV situations (please, see Country Report – T 1.1).

**What types of domestic violence are considered?**

Basically, DV is mainly according to its legal definition and as a gender issue.

**Do involved actors have different conceptions of DV, and which?**

Based on the field work we can attest that the conceptual differences weren't valued.

**Describe the education/training on DV that different actors have or have access to.**

It seems we have two different cohorts of actors involved in DV. The first ones haven't received direct contents about DV. The most recent ones, i.e. the ones from the last 5 to 6 years had the chance to be touched by this issue in terms of education and training. Maybe this is linked with the figures of DV that systematically grew in the last years, with a direct consequence in terms of the change of the penal code – in 2007, the Portuguese Penal Code (PPC; Law no. 59/2007, 4 September) finally made the crime of DV autonomous from other felonies against women, children, elders or other people living with the aggressor (https://dre.pt/pesquisa/-/search/640142/details/maximized). Nevertheless, this crime was already a public crime since 2000 (Law nº 7/2000, 27 May, related to adjustments to the Penal Code),

which means that knowing that a DV crime is being committed is sufficient for the authorities to intervene and open a criminal procedure and take protective measures.

Regarding the police professionals, there are different generations of people on duty. So, there are police officers working according with the 'old' method, and other police officers working according with the 'new' approach of DV. This means that the older ones make use of their 'feeling', or intuition. The new ones work by-the-book. Maybe we may talk about a (some kind of) generation gap. And this impacts on the possibility of having (or designing) a common approach of DV in terms of intra-organisations as well as inter-organisations. So far, the autonomy of every actor is immense. The result is that it is difficult to evaluate and so to make people accountable for any fiasco.

The above-mentioned Final Report from the Multidisciplinary Technical Commission for Improving the Prevention and Fight of DV (CTM; June 28, 2019) states the need for restructuring and reinforcement of the training and education on DV. This need had already been identified in the GREVIO Report (GREVIO Baseline Evaluation Report: Portugal, 2019) under Article 15 from Istanbul Convention, published by the European Council of January 21, 2019, under the title "Professional Training". The paragraph 99 recommends: "a. introduce compulsory initial training on all the forms of violence against women covered by the Istanbul Convention in the vocational and professional curricula for health professionals; b. expand and make compulsory the available in-service training for practicing health professionals, including on how to track and collect data on victims of violence; c. improve the capacity of health professionals to identify and provide appropriate treatment to victims of female genital mutilation; d. pursue their efforts to ensure that all law-enforcement officials who might enter into contact with victims receive continuous training on violence against women, which places a strong emphasis on the need to understand the dynamics of violence against women and on the role of law-enforcement agencies in seeking evidence to prosecute cases of violence; e. expand the available initial and in-service training opportunities for members of the judiciary to address all forms of violence against women covered by the Istanbul Convention, based on the development of appropriate guidelines; f. provide for compulsory professional training for serving legal professionals".

Furthermore, the recommendations accepted and under implementation from the 3rd Universal Periodical Exam of Portugal in Human Rights, from the UN, May 2019, say: to "develop a training program on gender equality and human rights for judges end judicial bodies in general, which contributes to eradicate impunity in cases related to domestic violence".

Considering the interviews collected, we feel that many interviewees have little commitment with their own continuous learning process. So, they put little effort when assigned to some courses, as it implies an increased workload when arriving back to their offices, no financial support to travel to another city, and also increased work for their colleagues.

Taking this into consideration, some bias may be found regarding the education issue, because of:

- the strive to have access to it;

- the organisation's demands;
- the contents of the courses (more theoretical);
- the education and training baseline of the interviewees (different levels, backgrounds and interests).

So, they want more education and simultaneously they do not. They do not know what kind of contents they need or want, though education is presented as the big panacea.

As a result of all this, we may state that one major finding is that education and training is a critical issue.

**Which actors see DV as a priority? Which do not?**

Because of the Portuguese figures of DV, this is a priority for every actor.

**Which actors work to make DV a more central concern?**

Because of the Portuguese figures of DV, this is a central issue for every actor. The field study took place at the same time that a huge national concern raised from the number of victims (deaths) occurred since the last December.

Remembering the timeline:

28FEB – Council of Ministers approved: the 7th of March as the Day of National Mourning as a way to pay tribute to all the DV victims, the new Multidisciplinary Technical Commission chaired by the coordinator of EARHVD (the retired Prosecutor Rui do Carmo) to present a report within three months with concrete proposals regarding the procedures decided in the meeting of 7 Feb: to speed up the collection, analysis and intersection of official data, to improve the mechanisms of victims' protection within the 72 hours after lodging a complaint near the criminal police bodies, and to strengthen and diversify the education and training modules.

07MAR – Day of National Mourning. Council of Ministers approved: to create special courts dedicated to DV.

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**

It seems there is no supervision in the case of police intervention in DV. Some of the interviewees talk about the absence of support by the hierarchy. Some of the police officers are afraid of making arrests. For instance, in the case of psychological violence, where there are no visible consequences, police officers do not know how to deal with these situations, and therefore it is difficult to make any arrest.

Despite, the lack of support, the actors involved do think about the whole DV phenomenon, perhaps because they have to give an answer to specific situations in the field. The hierarchy is concerned with the figures; in the field, the primary concern is with people. On the opposite, there are also police officers (commanders) who have never thought about DV, though they immediately postulate the need for further

education. These persons show little commitment regarding the intervention in DV situations, but also little proactivity in terms of searching for some more knowledge/education. It must be said that some police interviewees showed no commitment with DV, but this may be liked with an attitudinal, relapsed issue; they simply drag themselves in and through the DV occurrences.

It seems to us that it is in the field that the need for change is felt. Other times, it derives from formal rules. Is it a bottom-up or top-down approach? Do the police really have a model?

According with the interviewees, each actor in the field interprets the phenomenon in line with their own experiences. The pressure put on the hierarchy is linked with the diversity of cases, as there are no common rules to address them. In fact, this diversity enables the establishment of a common model with clear regulations and rules to follow.

On the other hand, it seems there is a logic of the process *versus* a logic of the person; logic of the production of legal proof *versus* logic of the security and protection measures regarding the DV victim. In other words: the articulation between who makes the proximity policing and who conducts the legal procedure is an absolute need to fulfil.

The last monitoring report of DV found available dates from 2016, and we couldn't find the reason for the delay in delivering the other two missing reports, though we know they have been written.

On the other hand, we found no capacitating reflection about DV (e.g. the example from the city of Setúbal: "they put the police officers here at the hospital and they say to the victims: when you feel better, please go to the police station to make the complaint").

The system of rules hasn't yet achieved a state of homeostasis, as people are just following the rules from a formal point of view. It is the rule by the rule… and this allows a completely discretionary interpretation, with no supervision. It shows the instability of the system of rules (Burns & Flam, 1987).

So, there is a regulatory dysfunction of the system – it is overloaded or in loss, and nobody knows or care about it.

Regarding the intervention of the medical profession there is supervision in DV cases. So, the medical profession brings a new level of demanding, as they have specific signals to look for in order to diagnose the consequences of violence (e.g. was the hematoma the result of a fall or an aggression, or not?).

## 3. Steps of a DV case

### How are victims identified and detected? Are there active measures to maximize victim detection?

To answer this question, we transcribe what we have written in our Country Report (T 1.1). So, according to our analysis, we may consider that there are three different levels of responders. All of them may be asked for help and/or advice in specific circumstances by the victims, their relatives, neighbours, working colleagues, or any citizen who may know about a DV occurrence. Any of these groups of citizens may now be quantified in terms of their reports to the whole figures.

The 1st level responders (first referral level) are responsible for the direct response to a DV occurrence:

- The Portuguese Public Security Police (PSP);
- The Portuguese National Guard (GNR);
- The Judiciary Police (PJ; only in cases of homicide), and
- The Public Prosecution Service (Public Ministry).

The 2nd level responders usually are not mobilised and do not intervene in the DV situation itself. They are services to which the victims appeal for help or assistance. They are also services where DV occurrences become disclosed in front of different situations (e.g. divorce, or child neglect). For instance:

- Police local service desks by the central hospitals;
- Hospitals (they communicate with the police whenever they find some specific evidences or strange situations – signalling to police authorities and providing medical treatment);
- APAV (local offices of the Portuguese Association for Victim Support);
- CPCJ local bureaus (local Commissions for the Protection of Children and Young Persons);
- Directorate-General of Reintegration and Prison Services.

The 3rd level responders are not related with the police. However, they provide specialised responses to help DV victims resolving particular situations in accordance with specific needs (e.g. regular medical assistance, job search, insolvency procedure). For instance:

- Health Centres – around 400 (for sure at the municipal level, though in many cases at parish level);
- Social Security – approximately 442 local offices for public attendance;
- Employment Agency – 106 offices (19 in the North of Portugal, 18 in the centre, 23 in Lisbon and Tagus valley,11 in Alentejo, 5 in Algarve, 19 in Azores, and 11 in Madeira);
- DECO (consumer protection) – 6 regional delegations;
- Education (13850 public schools, from pre-primary to secondary education).

We may also find regular campaigns in traditional and new media, to raise awareness amongst the general public and encourage victims to fill a complaint.

**Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?**

In Portugal, this crime is a public crime since 2000 (Law nº 7/2000, 27 May, related to adjustments to the Penal Code), which means that knowing that a DV crime is being committed is sufficient for the authorities to intervene and open a criminal procedure and take protective measures.

**Describe the process of filing a complaint. Are there active measures taken around this topic? Describe what happens after victims have filed a complaint: which problems arise then? Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

Following our Country Report (T 1.1):

The victims, witnesses, support or health services can make the report of DV situations to the police.

Considering the legal framework in what concerns DV and the Police Act, when the Portuguese police receive a DV complaint or an emergency call a patrol team goes to the DV scene to take the first contention measures. In the major cities, to solve a crime situation, a second line DV police unit is assigned to the case, collecting all relevant data and evidence and forward to the Public Prosecutor. During the first intervention, if there are injuries the police send the victim to the Hospital to receive treatment and notify the Medical forensic unit to deal with forensic exams.

The complaints of DV presented to the Police (PSP or GNR) originate two documents: a Complaint Report and a Risk Assessment Sheet (RVD 1L).

Both documents are sent jointly to the Public Prosecution Service (PPS). Considering the level of risk, a risk assessment revaluation may occur (RVD 2L). The time frame between RVD 1L and RVD 2L depends on the level of risk determined and the decision of the supervisor responsible for that documentation. The following revaluations are also sent to the PPS. The Police usually make the reassessments.

After the assessment is made, the Police may adopt immediate measures at their disposal; others may be proposed to the Public Prosecutor. So, the evaluation procedure also contains a set of strategies to promote the victim's safety and security. The Individual Security Plan begins here. In the highly risky situations, the adoption of protective measures will depend on the coordination between the Police, the Public Prosecutor and the Investigating Magistrate, and must be implemented as fast as possible. In these cases, the victim can be enrolled in the tele-assistance programme.

There is no deadline for the revaluation to cease, which will naturally stop if the judicial process ends.

Furthermore, as written before, a very recent Final Report from the Multidisciplinary Technical Commission for Improving the Prevention and Fighting of DV (CTM; June 28, 2019) presents some recommendations about accelerating the DV criminal process.

**In this process, what are the main obstacles and problems that victims face? What do you see, in the frontline response to DV, as "working" and "not working"?**

The main obstacles concern the lack of communication between organisations, impeding to speed up the process during the first 72 hours after the DV occurrence. Moreover, besides the existence of guidelines there is a quite large discretion amongst the FLR.

**Overall, according to you, in this section, what is of key interest on your case? Anything that you find relevant and that is not covered by the questions above:**

After analysing the interviews and discussing its content analysis results, the idea of a democratic monotony in the Portuguese society aroused in our mind. Meaning that we've achieved a mature situation and the causes of some phenomena seem to have just disappeared or vanished. This monotony leads to the opacity of regulation, which becomes dumb as the system of rules stop working. Or, at least, we may talk about the great instability in the system of rules, not in its strictly formal point of view but in its application.

## 4. Respect of international standards on service provision (SP) by the police and other FLR

## Location 1: Oeste Case Study

## Standards for all SPs

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Yes | More than one help line |
| There should be one specialist violence against women counselling service in every regional city. | Yes | As shown in our country report (T 1.1) |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | No | In some places (major towns), it is available. In rural areas it would be probably more difficult, namely, to migrants. |
| There should be a sufficient number of shelters available to victims of DV. | Yes | The network is pretty much supported by informal relationships… **but works** |
| Service user has a right to be treated with respect and dignity at all times. Face-to-face contact should be within a safe, clean, and comfortable environment. | Yes | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | Yes | |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Yes | It appears that in some residual cases the accountability of the perpetrators is not guaranteed. |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | Yes | It seems that in what concerns the security issues the standards are satisfactory accomplished.<br>Related to safety standards it's difficult to express a definitive statement about it, because it depends mostly from the victim's profile, their behavior towards the risk. |
| Services should be equitably distributed across geographic areas and population densities. | Yes | Tendentially.<br>To be sure it would be necessary an evaluation that it's out of the scope. |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Yes | But not all, especially in NGO's |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Do not know | The standard is not enough clarified to give a yes or no answer.<br>However, the first item is much more comprehensive and the answer is tendentially positive. |
| Services should be provided free of charge. | Yes | |
| Service providers should be mindful of the needs of children of service users. | Yes | As quite as possible. Once again, it depends on the setting where the action takes place. |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training | No | In some cases the initial and ongoing training are |

| | | |
|---|---|---|
| should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | | contemplated, whether is by organisational proposal, or by self-initiative.<br>In what concerns the specialists to provide the training it seems that is more advisable to have a wide spectrum of trainers, to provide a holistic approach to DV |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | Yes | We are not sure that this standard is absolutely fulfilled, but we found some evidence that the standard is accomplished. |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | Yes | Some are specific for specific communities |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Yes | |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Yes | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users' decision whether to make an official report to the police. | <br>Yes<br>Yes<br>Yes | <br><br><br>It is necessary to remind that DV is a public crime, therefore not depending on the service users' decision (Victim's wish) |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | Yes | The capacity to provide long-term support can't be assumed as to be true in all the cases |
| National and local governments should have funding streams for violence against women services. | Do not know | For sure national government to have an managed to emergency fund. In what concerns local government, we do not know. |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Do not know | We did not gather sufficient data in order to give a straight answer. |
| Services should develop guidelines for multi-agency co-operation. | Yes | However, the challenge is to know in what extent the guidelines are read, and if they are the most adequate for each case. |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | Do not Know<br>No | This information was not collected.<br>As far as we knew there is no analysis produced. |
| There should be clear protocols in place for data collection and information sharing between organisations. | Do not know | |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | Yes | |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | Yes | |

## Standards for the police

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | No | The police cannot be a part in the process. |
| Police personnel should be trained on all aspects of DV. | Yes | It depends on the understanding of “all aspects”. |
| DV offences should be treated at least as seriously as other violent offences. | Yes | According to the law, DV is a public crime with priority in terms of investigation. |
| Victims should be seen as soon as possible by a specially trained officer | Yes | It depends, because the questions of medical and legal forensics are far more important. |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | Yes | |
| Specialist Police units should be created in densely populated areas | Yes | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Yes | |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | Yes | |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | Yes | It depends on the background of the actors involved. |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV’s victims | Yes | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | Yes | |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | Yes | We have the system that enables to ask for information, but we have no systematic approach. |
| Police should have protocols on information sharing on DV with other agencies | Yes | |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | Yes | But it doesn’t depend only on the police, it also depends on the nature of the specific case. |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained and reports made are kept confidential | Yes | |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | Yes | |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | Yes | |
| Police should develop and implement strategies to eliminate or reduce victim risks | Yes | |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | Yes | The different approaches from the police officers considering their educational background, and experience. |

## Location 2: Porto Case Study

## Standards for all SPs

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Yes | |
| There should be one specialist violence against women counselling service in every regional city. | Yes | As shown in our country report (T 1.1) |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | Yes | |
| There should be a sufficient number of shelters available to victims of DV. | Yes | |
| Service user has a right to be treated with respect and dignity at all times. Face-to-face contact should be within a safe, clean, and comfortable environment. | Yes | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | Yes | |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Yes | It appears that in some residual cases the accountability of the perpetrators is not guaranteed. |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | Yes | It seems that in what concerns the security issues the standards are satisfactory accomplished.<br>Related to safety standards it's difficult to express a definitive statement about it, because it depends mostly from the victim's profile, their behavior towards the risk. |
| Services should be equitably distributed across geographic areas and population densities. | Yes | |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Yes | But not all, especially in NGO's |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Do not know | The standard is not enough clarified to give a yes or no answer.<br>However, the first item is much more comprehensive, and the answer is tendentially positive. |
| Services should be provided free of charge. | Yes | |
| Service providers should be mindful of the needs of children of service users. | Yes | As quite as possible. Once again, it depends on the setting where the action takes place. |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | No | In some cases, the initial and ongoing training are contemplated, whether is by organisational proposal, or by self-initiative.<br>In what concerns the specialists to provide the training it seems that is more advisable to have a wide spectrum of trainers, to provide a holistic approach to DV |
| Women's NGOs should be staffed by women, and other | Yes | We are not sure that this standard |

| | | |
|---|---|---|
| agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | | is absolutely fulfilled, but we found some evidence that the standard is accomplished. |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | Yes | Some are specific for specific communities |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Yes | |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Yes | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br><br>• All service providers should prioritise the best interests of the service user;<br><br>• It is the service users' decision whether to make an official report to the police. | <br>Yes<br><br>Yes<br><br>Yes | <br><br><br><br>It is necessary to remind that DV is a public crime, therefore not depending on the service users' decision (Victim's wish) |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | Yes | The capacity to provide long-term support can't be assumed as to be true in all the cases |
| National and local governments should have funding streams for violence against women services. | Do not know | For sure national government managed to have an emergency fund. In what concerns local government, we do not know. |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Do not know | We did not gather sufficient data in order to give a straight answer. |
| Services should develop guidelines for multi-agency co-operation. | Yes | However, the challenge is to know in what extent the guidelines are read, and if they are the most adequate for each case. |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br><br>Services should produce annual or bi-annual analysis of their users and their experiences. | Do not know<br><br><br><br>No | This information was not collected.<br><br><br>As far as we know there is no analysis produced. |
| There should be clear protocols in place for data collection and information sharing between organisations. | Do not know | |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | Yes | |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | Yes | |

## Standards for the police

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | No | The police cannot be a part in the process. |
| Police personnel should be trained on all aspects of DV. | Yes | It depends on the understanding of "all aspects". |

| | | |
|---|---|---|
| DV offences should be treated at least as seriously as other violent offences. | Yes | According to the law, DV is a public crime with priority in terms of investigation. |
| Victims should be seen as soon as possible by a specially trained officer | Yes | It depends, because the questions of medical and legal forensics are far more important. |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | Yes | |
| Specialist Police units should be created in densely populated areas | Yes | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Yes | |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | Yes | |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | Yes | It depends on the background of the actors involved. |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Yes | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | Yes | |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | Yes | We have the system that enables to ask for information, but we have no systematic approach. |
| Police should have protocols on information sharing on DV with other agencies | Yes | |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | Yes | But it doesn't depend only on the police, it also depends on the nature of the specific case. |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained, and reports made are kept confidential | Yes | |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | Yes | |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | Yes | |
| Police should develop and implement strategies to eliminate or reduce victim risks | Yes | |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | Yes | |

## VII. SCOTLAND

### Location 1

**Background information**
This case study is based on a rural/peri-urban local authority area with 16 police stations (population: 368,080). It has average rates of domestic abuse incidents recorded by police in Scotland (120 per 10,000 pop.). Similar to Location 2, police-led Multi Agency Risk Assessment Conferences (MARACs) and Multi Agency Tasking and Coordination meetings (MATACs) operate in this area. A particular point of interest in this case study area is that, unlike Location 2, the police operate dedicated domestic abuse unit (i.e. not combined with the rape and sexual assault unit).

### 1. Methodology

**How many interviews have been conducted? With whom?**

A total of 9 interviews were conducted specific to this case study area, all of which were with police officers who varied in rank and role (see Table 1). Interviews with non-police practitioners are ongoing.

*Table 1: Actors interviewed by role*

| | |
|---|---|
| Police Sergeant (local) | 1 |
| Response Officer (local) | 4 |
| Domestic Abuse Liaison Officer (divisional) | 1 |
| Domestic Abuse Investigation Officer (divisional) | 2 |
| Domestic Abuse Investigation Unit Detective Sergeant | 1 |

In addition to these interviews, observations were conducted at MARACs (n=2) and two MATACs (n=2) Observations were also undertaken at meetings concerning the disclosure of past instances of abusive behaviour to a perpetrator's current partner (Disclosure Scheme Domestic Abuse Scotland Decision Making Forum (DSDAS DMF) (n=2). During the MARAC, MATAC and DSDAS meetings, discussions took place with a wider range of police and other practitioners over and above those already interviewed (n=23) (Table 2).

*Table 2: Actors observed by role/organisation*

| | |
|---|---|
| Intelligence Officers | 2 |
| Detective Sergeant | 1 |
| Superintendent | 1 |
| Social Work sector | 3 |
| Representative from NGO | 6 |
| Medical Sector representative | 3 |
| Housing representative | 2 |
| Prosecution Service representative | 1 |
| Education representative | 2 |
| MARAC Co-ordinator | 1 |

Finally, a number of interviews (n=5) were conducted with participants working across both case study sites, including:

*Table 3: Inter-case study actors interviewed by role/organisation*

| | |
|---|---|
| Taskforce Officer | 4 |
| NGO representative: Safe Lives | 1 |

**How where they selected? How did you get access?**

Police participants were purposively sampled to capture Scotland's three-tired approach to DV policing, which includes officers who work at local, divisional and national levels. In terms of case study site, the majority of officers were selected at a local level (n=5) in order to give some variation in terms of gender (F=4; M=1) and service experience. Interviews at divisional level (n=3) were arranged to capture differences between those working in victim-facing (n=1), investigation-facing (n=2) and management (n=1) roles. A total of four interviews were conducted with Taskforce officers (F=1; M=3) operating at national level.

Access was arranged by our IMPRODOVA partners at Police Scotland. This introduction also facilitated access to MARAC and MATAC meetings (to be detailed in Template 2.3), through which introductions were made to the broader range of actors observed at Table 2. Snowball sampling was used after this point to conduct in-depth interviews with those willing.

**Describe the interviews (length, tape-recorded or not)**

Interviews lasted around 1.5 hours with either one or two participants per interview. They were conducted by a solo researcher who took notes. All interviews were audio-recorded with participants' consent and transcribed verbatim thereafter.

**Describe limitations**

Access to interview medical and social work practitioners has been difficult to obtain. Work to secure access to these practitioners is ongoing. As such, the majority of formal interviews have been with police. However, some understanding of how non-police actors' work with the police, and in relation to operational practice and risk management has been captured through observation at MATAC/MARAC/DSDAS DMF meetings.

**2. Overview**

**Which actors are involved in the handling of domestic violence (DV)?**

There are a broad range of actors actively involved in the handling of DV, including, but not limited to: police, NGOs, medical sector staff, prosecution services, social workers, housing sector staff and educational representatives.

**What do they do? What is the nature of their involvement?**

**Police:** In Scotland, the police respond to DV across three tiers: local, divisional and national. The nature of their involvement is with regards the prevention and detection of DV. At a local level they are responsible for responding to reported incidents of DV, and performing duties in relation to risk assessment; intelligence, crime and vulnerability reporting; liaising with partner agencies to detect criminality and manage risk; performing home safety checks; performing bail checks; carrying out specific tasks at the request of divisional and national tiers.

### *a. Local Police*

Local police are dispatched to domestic incidents via a centralised call centre. On arrival, their first task is to intervene and stop incidents of abuse if ongoing, as well as attending to any concerns regarding the safety of the public. Their work is then to gather evidence of any crime(s) by taking statements and doing door-to-door checks with local neighbours/witnesses. At this point they also conduct a formal risk assessment with any suspected victim(s), using the Domestic Abuse Questionnaire (DAQ) which is based on the DASH questionnaire but includes an additional three questions, totalling 27 questions asked of victims of DV in order to ascertain risk and level of abuse experienced. Statements, local checks and the DAQ are recorded analogue in police notebooks.

If criminality is suspected or detected, suspects are taken into custody. Police officers return to their station office and complete digital reports on multiple systems, including filing a 'SID log' (Scottish Intelligence Database), 'CrimeFile' report and updating 'STORM' reports to allow for the effective deployment of resources in future incidents. In all cases, whether or not evidence of criminality has been detected, officers file an entry on the Vulnerable Persons Database (VPD), which can be viewed by police officers across the entirety of Police Scotland, as well as contacts in social work. The DAQ forms part of the VPD entry.

In addition to dedicated response officers, there is a local specialist unit operating in this case study site. Officers working within the Drug and Alcohol Violence Reduction Unit (DAVRU) work to support their response colleagues by conducting further investigation and evidence gathering, as well as using community intelligence and local knowledge to track down suspects.

Local staff also perform victim safety and bail checks at the request of local sergeants and divisional staff (often tasked through the MARAC process), as well as gathering additional evidence at the request of divisional and national officers (often tasked through the MARAC and MATAC processes).

### *b. Divisional*

At a divisional level, DV policing takes a more dedicated form. Police are based within a specialist department within the Public Protection Unit (PPU) which deals with incidents of DV, sexual abuse and rape, flagged as requiring dedicated investigation and support. Cases requiring divisional response are detected through the daily reviewing of overnight CrimeFile and VPD entries by senior officers in the unit. From this unit, response staff work in two distinct roles. Investigation Officers conduct in-depth investigations and gather further evidence in order to detect criminality and/or build a criminal case. Domestic Abuse Liaison Officers (DALOs) perform a more victim-facing role, and are tasked with providing victim support, as

well as carrying out risk management, victim safety planning, and implementing measures to safeguard victims.

DALOs meet with victims very soon after the detection of DV at divisional level, in order to outline their role and the support that can be provided by the police. In addition to providing a single point of contact for a victim, a DALO's work involves the administering and management of the Disclosure Scheme for Domestic Abuse Scotland (DSDAS) (to be detailed further in Template 2.3), which allows members of the public and public agencies (including the police) to request information about a suspected perpetrator's criminal history, specifically in relation to DV. A proactive approach is taken to the administering of the scheme in this case study site, with the names of all new suspects that come through on the overnight VPD put forward to the scheme for disclosure to their current partner(s).

DALO staff also administer and manage the provision of GPS enabled personal safety alarms to victims (TecSOS alarms), which involves significant face-to-face time in setting up the alarms for proper use, as well as ongoing monitoring of their proper use thereafter. Recognising the labour-intensive work of processing DSDAS requests and managing personal safety alarms, this case study site has a dedicated officer whose sole responsibility is for administering the DSDAS and managing the TecSOS alarms. Finally, DALO staff also play a pivotal role in the organisation and planning of the MARAC through preparing cases to be heard; presenting cases at meetings; and liaising with victims and other agencies following meetings.

### *c. National*

At a national level, Taskforce officers investigate prolific and serial perpetrators of DV, using a 'pro-active approach' which involves identifying and speaking to ex- and current partners of a DV perpetrator in order to gather evidence of abusive behaviour and thereafter build a case against offenders that demonstrates patterns of abuse over time and/or against multiple victims. Senior police officers working within the Domestic Abuse Taskforce also attend MATAC meetings, during which they listen to the progress of ongoing cases in order to decide whether they might be more suited to the remit and resources at Taskforce level. During fieldwork, it was brought to our attention that arrangements for Taskforce involvement at MATAC meetings was currently under review and that significant changes were currently undergoing internal consultation.

**NGOs:** Scottish Women's Aid offer support and services to women (including transgender and those in same-sex relationships) and their children who are experiencing or have experienced DV. Services to women and children include temporary refuge accommodation or support to access other safe housing options; emotional and practical support; advocacy support; safety planning; and financial and legal advice. Women's Aid also play an important role in MARAC/MATAC processes in this area. Representatives from local Women's Aid branches regularly attend their local MARAC meetings, allowing them to feedback vital information on victims' perspectives. In addition, Women's Aid workers are able to refer their service users for MARAC. Some workers have also been MARAC chair-trained allowing them to lead the meetings.

**Medical sector:** There are no dedicated DV workers within the medical sector in Scotland. However midwifes, sexual health workers, substance abuse workers, mental health nurses and health visitors are all mandated to conduct the National Health Service's (NHS) flagship policy in the arena: *Routine Inquiry of Domestic Abuse*. This involves asking all women at initial assessment about abuse, whether or not there are any indicators or suspicions of abuse. In addition, *Selective Inquiries* are carried out by nursing staff, GPs and hospital doctors where there are suspicions/indicators. Medical staff also attend MARAC meetings, providing information on victims, perpetrators and their children. This includes general health information from GPs, insight from health visitors, as well as patient notes, histories and appointment details from addiction services, midwife appointments and mental health staff. It may also include writing and/or reviewing independent safety plans (ISP) for victims as well as perpetrators.

**Prosecution services:** The Crown Office and Procurator Fiscal Service (COPFS) in Scotland are responsible for the prosecution of DV. They communicate with police at divisional and national level, alerting them to bail conditions of suspects, as well as requirements for additional or further evidence. Representatives from COPFS regularly attend MATAC meetings, and provide information that might assist the police in disrupting criminal behaviour of DV perpetrators, leading to their arrest.

**Social Work:** Social workers in Scotland work across four remits and come into contact with DV largely through their work with 'Families and Children' and 'Criminal Justice'. With regards those working in Families and Children: social workers conduct safety planning in order to keep victims and their children safe, and often engage parents to attempt to see the world how their children do in order to motivate broader changes within household dynamics. Similarly, those working within a Criminal Justice capacity work with perpetrators to challenge and change their abusive behaviours. This holistic approach is further demonstrated at MARAC meetings, where representatives from both Families and Children and Criminal Justice are in regular attendance, each feeding back on their respective perspectives. In this case study site social workers are co-located with police at divisional level in the DAIU, and perform a vital role in victim risk-management on a daily basis.

**Housing sector:** At a local level, housing officials perform a pivotal role in intelligence gathering, through the good relationships that exist between them and response officers in the area. Representatives from housing regularly attend MATAC and MARAC meetings in this case study site. During MATAC meetings, housing representatives perform a similarly significant role in intelligence gathering, alerting the police to the past, present and potential whereabouts of perpetrators. During MARAC meetings they also play an active role in victim safety planning, ensuring that adequate safety and fire checks are carried out where victims and their families reside in housing provided by the local authority; as well as working with victims and local authorities to manage ongoing risk by considering suitable areas for re-housing.

**Educational authorities:** Representatives from education regularly attend MARAC meetings. They act to bridge communication between educational establishments (nurseries, schools, etc.) and other services in order to feedback to the meeting the ways in which DV is affecting and impacting the children of DV victims (bullying, lack of peer group, failure to progress as expected, absences, etc.), and to take back to

the educational establishments detailed measures for safety planning.

**What types of domestic violence are considered?**

Scotland adopts a broad police definition of DV as domestic abuse, which encompasses emotional, physical, sexual and financial abuse. This definition operates across all sectors. The recent introduction of the *Domestic Abuse (Scotland) Act 2018*, in April 2019, which criminalises coercive and controlling behaviour, further signals the extent to which non-physical violence of a psychological nature is considered to be integral to DV.

**Do involved actors have different conceptions of DV, and which?**

There appears to be a strong alignment in the way that different actors conceptualise DV. This is due to the national policy definition as noted above.

**Describe the education/training on DV that different actors have or have access to.**

See T1.4. for full information on training in this area.

**Which actors see DV as a priority? Which do not?**

At an organisational level, all actors consider DV a priority.

**Which actors work to make DV a more central concern?**

NGOs, such as Scottish Women's Aid and Safe Lives, work in a dedicated manner to raise awareness of the nature and dynamics of DV. Their role in being able to see a more holistic and 'bigger picture' of DV is not at odds with, but complementary to, the responsive modes that actors within the police, COPFS and social work within. Police Scotland have launched a range of public awareness campaigns (e.g. #everynineminutes) to highlight DV as a central concern.

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**

Inter-agency partnerships operate formally (within MATAC, MARAC and DSDAS DMF meetings), formally at divisional level through the co-location of social work within the DAIU, and informally at local level between response officers/sergeants and local actors from housing, health, education, and so on. On the whole, there appears a good deal of cooperation across each of these activities. Task sharing at MATAC meetings is directed by the meeting chair and appears well received amongst partners. At MARAC, however, the process of task sharing is handed over to partners in attendance at meetings. In addition, there is a dedicated MARAC-coordinator employed in this case study site who details minutes, actions and tasks during each meeting. This approach appears to secure an additional buy-in from partners, and results in a meeting that is effectively run and regularly well attended.

## 3. Steps of a DV case

### How are victims identified and detected? Are there active measures to maximize victim detection?

Most commonly, victims are identified and detected either through reports of DV made to the police, or by self-presenting at local NGOs. In addition, social work staff may identify victims/individuals at risk of DV. There are active measures within the medical sector, with staff tasked with the detection of victims through Routine (midwifes, sexual health workers, substance abuse clinicians, mental health nurses and health visitors) and Selective (doctors and nurses) Inquiry.

### Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?

Victims are encouraged to file criminal complaints by the police at both local and divisional level. At local level, response officers who identify criminal activity must report the crime, even if doing so is against the express wishes of the victim. At divisional level, DALO staff work closely with victims to support them in reporting, and in this sense are active in attempts to maximise complaints. NGOs, such as Women's Aid, do not specifically encourage reporting but provide a number of routine services (advocacy, emotional support, childcare) which would further assist victims in the event of them filing a criminal complaint. It is not clear the extent to which other statutory services (i.e. social work, medical sector) also encourage victims to file criminal complaints.

### Describe the process of filing a complaint. Are there active measures taken around this topic?

Complaints may be filed with local, divisional or national police officers. At the local level, this process begins when the police attend a victim's home/locus following a call by the victim or other person. Where criminal activity is detected, a statement is taken and the DAQ risk assessment conducted. At divisional level, where a case is flagged via a VPD entry, but a complaint has not been filed, a DALO will attend soon after to meet with the victim. At this point the DALO will discuss with the victim whether or not they want to file a complaint and will actively support them in doing so (working with partner agencies and NGOs, for example, to provide additional support to victims). During this visit the DALO will also conduct another DAQ with the victim in order to gather an up to date and potentially more accurate picture of risk. Should the victim then wish to file a complaint, arrangements will be made to take a statement in a location suitable to the victim's needs, such as their home, the police station or NGO offices. At national level, complaints are potentially made following the proactive approach to ex- and current partners of known perpetrators, which result in revealing a history of DV behaviour against them. Again, attending Taskforce officers will discuss whether or not a victim wants to make a complaint, and actively support them in doing so by arranging support from other agencies and/or taking a statement in a suitable location.

**Describe what happens after victims have filed a complaint: which problems arise then?**

Following a complaint being filed, work begins to gather evidence as appropriate at local, divisional and national levels. From a policing perspective, issues arise in cases where corroborative evidence is difficult to come by. Furthermore, with the introduction of *Domestic Abuse (Scotland) Act 2018*, there is early indication that evidence gathered must be more adept at portraying patterns of behaviours rather than simply detailing isolated incidents. Whilst it is difficult to say what problems arise from a victim's perspective, feedback of individual victim's views at MARAC meetings, as well as gaining insight into a more general sense of victims' concerns and perspectives from Women's Aid representatives, suggest this to be a high time of anxiety due to ongoing concerns over their own and their family's safety under bail conditions. The increased efforts of the police and other agencies at this point with regards safety planning (TecSOS alarms; fire safety checks; ISPs, etc.) suggest that such acute concerns are well founded and appreciated by actors across multiple spheres. That said, in addition to these immediate concerns, there exist many more practical, emotional and financial problems of a far more chronic nature which the police, and other response services, are not equipped to deal with.

**Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

Key support NGOs deliver advocacy services to victim-survivors of DV, whether or not they have reported to the police. If required, more specialist drug, alcohol and mental health services, are poised to provide ongoing assistance.

**In this process, what are the main obstacles and problems that victims face?**

In addition to deeply practical yet important issues of access to refuge, housing, support, benefits, legal aid and child contact, the stigma of being viewed as a DV victim represents a significant obstacle to some victims.

**What do you see, in the frontline response to DV, as "working" and "not working"?**

Frontline responses to DV are assisted by strong partnership working, including through the MARAC and MATAC processes; responses operate across agencies and tiers of policing, maximising the avenues through which support can be provided. The introduction of the *Domestic Abuse (Scotland) Act 2018*, appears an important step in recognising in legislation the array of forms that DV can take. There may be challenges in implementing and using this legislation in practice but it is too early to assess whether this may be the case (the legislation had only just been introduced at the time fieldwork was conducted).

**Overall, according to you, in this section, what is of key interest on your case?**

The formation of MATAC, MARAC and DSDAS DFM protocols, and the manner in which, beyond their dedicated function, they also represent a forum from which partnership working is operationalised. Of more general interest in this case is the

dedicated DV unit at divisional level.

**Location 2**

**Background information**

This case study is based on a largely rural local authority area with 2 police stations (population: 51,360). It has the highest rates of domestic abuse incidents recorded by police in Scotland (162 per 10,000 pop.). Similar to Location 1, police-led Multi Agency Risk Assessment Conferences (MARACs) and Multi Agency Tasking and Coordination meetings (MATACs) operate in this area. A particular point of interest in this case study area is that the police operate a dedicated domestic abuse unit.

**1. Methodology**

**How many interviews have been conducted? With whom?**

Eleven interviews were conducted in this case study area, ten of which were with police officers who varied in rank and role. One interview was with the manager of a national DV support NGO (see Table 1). Interviews with non-police practitioners are ongoing.

*Table 1: Practitioners interviewed by role*

| | |
|---|---|
| Acting Police Sergeant (local) | 1 |
| Drug and Alcohol Violence Reduction Unit Officer (local) | 2 |
| Response Officer (local) | 4 |
| Liaison Officer (divisional) | 2 |
| Investigation Officer (divisional) | 1 |
| Manager of local NGO project: Women's Aid | 1 |

In addition to these interviews, observations were conducted at two MARACs and two MATACs during which discussions took place with a wider range of police and other practitioners (n=21) (see Table 2).

*Table 2: Practitioners observed by role/organisation*

| | |
|---|---|
| Intelligence Officer | 3 |
| Detective Sergeant | 2 |
| Superintendent | 1 |
| Community Liaison Officer | 2 |
| NGO representative | 4 |
| Medical Sector representative | 1 |
| Prosecution Service representative | 1 |
| Housing representative | 2 |
| Social Work representative | 4 |
| Education representative | 1 |

Five other interviews were conducted with individuals working across both of the Scottish case study sites:

*Table 3: Inter-case study practitioners interviewed by role/organisation*

| | |
|---|---|
| Police Taskforce Officer | 4 |
| NGO representative: Safe Lives | 1 |

**How where they selected? How did you get access?**

Police participants were purposively sampled to capture Scotland's three-tired approach to DV policing, which includes officers who work at local, divisional and national levels. The majority of police officers interviewed in this case study site were selected at a local level (n=7) in order to give variation in terms of gender (F=3; M=4), service experience, and to capture the experiences of those working within the Drug and Alcohol Violence Reduction Unit – a local specialism particular to this case study site (local response = 5; local specialism = 2).

Interviews at divisional level (n=3) were arranged to capture both those working in victim-facing (n=2) and investigation-facing (n=1) roles. A total of four interviews were conducted with Taskforce officers (F=1; M=3) operating at national level.

Access was arranged by our IMPRODOVA partners at Police Scotland. This introduction also facilitated access to MARAC and MATAC meetings (to be detailed in Template 2.3), through which introductions were made to the broader range of actors observed at Table 2. Snowball sampling was used after this point to conduct in-depth interviews with those willing.

**Describe the interviews (length, tape-recorded or not)**

Interviews lasted around 1.5 hours with either one or two participants per interview. They were conducted by a solo researcher who took notes. The majority were also audio recorded with participants' consent (n=9) and transcribed verbatim. Two participants did not consent to their interviews being audio recorded. In these cases, comprehensive written notes were taken during the interviews, and the researcher dictated her reflections immediately after, which were then transcribed.

**Describe limitations**

Access to interview medical and social work practitioners has been difficult to obtain. Work to secure access to these practitioners is ongoing. As such, the majority of formal interviews have been with police. However, some understanding of how non-police actors' work with the police, and in relation to operational practice and risk management has been captured through observation at MATAC/MARAC meetings.

**2. Overview**

**Which actors are involved in the handling of domestic violence (DV)?**

There are a broad range of actors actively involved in the handling of DV, including, but not limited to: police, NGOs, medical sector staff, prosecution services, social workers, housing sector staff and educational representatives.

**What do they do? What is the nature of their involvement?**

**Police:** In Scotland, the police respond to DV across three tiers: local, divisional and national. The nature of their involvement is with regards the prevention and detection of DV. At a local level they are responsible for responding to reported incidents of DV, and performing duties in relation to risk assessment; intelligence, crime and vulnerability reporting; liaising with partner agencies to detect criminality and manage risk; performing home safety checks; performing bail checks; carrying out specific tasks at the request of divisional and national tiers.

***a. Local Police***

Local police are dispatched to domestic incidents via a centralised call centre. On arrival, their first task is to intervene and stop incidents of abuse if ongoing, as well as attending to any concerns regarding the safety of the public. Their work is then to gather evidence of any crime(s) by taking statements and doing door-to-door checks with local neighbours/witnesses. At this point they also conduct a formal risk assessment with any suspected victim(s), using the Domestic Abuse Questionnaire (DAQ) which is based on the DASH questionnaire but includes an additional three questions, totalling 27 questions asked of victims of DV in order to ascertain risk and level of abuse experienced. Statements, local checks and the DAQ are recorded analogue in police notebooks.

If criminality is suspected or detected, suspects are taken into custody. Police officers return to their station office and complete digital reports on multiple systems, including filing a 'SID log' (Scottish Intelligence Database), 'CrimeFile' report and updating 'STORM' reports to allow for the effective deployment of resources in future incidents. In all cases, whether or not evidence of criminality has been detected, officers file an entry on the Vulnerable Persons Database (VPD), which can be viewed by police officers across the entirety of Police Scotland, as well as contacts in social work. The DAQ forms part of the VPD entry.

In addition to dedicated response officers, there is a local specialist unit operating in this case study site. Officers working within the Drug and Alcohol Violence Reduction Unit (DAVRU) work to support their response colleagues by conducting further investigation and evidence gathering, as well as using community intelligence and local knowledge to track down suspects.

Local staff also perform victim safety and bail checks at the request of local sergeants and divisional staff (often tasked through the MARAC process), as well as gathering additional evidence at the request of divisional and national officers (often tasked through the MARAC and MATAC processes).

***b. Divisional***

At a divisional level, DV policing takes a more dedicated form. Police are based within a specialist department within the Public Protection Unit (PPU), which deals with incidents of DV, sexual abuse and rape, flagged as requiring dedicated investigation and support. Cases requiring divisional response are detected through the daily reviewing of overnight CrimeFile and VPD entries by senior officers in the unit. From this unit, response staff work in two distinct roles. Investigation Officers conduct in-depth investigations and gather further evidence in order to detect

criminality and/or build a criminal case. Domestic Abuse Liaison Officers (DALOs) perform a more victim-facing role, and are tasked with providing victim support, as well as carrying out risk management, victim safety planning, and implementing measures to safeguard victims.

DALOs meet with victims very soon after the detection of DV at divisional level, in order to outline their role and the support that can be provided by the police. In addition to providing a single point of contact for a victim, a DALO's work involves the administering and management of the Disclosure Scheme for Domestic Abuse Scotland (DSDAS) (to be detailed further in Template 2.3), which allows members of the public and public agencies (including the police) to request information about a suspected perpetrator's criminal history, specifically in relation to DV. A proactive approach is taken to the administering of the scheme in this case study site, with the names of all new suspects that come through on the overnight VPD put forward to the scheme for disclosure to their current partner(s).

DALO staff also administer and manage the provision of GPS enabled personal safety alarms to victims (TecSOS alarms), which involves significant face-to-face time in setting up the alarms for proper use, as well as ongoing monitoring of their proper use thereafter. Recognising the labour-intensive work of processing DSDAS requests and managing personal safety alarms, this case study site has a dedicated officer whose sole responsibility is for administering the DSDAS and managing the TecSOS alarms. Finally, DALO staff also play a pivotal role in the organisation and planning of the MARAC through preparing cases to be heard; presenting cases at meetings; and liaising with victims and other agencies following meetings.

### *c. National*

At a national level, Taskforce officers investigate prolific and serial perpetrators of DV, using a 'pro-active approach' which involves identifying and speaking to ex- and current partners of a DV perpetrator in order to gather evidence of abusive behaviour and thereafter build a case against offenders that demonstrates patterns of abuse over time and/or against multiple victims. Senior police officers working within the Domestic Abuse Taskforce also attend MATAC meetings, during which they listen to the progress of ongoing cases in order to decide whether they might be more suited to the remit and resources at Taskforce level. During fieldwork, it was brought to our attention that arrangements for Taskforce involvement at MATAC meetings was currently under review and that significant changes were currently undergoing internal consultation.

**NGOs:** Scottish Women's Aid offer support and services to women (including transgender and those in same-sex relationships) and their children who are experiencing or have experienced DV. Services to women and children include temporary refuge accommodation or support to access other safe housing options; emotional and practical support; advocacy support; safety planning; and financial and legal advice. Women's Aid also play an important role in MARAC/MATAC processes in this area. Representatives from local Women's Aid branches regularly attend their local MARAC meetings, allowing them to feedback vital information on victims' perspectives. In addition, Women's Aid workers are able to refer their service users for MARAC. Some workers have also been MARAC chair-trained allowing them to lead the meetings.

**Medical sector:** There are no dedicated DV workers within the medical sector in Scotland. However midwifes, sexual health workers, substance abuse workers, mental health nurses and health visitors are all mandated to conduct the National Health Service's (NHS) flagship policy in the arena: *Routine Inquiry of Domestic Abuse*. This involves asking all women at initial assessment about abuse, whether or not there are any indicators or suspicions of abuse. In addition, *Selective Inquiries* are carried out by nursing staff, GPs and hospital doctors where there are suspicions/indicators. Medical staff also attend MARAC meetings, providing information on victims, perpetrators and their children. This includes general health information from GPs, insight from health visitors, as well as patient notes, histories and appointment details from addiction services, midwife appointments and mental health staff. It may also include writing and/or reviewing independent safety plans (ISP) for victims as well as perpetrators.

**Prosecution services:** The Crown Office and Procurator Fiscal Service (COPFS) in Scotland are responsible for the prosecution of DV. They communicate with police at divisional and national level, alerting them to bail conditions of suspects, as well as requirements for additional or further evidence. Representatives from COPFS regularly attend MATAC meetings, and provide information that might assist the police in disrupting criminal behaviour of DV perpetrators, leading to their arrest.

**Social Work:** Social workers in Scotland come into contact with DV largely through their work with 'Children and Families' and 'Criminal Justice' social work. Those working in 'Children and Families' conduct safety planning in order to keep victims and their children safe. Those working within a 'Criminal Justice' capacity work with perpetrators to challenge and change their abusive behaviours. This holistic approach is further demonstrated at MARAC meetings, where representatives from both 'Children and Families' and 'Criminal Justice' are in regular attendance.

**Housing sector:** At a local level, housing officials perform a pivotal role in intelligence gathering, through the good relationships that exist between them and response/DAVRU officers in the area. Housing representatives regularly attend MATAC meetings but are notably absent from the MARAC meetings in this case study site. During MATAC meetings, housing representatives perform a similarly significant role in intelligence gathering, alerting the police to the past, present and potential whereabouts of perpetrators.

**Educational authorities:** Representatives from education regularly attend MARAC meetings. They act to bridge communication between educational establishments (nurseries, schools, etc.) and other services in order to feedback to the meeting the ways in which DV is affecting and impacting the children of DV victims (bullying, lack of peer group, failure to progress as expected, absences, etc.), and to take back to the educational establishments detailed measures for safety planning.

**What types of domestic violence are considered?**

Scotland adopts a broad police definition of DV as domestic abuse, which encompasses emotional, physical, sexual and financial abuse. This definition operates across all sectors. The recent introduction of the *Domestic Abuse (Scotland) Act 2018*, in April 2019, which criminalises coercive and controlling

behaviour, further signals the extent to which non-physical violence of a psychological nature is considered to be integral to DV.

**Do involved actors have different conceptions of DV, and which?**
There appears to be a strong alignment in the way that different actors conceptualise DV. This is due to the national policy definition as noted above.

**Describe the education/training on DV that different actors have or have access to.**

See T1.4. for full information on training in this area.

**Which actors see DV as a priority? Which do not?**

At an organisational level, all actors consider DV a priority.

**Which actors work to make DV a more central concern?**

NGOs, such as Scottish Women's Aid and Safe Lives, work in a dedicated manner to raise awareness of the nature and dynamics of DV. Their role in being able to see a more holistic and 'bigger picture' of DV is not at odds with, but complementary to, the responsive modes that actors within the police, COPFS and social work within. Police Scotland have launched a range of public awareness campaigns (e.g. #everynineminutes) to highlight DV as a central concern.

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**

Inter-agency partnerships operate formally (within MATAC and MARAC meetings), and informally at local and divisional level. On the whole, there appears a good deal of cooperation across these activities. Task sharing at MARAC and MATAC meetings is directed by the meeting chair and appears well received amongst partners. With regards cooperation between police and housing, whilst strong informal relationships are reported at local and divisional levels, representation at MARAC meetings is notably absent within this case study area.

## 3. Steps of a DV case

**How are victims identified and detected? Are there active measures to maximize victim detection?**

Most commonly, victims are identified and detected either through reports of DV made to the police, or by self-presenting at local NGOs. In addition, social work staff may identify victims/individuals at risk of DV. There are active measures within the medical sector, with staff tasked with the detection of victims through Routine (midwifes, sexual health workers, substance abuse clinicians, mental health nurses and health visitors) and Selective (doctors and nurses) Inquiry.

**Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?**

Victims are encouraged to file criminal complaints by the police at both local and divisional level. At local level, response officers who identify criminal activity must report the crime, even if doing so is against the express wishes of the victim. At divisional level, DALO staff work closely with victims to support them in reporting, and in this sense are active in attempts to maximise complaints. NGOs, such as Women's Aid, do not specifically encourage reporting but provide a number of routine services (advocacy, emotional support, childcare) which would further assist victims in the event of them filing a criminal complaint. It is not clear the extent to which other statutory services (i.e. social work, medical sector) also encourage victims to file criminal complaints.

**Describe the process of filing a complaint. Are there active measures taken around this topic?**

Complaints may be filed with local, divisional or national police officers. At the local level, this process begins when the police attend a victim's home/locus following a call by the victim or other person. Where criminal activity is detected, a statement is taken and the DAQ risk assessment conducted. At divisional level, where a case is flagged via a VPD entry, but a complaint has not been filed, a DALO will attend soon after meeting with the victim. At this point the DALO will discuss with the victim whether or not they want to file a complaint and will actively support them in doing so (working with partner agencies and NGOs, for example, to provide additional support to victims). During this visit the DALO will also conduct another DAQ with the victim in order to gather an up to date and potentially more accurate picture of risk. Should the victim then wish to file a complaint, arrangements will be made to take a statement in a location suitable to the victim's needs, such as their home, the police station or NGO offices. At national level, complaints are potentially made following the proactive approach to ex- and current partners of known perpetrators, which result in revealing a history of DV behaviour against them. Again, attending Taskforce officers will discuss whether or not a victim wants to make a complaint, and actively support them in doing so by arranging support from other agencies and/or taking a statement in a suitable location.

**Describe what happens after victims have filed a complaint: which problems arise then?**

Following a complaint being filed, work begins to gather evidence as appropriate at local, divisional and national levels. From a policing perspective, issues arise in cases where corroborative evidence is difficult to come by. Furthermore, with the introduction of *Domestic Abuse (Scotland) Act 2018*, there is early indication that evidence gathered must be more adept at portraying patterns of behaviours rather than simply detailing isolated incidents. Whilst it is difficult to say what problems arise from a victim's perspective, feedback of individual victim's views at MARAC meetings, as well as gaining insight into a more general sense of victims' concerns and perspectives from Women's Aid representatives, suggest this to be a high time of anxiety due to ongoing concerns over their own and their family's safety under bail conditions. The increased efforts of the police and other agencies at this point with

regards safety planning (TecSOS alarms; fire safety checks; ISPs, etc.) suggest that such acute concerns are well founded and appreciated by actors across multiple spheres. That said, in addition to these immediate concerns, there exist many more practical, emotional and financial problems of a far more chronic nature which the police, and other response services, are not equipped to deal with.

**Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

Key support NGOs deliver advocacy services to victim-survivors of DV, whether or not they have reported to the police. If required, more specialist drug, alcohol and mental health services, are poised to provide ongoing assistance.

**In this process, what are the main obstacles and problems that victims face?**

In addition to deeply practical yet important issues of access to refuge, housing, support, benefits, legal aid and child contact, the stigma of being viewed as a DV victim represents a significant obstacle to some victims.

**What do you see, in the frontline response to DV, as "working" and "not working"?**

Frontline responses to DV are assisted by strong partnership working, including through the MARAC and MATAC processes; responses operate across agencies and tiers of policing, maximising the avenues through which support can be provided. The introduction of the *Domestic Abuse (Scotland) Act 2018*, appears an important step in recognising in legislation the array of forms that DV can take. There may be challenges in implementing and using this legislation in practice but it is too early to assess whether this may be the case (the legislation had only just been introduced at the time fieldwork was conducted).

**Overall, according to you, in this section, what is of key interest on your case?**

The formation of MATAC, MARAC and DSDAS DFM protocols, and the manner in which, beyond their dedicated function, they also represent a forum from which partnership working is operationalised. Of more general interest is the lack of a dedicated DV unit at divisional level in this case study site, but rather the DV unit is co-located with the Rape and Sexual Assault Unit, which can assist or dilute the response to DV depending on capacity and case volume.

## 4. Respect of international standards on service provision (SP) by the police and other FLR

## Location 1

### Standards for all SPs

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Y | Scottish Women's Aid operate a national helpline.<br><br>Should be noted that there is no 'helpline' offered by the police; calls to 101 and 999 are to report DV. Service users directed to support service help lines via Police Scotland website. |
| There should be one specialist violence against women counselling service in every regional city. | Y | |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | Y | |
| There should be a sufficient number of shelters available to victims of DV. | Do not know | From discussion in MARACs it appears that need/demand outstrips supply, especially for victims who do not have children. NGO reports innovative practice to move away from anonymity in urban settings, towards more visible placement and integration of victims in more rural communities. Results appear promising. |
| Service user has a right to be treated with respect and dignity at all<br>Times. Face-to-face contact should be within a safe, clean, and comfortable environment. | Y | But difficult to comment on 'comfort' and 'safety' due to lack of victim's perspective within data. |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk. | Y | |
| Confidentiality policies should be explained clearly to the service user before any services are provided. | Y | In principle, yes, but difficult to comment conclusively due to lack of victim's perspective within data. |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Y | Yes, in theory, but in practice it should be noted that the lines between victim and perpetrator are not necessarily neatly maintained in a large number of the DV cases that the police deal with. |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | Y and N | Services appear to prioritize safety and use many tools to achieve this (Individual Safety Plans, fire safety checks, personal alarms, etc.). Such efforts work well to secure a victim's immediate physical protection but do not necessarily meet a victim's need to 'feel' safe. |
| Services should be equitably distributed across geographic areas and population densities. | Do not know | Case study sites not varied enough in terms of geographic area and population density to comment on this |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a | Y | |

| | | |
|---|---|---|
| year. | | |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Y | Viewed through the MARAC process, there appears to be cooperation to provide services across and between agencies in these terms. That said, during observations there were a couple of cases discussed where services could not meet victims' needs, requests, nor provide reassurance with regards a victim's perceived sense of safety. |
| Services should be provided free of charge. | Y | |
| Service providers should be mindful of the needs of children of service users. | Y | |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | Y | Strong collaboration between civilian DALO and Safe Lives. |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | Y | |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | Y | |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Do not know | Unclear from interviews whether this is implied or made explicit. |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Y | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users decision whether to make an official report to the police. | N | Once the police become alerted to a report of DV they have a duty to officially investigate even in cases where a service user makes an express wish for them not to do so. This is not the case with other services providers (health, NGO, social work) unless there is a suggested or perceived risk to a third party (vulnerable adults, children). |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | Y | |
| National and local governments should have funding streams for violence against women services. | Y | Yes, but funding climate is challenging |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | | DV victim's views not routinely surveyed in regular monitoring police services. Victims' views gathered in NGOs but unclear whether this is regular and routine, or more ad hoc. |
| Services should develop guidelines for multi-agency co-operation. | Y | Protocols in place for specific modes of cooperation: MATAC, MARAC, etc. |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality. | N | Data is not systematic across all SPs. GDPR is proving challenging. Police collect and keep data on vulnerability and criminality, but unclear whether there is specific demographic information also collected that might be collated with 'nature of offences'. |
| Services should produce annual or bi-annual | Do not know | Not clear from interviews. |

| | | |
|---|---|---|
| analysis of their users and their experiences. | | |
| There should be clear protocols in place for data collection and information sharing between organisations. | Y | |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | Y | In principle, yes, but difficult to ascertain in practice due to lack of data from actors in this area. |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | N | Gender of forensic staff is not guaranteed. |

## Standards for the police

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | N | An application can be made but legal aid is not guaranteed. |
| Police personnel should be trained on all aspects of DV. | N | Whilst training is ongoing, at the point of interview not all who had participated had been trained on new legislation. |
| DV offences should be treated at least as seriously as other violent offences. | Y | |
| Victims should be seen as soon as possible by a specially trained officer | Y | In some DV calls evidence of criminality and an individual's status as a 'victim' can be difficult to ascertain (such as in cases where there is a reluctant complainer). While an entry will be made on the Vulnerable Persons Database this will not necessarily be picked up by a specially trained officer. VPDs are closely examined in this area and DSDAS Power to Tell requests are made using VPD information and local intelligence. Proactive approach to identifying nominals as victims, and facilitating a more specialist response. |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | N | Not at local 'police station' level. Specialist officers at divisional level, however, no separate DAIU but rather unit deals with cases of a DV AND rape/sexual assault nature. DAVRU operates in at local level in this area which deals with many of the mediating factors surrounding DV (drugs, alcohol, violence). Staff have a more nuanced understanding but are not necessarily 'specialized'. |
| Specialist Police units should be created in densely populated areas | Y | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Y | |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | Y | |

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|---|---|---|
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | Y | In principle, yes, but difficult to comment conclusively due to lack of victim's perspective within data. |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Y | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | Y | Pathways are there but more dedicated advocacy and non-police support needed. |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | Y | |
| Police should have protocols on information sharing on DV with other agencies | Y | |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | Y | DALO staff work in a trauma informed manner and appear sensitive to victim's needs. |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained and reports made are kept confidential | Y | But VPD entries are automatically shared with social work. |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | Y | |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | Y | |
| Police should develop and implement strategies to eliminate or reduce victim risks | Y | |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | Y | In principle, yes, but difficult to comment on practice due to lack of victim's perspective within data. |

## Location 2

## Standards for all SPs

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Y | Scottish Women's Aid operate a national helpline.<br><br>Should be noted that there is no 'helpline' offered by the police; calls to 101 and 999 are to report DV. Service users directed to support service help lines via Police Scotland website. |
| There should be one specialist violence against women counselling service in every regional city. | Y | |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | Y | |
| There should be a sufficient number of shelters available to victims of DV. | Do not know | From discussion in MARACs it appears that need/demand outstrips supply, especially for victims who do not have children. NGO reports innovative practice to move away from anonymity in urban settings, towards more visible placement and integration of victims in more rural communities. Results appear promising. |
| Service user has a right to be treated with respect and dignity at all<br>Times. Face-to-face contact should be within a safe, clean, and comfortable environment. | Y | But difficult to comment on 'comfort' and 'safety' due to lack of victim's perspective within data. |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is reason to believe that they may be at risk. | Y | |
| Confidentiality policies should be explained clearly to the service user before any services are provided. | Y | In principle, yes, but difficult to comment conclusively due to lack of victim's perspective within data. |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Y | Yes, in theory, but in practice it should be noted that the lines between victim and perpetrator are not necessarily neatly maintained in a large number of the DV cases that the police deal with. |
| Safety and security should be the paramount considerations. This refers to the safety of the service user, any children and vulnerable persons related to their case, and staff. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | Y and N | Services appear to prioritize safety and use many tools to achieve this (Individual Safety Plans, fire safety checks, personal alarms, etc.). Such efforts work well to secure a victim's immediate physical protection but do not necessarily meet a victim's need to 'feel' safe. |
| Services should be equitably distributed across geographic areas and population densities. | Do not know | Case study sites not varied enough in terms of geographic area and population density to comment on this |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Y | |
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| | | |
|---|---|---|
| requesting;<br>• where this is not possible, refer the service user to relevant services. | | these terms. That said, during observations there were a couple of cases discussed where services could not meet victims' needs, requests, nor provide reassurance with regards a victim's perceived sense of safety. |
| Services should be provided free of charge. | Y | |
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| There should be clear protocols in place for data collection and information sharing between organisations. | Y | |

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| Victims should be seen as soon as possible by a specially trained officer | Y | In some DV calls evidence of criminality and an individual's status as a 'victim' can be difficult to ascertain (such as in cases where there is a reluctant complainer). While an entry will be made on the Vulnerable Persons Database this will not necessarily be picked up by a specially trained officer. VPDs are closely examined in this area and DSDAS Power to Tell requests are made using VPD information and local intelligence. Proactive approach to identifying nominals as victims, and facilitating a more specialist response. |
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| Specialist Police units should be created in densely populated areas | Y | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Y | |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | Y | |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | Y | In principle, yes, but difficult to comment conclusively due to lack of victim's perspective within data. |

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|---|---|---|
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Y | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | Y | Pathways are there but more dedicated advocacy and non-police support needed. |
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| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | Y | DALO staff work in a trauma informed manner and appear sensitive to victim's needs. |
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| Police should develop and implement strategies to eliminate or reduce victim risks | Y | |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization, and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | Y | In principle, yes, but difficult to comment on practice due to lack of victim's perspective within data. |

# VIII. SLOVENIA

## 1. Methodology

### How many interviews have been conducted? With whom?

The analysis of the implementation of policies and guidelines of frontline responder practices in the context of domestic violence in Slovenia is based on 34 interviews conducted in two case locations, Ljubljana and Murska Sobota, between March and July 2019. Respondents included persons working in law enforcement agencies, social and health-care sector, and government officials on regional or national level positions.

In case location Ljubljana we interviewed seven police officers: four Senior Police Officers, two Senior Criminal Police Inspectors Specialists, and one Criminal Police Inspector Specialist. We interviewed also three social workers (two of them senior social workers), four physicians (one of them is psychiatrist, one is senior lecturer at the faculty), and three government officials. In addition, one interviewee was NGO representative. Altogether 18 interviews were conducted.

In case location Murska Sobota we interviewed ten police officers: three Senior Police Officers - Criminal Investigators, two Police Officers - Criminal Investigators, two Police Inspector Specialists - Assistant Commanders, one Senior Police Inspector, one Criminal Police Inspector Specialist and one Senior Police Superintendent. We interviewed also three senior social workers (one of them is Doctor of Psychology who deals mostly with perpetrators), two physicians and one dentist. Altogether 16 interviews were conducted.

With excellent infrastructure, a well-educated workforce, and a strategic location between the Balkans and Western Europe, Slovenia has one of the highest per capita GDPs in Central Europe. Slovenia is not only one of the safest countries in the world it also has one of the lowest crime rates. Slovenia is divided into eight police directorates (Slo.: policijskih uprav [PU]) (see figure 1).

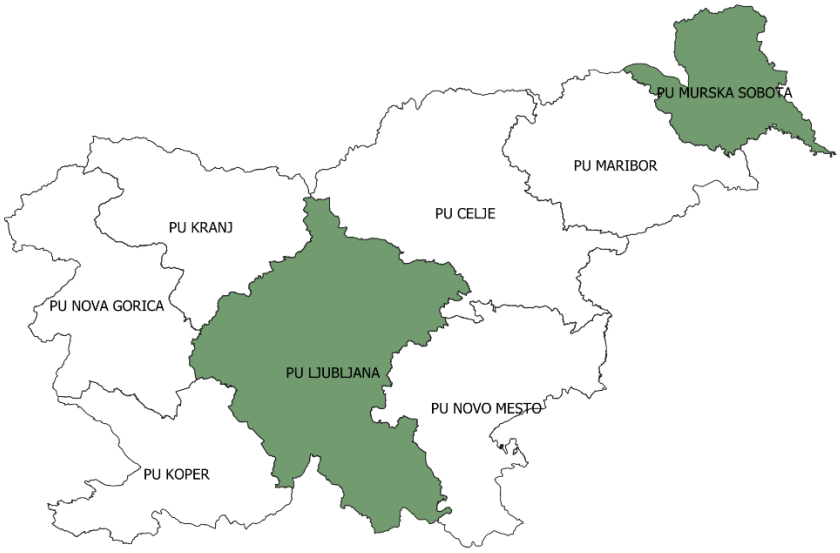


*Figure 1: How the Slovenian territory is divided in regard to police directorates. The locations that are selected for analyses are marked green.*

Figure 2 (below) shows some data in regard to the rate on DV per police directorate, however, the numbers are not balanced as they are not calculated on per 1000 inhabitants.

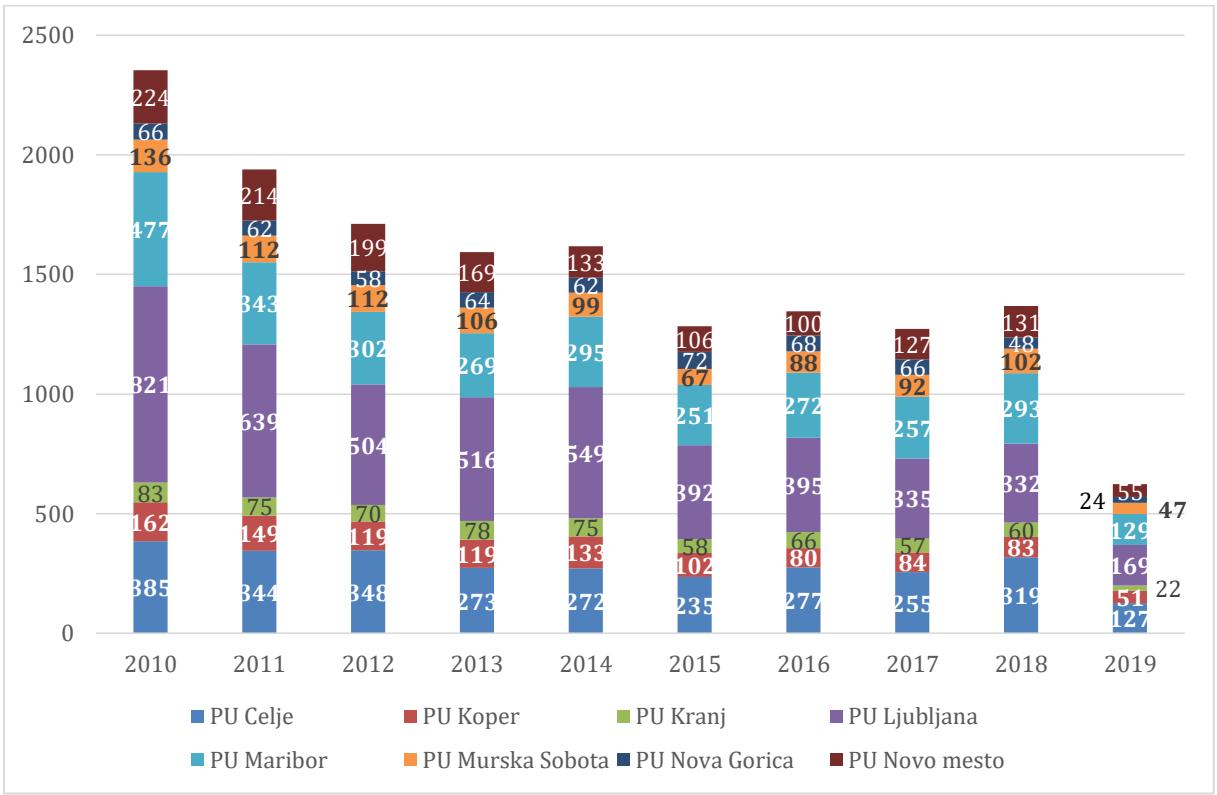


*Figure 2: Criminal acts of domestic violence per police directorate*

More suitable data is presented in table 1 (below)

| Police Directorate | Percentage of Criminal act of Domestic violence per police directorate per 1000 Inhabitants [%] |
|---|---|
| Celje | 35,7 |
| Koper | 9,8 |
| Kranj | 6,8 |
| Ljubljana | 43 |
| Maribor | 32,9 |
| Murska Sobota | 12 |
| Nova Gorica | 5,7 |
| Novo mesto | 14,7 |

*Table 1: Percentage of criminal act of domestic violence per police directorate per 1000 inhabitants [%] in 2018*

**Location 1 - LJUBLJANA (urban settings, higher- than-average rates of DV, as reported to the police)**

Police directorate Ljubljana is territorial and population-wise, the largest in Slovenia. It covers a 4.290 km2, accounting for 21.2 % of the entire territory of Slovenia. Its crucial trademark is that it includes the Slovenian capital Ljubljana. The city itself has 284.355 inhabitants, who are mostly Slovenes and first, second and even third generations of Bosnians, Serbs, Albanians and others from ex-Yugoslavia. Ljubljana is also the cultural, educational, economic, political, and administrative centre of Slovenia. On the south, police directorate Ljubljana includes highly dense green areas and shares a border with the Republic of Croatia. In a sense, this police directorate combines the most urban regions as well as highly rural regions. It ecompass the osrednjaslovenska statistical region (NUTS-3) as well as small part of two other regions. The share of people living below the at-risk-of-poverty threshold in osrednjaslovenska region was second lowest in the country (11.8%). The unemployment rate (7.3%) was lower than the national average. A large majority of the region's employed citizens also worked in the region (91%).

Statistically speaking, the police directorate Ljubljana is also known for higher than average rates of DV, while it also concentrates the largest number of national and regional first line responders active in the field of DV. These are mostly located in the capital city of Ljubljana. The jurisdiction of the capital of Slovenia, Ljubljana, was recognized for the presence of best practices and for a high degree of compliance with international guidance.

**Location 2 - MURSKA SOBOTA (rural settings, average rates of DV, as reported to the police)**

Police directorate Murska Sobota covers the north-eastern part of the country and measures 1.337 km2, which represents 6.6 % of the territory of the country. The most urban part of the directorat is the city Murska Sobota with 11.113 inhabitants. Police directorate Murska Sobota does have a high degree of a rural setting. In the north

and northwest is bordering the Republic of Austria in the east and northeast with the Republic of Hungary and in the southeast with the Republic of Croatia. The area traditionally belongs to the region of Prekmurje, nowadays the Pomurska region. For several years, the region stands out with the highest unemployment rate and high rate of citizens leaving the region.

According to statistics, Murska Sobota has average rates of DV, as reported to the police. Police directorate Murska Sobota is a jurisdiction where the quality of frontline response to HIDV (police and collective) is presumed to be typical (to get a view of standard practices in Slovenia).

We would like to stress that there is a lot of similarity between our two case study areas. This is because Slovenian Police operate as a national force, and practices are mostly standardized across different local areas. The same applies also to the social and health-care sector. That is why we consolidated the report into one document and described the specifics for each case location.

**How were they selected? How did you get access?**

An introduction letter was sent to our IMRODOVA police partner, the Police Academy, who forwarded our request to the superintendents and chief inspectors of two police directorates (the case locations of the study) in March 2019. They granted us all interviews with police officers. We did desk research and used personal contacts of social workers and most relevant physicians in Ljubljana and Murska Sobota.

**Describe the interviews (length, tape-recorded or not)**

The longest interview took 135 minutes. The shortest interview took 50 minutes. The average length of the interviews was 1,5 hours. All interviews were audio-recorded and transcribed.

**Describe limitations**

Getting access was easy. No challenges were faced. We had no problems discussing any subjects. Everyone, especially police officers, was very open and shared a lot of information.

**2. Overview**

**Which actors are involved in the handling of domestic violence? What do they do? What is the nature of their involvement?**

A typical DV case is usually handled by police officer(s) and social workers, as they are also actors who detect DV most frequently. In certain instances, NGOs and healthcare practitioners are involved.

Upon arrival at scene, police patrol officers determine location and condition of the victim, determine if the suspect is still at the location, what happened, and if any

criminal offence or minor offences have occurred. Then they start a preliminary investigation. They interview the victim and suspect separately, note signs of injury, advise the victim of his/her right to file a criminal complaint. They also explain to the victim the procedure to obtain a restraining order in emergency situations. In non-emergency situations they will refer the victim to an appropriate social service or NGO. In the meantime, they will check any previous police record the suspect may have, obtain all statements (both parties, possible witnesses), document past history of violence, secure evidence, photograph and document the scene, document injuries, and transport the victim to the hospital, if necessary.

Social workers would advise the victim about possibilities and resources and NGO would provide all necessary help and assistance for the victim. Making sure the children and the victim are safe are key tasks for the social workers. Social workers are focused on the whole family. In days after the incident, they engage in a safe way with the perpetrator, addressing his/hers behaviour, suggesting procedure that would bring about a change in such behaviour etc.

A DV case can differ from one place to another. The involvement in handling DV depends on the specific police station and how officers were trained to respond. In case study Murska Sobota we found that police and social workers work closely together, and treat DV calls as a high priority. An integrative approach has been more fully recognized and advanced than in Ljubljana, where police officers commonly reported they are overworked and that they are burning out: "*The stresses that a police officer working in Ljubljana are subjected to are quite different than those experienced by our counterparts in other regions*".

**What types of domestic violence are considered?**

Patrol officers who arrive first at the scene, usually deal with physical violence only. Victim's reports on other types of violence (psychological, economic abuse, stalking, etc.) may find a lack of police response or poor handling.

Family violence is a common social problem infringing on basic human rights. Such a view of family violence is also expressed in the Penal Code. In the chapter "Criminal offences against marriage, family and children" family violence is stipulated as an independent criminal offence[13]. The family-related criminal offences that are subject

[13] *"Criminal offence: domestic violence*

1. Whoever within a family treats other persons badly, beats them, or in any other way treats them painfully or degradingly, threatens with direct attack on their life or limb to throw them out of the joint residence or in any other way limits their freedom of movement, stalks them, forces them to work or give up their work, or in any other way puts them into a subordinate position by aggressively limiting their equal rights shall be sentenced to imprisonment for not more than five years.
2. The same punishment shall be imposed on whoever commits the acts under the preceding paragraph in any other permanent living community.
3. If the act under paragraph 1 is committed against a person with whom the perpetrator lived in a family or other permanent community, which fell apart, however this act is connected to the community, the perpetrator shall be sentenced to imprisonment for not more than three years.

*Criminal offence: neglect and maltreatment of a child*

*1.* A parent, adoptive parent, guardian or other person who seriously breaches his obligations to a child shall be sentenced to imprisonment for not more than three years.

to prosecution by the police are “domestic violence” under Article 191 of the Penal Code (a victim is a person of legal age) and “neglect and maltreatment of a child” (Article 192) (a victim is a person under the age of 18).

**Do involved actors have different conceptions of DV, and which?**

No. In Slovenia, the main national legislation in the area of domestic violence management is Domestic Violence Prevention Act and Act Amending the Domestic Violence Prevention Act. Family Violence Act defines domestic violence as a prohibited behaviour. Violence denotes any form of physical, sexual, psychological or economic violence inflicted by one family member against another, or neglect or stalking of the victim regardless of age, gender or any other personal circumstance of the victim or the perpetrator of the violence, and corporal punishment of children.

Physical violence denotes any use of physical force or threat to use physical force that coerces the victim to do something or to refrain from doing something, or makes the victim suffer or restricts the victim's movement or communication and causes the victim pain, fear or shame, regardless of whether injuries were inflicted. Sexual violence involves actions of a sexual nature without the victim's consent, to which the victim is forced or does not understand their meaning owing to the victim's stage of development, threats to use sexual violence and publication of material of a sexual nature relating to the victim. Psychological violence denotes such actions and dissemination of information through which the perpetrator of violence induces fear, shame, feelings of inferiority, endangerment and other anguish in the victim, including the use of information and communication technology. Economic violence is the undue control or placing of restrictions on a victim concerning disposal of one's income or managing the assets of which the victim independently disposes or manages, or the undue restricting of disposal or management of the common financial assets of family members, undue failure to fulfil financial or material obligations to a family member, or undue transfer of financial or material obligations to a family member. Neglect is a form of violence in which a perpetrator of violence does not provide due care for a victim who is in need of it due to illness, disability, old age, developmental or any other personal circumstances. Stalking is wilful, repeated and unwanted establishment of contact, following, physical intrusion, watching, loitering in places frequented seen by the victim, or other unwanted forms of intrusion in the victim's life. In the article 3a the Act Amending the Domestic Violence Prevention Act from 2016 *Prohibition of corporal punishment of children* is defined. Corporal punishment of children shall be considered any physical, cruel or degrading punishment of children or any other Act with the intention to punish children containing elements of physical, psychological or sexual violence or neglect as a method of upbringing.

2. A parent, adoptive parent, guardian or other person who forces a child to work excessively or to perform work unsuitable to his age, or who out of greed inures a child to begging or other conduct prejudicial to his proper development, or who tortures him/her shall be sentenced to imprisonment for not more than five years.”

**Describe the education/training on DV that different actors have or have access to.**

Police officers receive training on family violence on regular basis at the Police Academy in the course of training on how to use their police powers – the implementation of restraining order in particular. Police officers are trained to impose, at their own discretion, a restraining order to protect the victim and prevent further violence**.** A local social work centre will be notified of such a measure. If the perpetrator is instructed to stay away from the educational institution attended by a child or minor victim, the police will notify that institution of the duration of the order and provide it with information on the child's or minor's protection. A police officer imposes a restraining order orally first and then issues an order in writing within six hours**.** The first order is valid for 48 hours. The legitimacy of a restraining order is automatically checked by an investigating judge (court), who issues a special decision thereon. If she/he affirms the order imposed by the police, the judge usually extends its validity to 10 days (from the day the restraining order was given orally by the police officer).
Slovenian police also has the so-called multiplicators. A number of police officers that when trough an additional training in regard of DV, and whose job is to share this knowledge with fellow police officers.

The Institute of Criminology at the Faculty of Law implemented the project "Systemic Response to Domestic Violence – Training for Teaching Professionals". The training programme focused on the legal bases for addressing domestic violence, its identification and prevention, the duties of staff at education institutions in addressing violence, and cooperation with other institutions. The programme also included practical testing of acquired knowledge, reflection and exchange of experience. The training was successfully concluded by approx. 1400 qualified professionals, who acquired relevant information and material to teach pupils. In 2013, the Ministry of Education, Science and Sport, in cooperation with the Ministry of Labour, Family, Social Affairs and Equal Opportunities, and the Police, drafted the "Arrangement for the Implementation of Tasks to Protect Children".

In health care sector the project ‘Pond’ (which stands for ‘Recognizing and treating victims of domestic violence in health care settings: guidelines and training for health professionals’) which was supported by Norway Grants under the Public Health Initiatives programme in Slovenia was developed. The project was implemented by a consortium of project partners comprising the Research Centre of the Slovenian Academy of Sciences and Arts, the Medical Chamber of Slovenia, the Maribor Social Service Centre, the Emma Institute (NGO - Support Centre for Victims of Violence) and the Brøset Forensic Department, Centre for Research and Education in Forensic Psychiatry St. Olavs University Hospital in Norway. The main objective of the project was the implementation of the Family Violence Prevention Act in the health sector in order to increase the competence of health workers to recognise domestic violence. The Professional Guidelines for Responding to Domestic Violence in Health Care Services were developed in 2014. The Guidelines were approved by Slovenian Medical Council in April of that year and are publicly accessible. The Professional Guidelines consist of a collection of recommended conduct in responding to child victims of abuse and violence and adult victims of violence. They seek to equip health professionals coming into contact with victims of domestic violence with basic

skills and know-how for identifying and responding to victims of domestic violence (POND, n.d.). Since around 2009 the content of DV is also included in curriculums at the Faculty of medicines in the specialization for family doctors. The inclusion of DV content was also a result of the POND project and certain highly motivated persons/researchers that recognized the need for such contend at the medical faculties.

**Which actors see DV as a priority? Which do not?**

According to interviews, unfortunately, health care professionals do not routinely screen for health risks such as DV or abused or neglected children. Usually do not ask about or identify DV, even in cases where it is obvious. They are more focused on treating the injuries and they often disregard the violence that caused those injuries.

**Which actors work to make DV a more central concern?**

Police and Social Work Centre, and two NGOs, namely Association for Nonviolent Communication [ANC] (slo. Društvo za nenasilno komunikacijo) and Association SOS Help-line for Women and Children - Victims of Violence [SOS phoneline] (Slo. Društvo SOS telefon za ženske in otroke - žrtve nasilja).

**Briefly describe the main findings regarding inter-agency partnerships (cooperation, conflict, mutual ignorance, subordination, task-sharing).**

Within each Social Work Centre (SWC)[14] a service for coordination and assistance to victims is formed. The SWC perform services are pursuant to the act “governing social security”, and “urgent measures for protecting the child’s interest” pursuant to the act “governing family relationships”. Each service includes an intervention service and crisis centre. SWC also call (and organize) also the so-called multidisciplinary teams. Such teams are called / organized for a specific cases and can include participants from SWC, police officers, healthcare practitioners, NGOs and other revenant personnel. Rules on the organisation and work of multidisciplinary teams and regional services and on the activities of social work centres in dealing with domestic violence were adopted within the scope of Domestic Violence Prevention Act and Amending the Domestic Violence Prevention Act.

Police and Social Work Centers found the cooperation very good, although they told us that these good practices vary across the country depending on the concrete individuals rather than institutions. This is especially the case in Murska Sobota where Police and SWC established good informal relationships, the meetings are regular, and the protocols are in place. There are good practices of cooperation available in all sectors, but they are not unified. Medical profession and the judiciary still need to strengthen their efforts, e.g., via trainings. Taking victim's interests into account requires a high degree of professionalism from all the relevant professional

[14] The aim is to provide assistance to victims of violence, intervention services, coordinating activities of authorities and organizations, and monitoring and analysing the occurrence of violence in the area of SWC

groups and in all areas of action (such as schools, nursery schools, general practitioners in medical professions, and courts – especially).

## 3. Steps of a DV case

### How are victims identified and detected? Are there active measures to maximize victim detection?

Victims can be identified by the police (emergency calls) or other first-line responders as well, but the connection between FLR and a victim is almost always initiated by a victim. The exception is when someone else, relatives, neighbours or other people call the police. Government and NGO's try with general information and prevention campaigns (public events that focus on the awareness of violence, as well as expert and public discussions) destigmatize DV and encourage people not to step back when they identify this problem in their environment, but to report their suspicions and take an active role against violence.

In case of Murska Sobota, police and Social Work Center are very active in prevention campaigns to maximize victim detection in order to achieve zero tolerance of DV (prepare and expand the educational, awareness-building and informational material - brochures for kindergartens, schools, health practitioners, retirement homes, etc.). The number of reported criminal offenses of family violence is increasing every year.

In general, domestic violence can be reported by anyone - a victim, a child, a minor, an NGO, a private entity or a state agency.

### Are victims encouraged to file criminal complaints? Are there active measures to maximize complaints?

Patrol officers have to write a report, but usually they do not recommend anything to the victims (unless the victim is at high risk; in that case filling a complaint is highly recommended). NGOs explain victims of all the procedures but do not explicitly encourage them to file complaints. No active measures to maximize complaints were found.

In case of Murska Sobota, we have no information about how FLR deal with this, except about standard police procedures - when patrol officers arrive at the scene, they file a complaint against the perpetrator and the victims make a statement after the incident. Police will protect the victim of family violence against direct danger along with advising victims of possible assistance for a solution. NGO's and medical professionals would inform victims about their possibilities.

FLR in both case locations report that victims many times withdraw their statements, which is many times discouraging for their work.

**Describe the process of filing a complaint. Are there active measures taken around this topic?**

Police do not require authorization by the victim in order to prosecute the perpetrator. The family-related criminal offences that are subject to prosecution by the police are domestic violence under Article 191 of the Penal Code. Knowing that a DV criminal offence is being committed is enough for taking all required measures and procedures. An official record is made of a reported incident, usually called a record of an oral crime report. If the police note, in the course of their work, that a criminal offense was committed, they draw up an official note thereof. If an incident is reported by a child, the police also make an official note. Another reporting option is by post. The police will talk to the reporting person subsequently. Domestic violence may also be reported by completing an online crime report. However, police advise that this option should only be taken exceptionally. Such reports cannot be considered urgent, they merely serve as information and it is very difficult for the police to respond effectively because there is no cooperation from persons involved. When the patrol officers arrive at a crime scene, they will file a complaint against the perpetrator, open a case and take all the necessary protective measures. When filing a criminal complaint, a victim may be accompanied by a confidential person (i.e. NGO assistant) to support her in procedures before state bodies.

**Describe what happens after victims have filed a complaint: which problems arise then?**

One of the main problems was already mentioned: victims often withdraw their statements. The other two are lack of evidence and witnesses who would later testify on the court. Fear against possible testimony in court is the most common reason why people do not react the way they should – with a report.

FLR in both case locations, Ljubljana and Murska Sobota, try to encourage victims to seek help more rapidly (or frequently) and to challenge perpetrators with the responsibility for their actions. A big problem is lack of evidence (especially in case of psychological abuse) and lack of reliable witnesses who are willing to testify later at the court. Police reports that it is difficult to conduct investigation in the way that would end up in a criminal charge imposed by the prosecution.

**Describe victims' support networks, whether or not they have filed a complaint or gone to court.**

Victims can receive two types of help: from government (Social Work Centers) and NGO's. The program of accompaniment for victims of violence to procedures at different institutions (police, prosecutor's office, court of justice and Centres for social work) is one of the possibilities for victims of DV offered by NGO's (Association for Nonviolent Communication design this program to increase safety of victims of violence).

In Ljubljana, various forms of assistance (SWC, NGO's, help line, shelters) are at the disposal of victims; however, their accessibility (especially programmes of non-governmental organisations) is unevenly divided by areas. In Murska Sobota the issue of accessibility of suitable assistance programs is especially important for

inhabitants who live in more rural surroundings: socially endangered persons have worse access to services due to lack of funds. There is also the problem of mobility and control by the perpetrator of DV. Elderly persons often doubt that other persons will believe them, they do not talk about it, and they do not want press charges against their abusive family member.

**In this process, what are the main obstacles and problems that victims face?**

One of the problems mentioned by NGO's and social workers was "betrayal of trust in institutions". One of the social workers also expressed "*concern that perpetrators has been brought to justice, and that some of those individuals are or have been holding more rights than victims have.*" Victims feel betrayed and sometimes do not believe, the system will punish perpetrators, and help, protect and support the victims. As we did not talk to the victims, we are not in possession of any information about what their main obstacles and problems are.

**What do you see, in the frontline response to DV, as "working" and "not working"?**

Police officers and social workers cooperate well, especially in the context of crisis centers. There seem to be some gaps on local capacities/attitudes or approaches. DV should be reported by pre-schools, schools and healthcare institutions (doctors, therapists, psychiatrists, etc.), whereas persons acting in an official capacity must report it ex officio, but this is often not the case on both our locations.

At the level of the state, the social work centers, police and healthcare institutions are evenly distributed, while non-governmental organizations are concentrated in central Slovenia and larger centers, which doesn't provide many choices to the victims. Few social workers and the representative of NGO's told us that they have the feeling that the rights of the perpetrator as a parent are more important than the rights of their children.

The medical profession mentioned that they have to carry out their own work (to save and preserve life), and to deliver on it, and that is why it is hard for them to see DV as a priority. Two doctors and one government official mentioned that all the trainings that are offered in the medical field are on a voluntary basis and that they should be mandatory.

**Overall, according to you, in this section, what is of key interest on your case?**

The legislation and network are good and adequate and that is also what FLR often told us. We noticed that in every sector (police, social work, heath sector, even NGO's) one of the biggest problems is lack of time and insufficient personal resources. Another great challenge can be the complicated and bureaucratic procedures. People who work on DV cases are often overworked, overloaded and over-stressed. This can apply on both our locations.

## 4. Respect of international standards on service provision (SP) by the police and other FLR

### Standards for all SPs: LJUBLJANA (Location 1)

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Y | Whenever citizens require police assistance, they can call the 113 emergency number 24/7. NGO's SOS Help-line is operating on a national level, providing help to callers from all around Slovenia, but not 24/7. |
| There should be one specialist violence against women counseling service in every regional city. | Y | Social services within the framework of public services are regionally represented, as well as social welfare programs, in each region (with the exception of the Zasavje region), safe houses for victims and free counseling are available. |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | N | Only partially.<br>Migrant women face the biggest problems because most SP cannot provide interpreters. Police yes, but others usually do not. |
| There should be a sufficient number of shelters available to victims of DV. | Y | |
| Service user has a right to be treated with respect and dignity at all<br>Times. Face-to-face contact should be<br>within a safe, clean, and comfortable<br>environment. | Y | Place for improvements: In some environments, the victim can run into or be faced with the perpetrator, so it is not safe enough. |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is a reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is a reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | Y/N | Most SP will share information with other SP without the victim's consent. Special training of workers who deal with DV, the police, the prosecutor's offices, the judicial administration, schools and health services, and education would be beneficial. |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Y/N | Some deviations from this norm were detected in the field of prosecution, the court system, and health sector.<br><br>From the perspective of NGO's: victim's words are heavily doubted every step of the way and accountability for the DV often divided between the victim and the perpetrator. |
| Safety and security should be paramount considerations. This refers to the safety of the service user, any children, and vulnerable persons. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | Y | NGO's perspective: Victims and their children are often treated as means to the end by different SP. |
| Services should be equitably distributed across geographic areas and population densities. | N | The capital is more privileged compared to rural areas and other cities. |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Y | |
| Services should be holistic, and user led. The service provider should be competent to: | Y/N | NGO's: they often encounter SP who themselves are not aware of other SP. |

| | | |
|---|---|---|
| • provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | | |
| Services should be provided free of charge. | Y | |
| Service providers should be mindful of the needs of children of service users. | N | Needs of children are often neglected to satisfy the needs of their abusive fathers. |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | Y/N | Training is not a part of employment contracts.<br><br>Judges, prosecutors, doctors and teachers often have no training in regard of DV at all. And even if some do, it is not mandatory for all. |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | N | |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | Y | The efforts are directed towards the treatment of victims and perpetrators by two different social workers. |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Y/N | Some SP do not even know that. |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Y | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users decision whether to make an official report to the police. | Y/N | Reporting to the police is mandatory for all institutions who come in contact with the victims.<br><br>In case that a service user has children, or if a service user is minor, reporting to social services or police is mandatory. |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | Y | NGOs are autonomous, non-profitable and some of them (e. g. ANC) have a stable government funding. They are capable of providing long-term good support. |
| National and local governments should have funding streams for violence against women services. | Y | |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Y/N | Partially. |
| Services should develop guidelines for multi-agency co-operation. | Y | |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | N | |
| There should be clear protocols in place for data collection and information sharing between organisations. | Y | But they are often not respected. |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | ? | Unknown. Some have training and some do not, since it is not mandatory. No information about protocols. |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico- | N | Forensic examiner is not always female. |

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| legal reports. | | |

## Standards for the police: Case Location Ljubljana (Location 1)

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | Y | |
| Police personnel should be trained on all aspects of DV. | N | Achieving targeted training and personalized learning is necessary: police officers often reported about inadequate training (too general and ex-cathedra); effectiveness of DV training should be evaluated |
| DV offences should be treated at least as seriously as other violent offences. | N | While on a declarative level police does see DV as seriously and the police officers that we have interviewed do react in a manner that indicate such perception (interviewed police officers also believe that this is true for their colleges as well), yet, there are indications that overall procedure (especially later on when it comes to processors and judges) in not actually treated as such.. |
| Victims should be seen as soon as possible by a specially trained officer | N | There are no specially trained officers. Victims of DV are sometimes treated in an almost conveyor-belt fashion = the case may change hands many times. |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | N | Criminal police should be in charge of these cases, but they are often overloaded with other tasks. |
| Specialist Police units should be created in densely populated areas | N | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Y | |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | Y | The legislation is satisfactory, still we do not have the exact protocols. Level of victim protection is therefore often left to subjective judgments |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | Y | |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Y | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | Y | |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization | Y | |

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| and case outcomes | | |
| Police should have protocols on information sharing on DV with other agencies | Y | Police share information with social work centers and with schools |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | N | The norm is still not respected (except when children are involved) |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained, and reports made are kept confidential | Y | |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | Y | |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | Y | |
| Police should develop and implement strategies to eliminate or reduce victim risks | Y/N | Only the restraining order |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | Y/N | Not always, because we do not have specially trained officers |

## Standards for all SPs: Case Location Murska Sobota (Location 2)

| | Respected? Y/N/do not know | Comment (if any) |
|---|---|---|
| There should be a help line covering DVs which is able to answer all incoming calls | Y | Only Police provide emergency line 24/7 |
| There should be one specialist violence against women counseling service in every regional city. | Y | |
| Services should be linguistically and culturally accessible to migrant victims, to victims with disabilities, to victims living in rural areas. | N | Only partially. |
| There should be a sufficient number of shelters available to victims of DV. | Y | |
| Service user has a right to be treated with respect and dignity at all<br>Times. Face-to-face contact should be<br>within a safe, clean, and comfortable<br>environment. | Y | |
| Confidentiality must be guaranteed. Any written or spoken communication or other information containing anything that can identify the service user should only be passed on to others with the service user's informed consent. The only exceptions are:<br>• to protect the service user, when there is a reason to believe that her life, health or freedom is at risk.<br>• to protect the safety of others, when there is a reason to believe that they may be at risk.<br>Confidentiality policies should be explained clearly to the service user before any services are provided. | Y/N | Most SP will share information with other SP without the victim's consent. |
| All services should begin from the twin principles of a culture of belief with respect to victims and accountability of perpetrators. | Y/N | To a large extent (except when dealing with divorce cases, social workers are more cautious). |
| Safety and security should be paramount considerations. This | Y | |

| | | |
|---|---|---|
| refers to the safety of the service user, any children, and vulnerable persons. Safety here is not just immediate physical protection, but psycho-social safety, including social inclusion. | | |
| Services should be equitably distributed across geographic areas and population densities. | Y | |
| Crisis services should be available and accessible round the clock, i.e. 24 hours a day, 365 days a year. | Y | |
| Services should be holistic and user-led. The service provider should be competent to:<br>• provide what the service user needs or is requesting;<br>• where this is not possible, refer the service user to relevant services. | Y/N | To a large extent. |
| Services should be provided free of charge. | Y | |
| Service providers should be mindful of the needs of children of service users. | N | Not always. Needs of children are often neglected to satisfy the rights of their abusive parent. |
| Staff should be appropriately qualified and trained:<br>• Minimum initial training and a minimum ongoing training should be part of employment contracts;<br>• This standard also applies to all relevant professionals in state and non-state agencies. Here, specialist NGOs should be used as trainers and paid appropriately. | Y/N | We do not know if training is a part of employment contracts.<br><br>Sometimes there is a perception, that DV concern only police and social workers. |
| Women's NGOs should be staffed by women, and other agencies should ensure availability of sufficient professional female staff, including interpreters, medical staff, and police officers. | Y | |
| Action of the SP should be based on an integrated approach which takes into account the relationship between victims, perpetrators, children and their wider social environment. | Y | |
| Service users should be informed of their rights i.e. what services they are entitled to receive, what their legal and human rights are. | Y/N | Mostly, but not sufficiently. |
| Service user's right to receive information and support should not be conditional upon making an official complaint or agreement to attend any kind of programme/group/service. | Y | |
| All information, advice and counselling should be based on empowerment and victim rights models:<br>• Informed consent should be obtained before any action or procedure is undertaken;<br>• All service providers should prioritise the best interests of the service user;<br>• It is the service users decision whether to make an official report to the police. | N | Reporting to the police is mandatory for all institutions who come in contact with the victims. |
| Services provided by NGOs should be autonomous, non-profit-making, sustainable and capable of providing long-term support. | Y | |
| National and local governments should have funding streams for violence against women services. | Y | |
| Services should develop through attention to service user needs; actively seeking the views of service users and taking them into account should be a core part of regular monitoring procedures. | Y | |
| Services should develop guidelines for multi-agency co-operation. | Y | |
| Data should be collected and maintained in a systematic way on service user demographics and nature of offences, in ways that do not violate the service user's rights to confidentiality.<br>Services should produce annual or bi-annual analysis of their users and their experiences. | N | |
| There should be clear protocols in place for data collection and information sharing between organisations. | Y | |
| Hospital emergency departments should have protocols for handling sexual violence and staff training. | ? | We do not know. |
| Forensic examiners should be female, unless the service user specifies otherwise. Services should build skills of forensic examiners in evidence collection, documentation, including writing medico-legal reports. | N | Forensic examiner is not always female. |

## Standards for the police: Case Location Murska Sobota (Location 2)

| | Respected? Y/N | Comment |
|---|---|---|
| Provision of free legal advice or legal aid for all stages of legal proceedings | Y | |
| Police personnel should be trained on all aspects of DV. | Y/N | They are some good local initiatives, but trainings are not always adequate. Inadequate training leads to skills gaps. |
| DV offences should be treated at least as seriously as other violent offences. | Y | |
| Victims should be seen as soon as possible by a specially trained officer | N | There are no specially trained officers. |
| There should be at least one specialized officer per police unit, for DV and for sexual violence | N | |
| Specialist Police units should be created in densely populated areas | N | |
| Police should actively encourage reporting of violence: through provision of information to the community on police commitment to effective response to DV ; by ensuring police can be contacted 24 hours a day, 365 days a year; by working with other service providers and the community to ensure the first door is the right door for reporting incidents of violence, regardless of whether those reports are made (directly to police, to health service providers, to social service providers or to court officials) | Y/N | Very good local practise in Murska Sobota, but not so good several km away in Lendava |
| Police should have powers to enter private property, arrest and remove a perpetrator. Protection orders should be available from the police to tackle all forms of DV. Protection orders should be mandatory where there is a risk to life, health or freedom of a victim. Removal orders should be available to remove a perpetrator from the home, even when the perpetrator is the legal owner | Y | |
| Police should ensure that victims receive adequate and timely information on available support services and legal measures in a language they understand | Y | |
| Police agencies should co-ordinate with, and refer to, specialist support services for DV's victims | Y | |
| Police should permit and enable advocates or other support persons to attend during police interviews and court proceedings – subject to the request or consent of the victim | Y | |
| Police record systems should enable identification of cases of DV, and permit monitoring of interventions, repeat victimization and case outcomes | Y | |
| Police should have protocols on information sharing on DV with other agencies | Y/N | Regulated with protocols, but not always respected |
| Police should make efforts to limit the number of people a victim must deal with, and to minimize the number of times a victim has to relay her story, and thereby reduce secondary victimization | N | |
| Police should ensure that all reported incidents of violence against women are documented, whether or not they are a crime, and that all information obtained, and reports made are kept confidential | Y | |
| Police should ensure that immediate action is instituted when a victim reports an incident of violence against her/him | Y | |
| Police should proceed to a risk assessment supported by timely gathering of intelligence. This intelligence should be gathered from multiple sources and seek victim perspective on potential threat | Y | |
| Police should develop and implement strategies to eliminate or reduce victim risks | Y/N | For now, only the restraining order |
| Police should ensure that police personnel meeting a victim is non-judgmental, empathetic and supportive, proceeds in a manner that considers and prevents secondary victimization and responds to the victim concerns but is not intrusive. The victim should have the opportunity to tell her/his story, be listened to, and have her/his story accurately recorded | Y | |