Building Safety for Battered Women and their Children into the Child Protection System

A Summary of Three Consultations

Praxis International
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INTRODUCTION

Praxis International, along with local multi-agency teams, conducts audits or assessments of institutional interventions involving violence against women. In 2001-02, we worked with three communities who were particularly interested in understanding how the intervention of child protection agencies in the lives of battered women served to strengthen or weaken women's capacity to protect their children. Each of these communities are currently exploring new interventions on behalf of battered women and their children, all of whom are harmed by violence from the women's partners.[1] Each of these community collaboratives was interested in exploring some aspect of the state's intervention in these cases. Each community asked Praxis to help them think through the possibility of using the Safety and Accountability Audit as a planning tool to analyze and change current practices.[1] This report is a composite of the reports filed by Praxis following a brief consultation with each site.[2]

Praxis helped to conduct a small audit in Minnesota on behalf of Minnesota Program Development, Inc. (MPDI) to fulfill the requirements of a grant it received from the McKnight Foundation. The objective of this grant was to form a multi-agency

[1] The safety and accountability audit refers to the process developed by Ellen Pence, Ph.D., in Duluth, Minnesota. The audit is a systematic observation and analysis of the work routines and documents produced and used between and among institutions as these process "cases" of domestic abuse. For a detailed outline of this method, see Pence, E., & Lizdas, K. (1998). The Duluth Safety and Accountability Audit: A Guide to Assessing Institutional Responses to Domestic Violence. MPDI.

[2] The three projects are: (1) The McKnight Project: Developing a Minnesota Strategic Plan to Protect Battered Women and Their Children Who are Harmed by Domestic Violence (October 2000); (2) St. Louis County Missouri Greenbook Initiative (2002); and (3) El Paso County Colorado Greenbook Initiative (2002). The individual reports on these sites may be obtained from Praxis International, Inc.

collaborative to better understand how institutional interventions in domestic violence related cases could unintentionally be injurious to battered women as mothers and inadequate in protecting children from the harmful effects of abuse. The project was coordinated by MPDI in partnership with four Duluth-based programs.[3] Praxis organized a two-day meeting in which twenty-two participants, including local CPS and domestic violence workers, state and national domestic violence and CPS experts, and several academics in the field of violence against women, analyzed CPS, police, and protection order files involving three battered women who temporarily lost their children to foster care because of their partners' violence, and one who lost custody of her children to the abuser. Canadian sociologist Dorothy Smith, who is considered by many to be North America's leading expert on the study of institutional processes, and Ellen Pence, Director of Praxis, co-facilitated the meeting.

The report written from that meeting provides the basis of this report. However, within months of that project's completion, Praxis was asked to facilitate exploratory meetings with two Greenbook sites, one in El Paso County, Colorado, and the other in St. Louis County, Missouri.[4] Like the Duluth collaborative, these communities were seeking ways to uncover how case processing procedures of CPS and related agencies were producing many of the problematic outcomes in cases involving battered women whose children were also victims of abuse. We asked the Board Chair of Praxis, Shamita Das Dasgupta, to rewrite the Duluth report, incorporating many of the findings from our short but insightful time with these two Greenbook sites.

[3] The four programs were: the Women's Shelter, Child Protection Services, First Witness Child Abuse Resource Center, and the Batterer's Intervention Project.
[4] See Attachment A for a description of the Greenbook sites.

THE PROCESS

The process of our consultations was to help each community use existing multi-disciplinary teams of practitioners and domestic violence advocates to restructure their working relations in order to act as a cohesive exploratory body. To conduct a full audit we would have to map the steps of institutional intervention that we wanted to examine, observe cases being processed through each of these steps, interview practitioners individually and in focus groups, and read both domestic violence and child protection case files. Because of our limited resources, we contracted the process in Minnesota to a group review of four case laws. In Colorado we examined three files and in Missouri we conducted a series of focus groups and interviews.[5]

We began in Minnesota by organizing and redacting four full files for group analysis. The case files were not meant to be representative samples of child protection cases with histories of battering.[6] Furthermore, they were not necessarily representative of the demographics of cases in the three locations of our consultations. In fact, the files were simply drawn from recent cases which workers or advocates recognized as having both child neglect or abuse claims and domestic abuse claims. The files did, however, demonstrate laws, typical policies, and fairly standard child protection procedures, as well as conceptual practices in action. As such, they represented general case

[5] In St. Louis County, Missouri, we were looking at how the courts used batterers groups to hold batterers accountable to their children for the harm caused by the abuse of their mothers. There we held five focus groups; one of judges, one of batterer intervention program representatives, one of advocates, one of men in batterer educational groups and one of battered women with open CPS files.

[6] See Attachment B for a list of analysts involved in reviewing the three studies.

management practices that coordinate activities in the child protection field; e.g., parenting assessment forms, case notation practices, the application of structured decision-making tools, the use of psychological testing, the formulation of service plans, the documentation of the county's reasonable efforts toward reunification.

As we began our work, we were aware of the pioneering work of projects in Massachusetts, Michigan, Minnesota and elsewhere.[7] These projects informed our efforts and guided us to look for certain practices that might prove helpful or problematic for families. To date, reform efforts have understandably emphasized the need to place experts on domestic violence within the child protection system, form collaborations in the practice of intervention, and intensify training of child protection workers to enhance their knowledge and attentiveness to aspects of domestic violence in a case. Today the projects we have worked with and those who pioneered this work are beginning to identify key structural limitations to effective intervention by workers within the CPS system. [8]

CONCEPTUAL FOUNDATION

In the Minnesota project our central premise was: *Even if every child protection worker in the state were completely knowledgeable about the power dynamics that characterize battering relationships, and even if every worker were fully aware of and sensitive to the social conditions which limit battered women's options when being abused, there would*

[7] Findlater, J.E. & Kelly, S. (1999)
[8] Edleson, J.L. & Beeman, S.B. (1999)

be limited change in how these cases are currently handled. ***The problem lies less in what goes on in the heads of workers than in how workers are institutionally required, directed, guided, resourced, and organized to think about and act in these cases.***

Although our work indicated a number of structural problems in the approach taken by the child protection system, none of the structural or conceptual processes that we found harmful to battered women or their children originated exclusively in local policy or procedures. All, however, were played out in local courtrooms and child protection agencies.

This report consolidates the findings of all three projects and explicates a number of key structural processes that, we believe, need to be altered to create effective state intervention. In addition, it details a strategy for Minnesota to correct the problems of inadequate state intervention on behalf of children whose mothers are being battered.

STRUCTURAL PROBLEMS INTEGRAL TO ADMINISTRATIVE AND CONCEPTUAL PRACTICES OF CPS WORK

Workers in any institution are organized – through institutional standardizing tools such as guidelines, screening and intake forms, risk assessment forms, parenting assessment forms, etc. – to treat similar cases in the same way. We scrutinized the ways in which these standardizing tools were operative in the cases we analyzed and found that none of the tools were designed with domestic abuse cases in mind, nor were they designed to

account for the cultural, class, and ethnic differences of people whose experiences are routinely processed through them. We also found that these tools served as ideological capsules in which the experiences of children and their abused mothers were encased, with the result that alternative interventions were prevented from being considered at any stage of case processing. For example, it was routine for CPS workers to order parenting assessment evaluations of a woman who lived with a man who battered her and either physically abused the children or harmed them by exposing them to the trauma of seeing their mother beaten. Once these evaluations were operative, the case proceeded as a parenting problem situation. We wondered what if, instead of using a parenting evaluation, the evaluator was charged with determining all the ways in which the offender had established control over the children and their mother. This would frame the intervention very differently.

We realized that workers' actions on a case are only partially determined by their attitudes and knowledge about domestic abuse. Subsequently, we assumed that most adequately trained workers would take steps similar to those taken by the workers in all cases. We began by mapping each step of the CPS intervention process and any other legal process active during the CPS case (e.g., criminal assault cases, divorces, protection orders). At each step of case processing, from the initial intake to case closure, we searched for the institutional processes that acted as determinants of a worker's actions. We were looking not for actions characteristic of a specific worker, but for actions linked to institutional directives, courses of action, and processes. To uncover these institutional determinants, we asked questions using the case files or case examples as a guide.

When we refer to people in the following questions we do not mean to conceptualize a universal battered woman, abuser, or child. Instead, we want to recognize that each of us experiences our world through our race, class, ethnic, religious, and physical experiences. We asked variations of the questions below about every processing step or interchange between the system and the battered woman, her abuser, or her children:

1. How does the institution coordinate and organize workers to think and act on these cases in relation to the social position of the people whose lives are being managed? (Social position includes class, race, ethnicity, immigrant status, marital status, etc.)
2. What intervention goal or institutional mandate is driving the process at this step of the case?
3. What underlying assumptions are present in this institutional action regarding responsibilities for causing and stopping harm to children?
4. Is there a lack of resources, funding or services constraining the worker's options?
5. How does the worker's job description allow or restrict an adequate response?
6. What are the legal or institutional obligations of the worker towards children, mothers, and fathers?
7. How does the agency's exposure to lawsuits negatively or positively influence the worker's actions?
8. What are the laws, rules, or regulations that restrict a worker's use of discretion to act, or direct the worker to act in a certain way?

9. Corresponding to question eight above, how do these laws, rules, and procedures take into account conditions that make women and/or children vulnerable to domestic violence?
10. How does the use of a standardizing tool (e.g., a parenting assessment form, risk assessment tool, service plan format) work as an ideological tool in the case process? (Does it direct the worker to think about or conceptualize the case or their work in a specific way?)
11. How does the work of previous practitioners affect the ability of this worker to act?
12. How does the work that will likely be done by subsequent interveners affect the worker's actions?
13. How do the administrative procedures enacted at each step of case processing, from the initial screening to the final disposition, take into consideration the power dynamics characteristic of domestic abuse cases? How do they ignore or obscure those dynamics, and with what impact? How do they influence all the dynamics involved? (Children with mother, father, interveners; mother with children, partner, interveners, and so forth.)
14. How do the laws, rules, and policies governing each step of case processing take into consideration the power dynamics characterizing domestic abuse cases? How do they ignore or obscure those dynamics, and with what impact? How do they influence them?
15. Assuming that the texts used in these processes are doing something—screening, prioritizing, highlighting, categorizing, etc. – how is the action of a text such as a form or report promoting the safety of women and children and strengthening the

relationships of mothers with their children? How are any of these texts problematic in this regard? Do the texts participate in the process of obscuring issues of class, culture, gender, and ethnicity?

16. How does the design of standardizing tools such as parenting assessment forms, risk assessment tools, structured decision-making instruments (see # 10), allow the worker to take up the particularities of women and children's experiences in this case? Is there a homogenizing process that precludes this?
17. How does the intervening agency's orientation to professional discourse, theories, and concepts operate in this processing interchange?
18. How does the orientation of the worker's specific discipline to professional discourse, theories, and concepts operate in this processing interchange?
19. Is there any evidence that a worker's personal orientation to professional discourse, theories, and concepts are operative in this interchange? If so, with what impact?
20. Where is the worker obligated to use categories (e.g., offending parent, failure to protect, cooperative, reasonable efforts, etc.) in order to think about or act in this case? Would the institutional category used be a "best fit" from the perspective of the battered woman? Is there a disjuncture between the manner in which a woman would explain her situation and the way in which the worker would categorize the case? What contributes to that disjuncture? Is this mismatch relevant to the safety of the children and of the battered woman?
21. Is there a way for a child's experience to be adequately known and then taken up in case processing? (Can we tell specifically how the child is being harmed, with what impact; how the child is or is not being helped, with what impact?)

22. In what ways is this worker linked to others in the system? How is the strength or weakness of these links playing a role in the case processing (i.e., in criminal, juvenile, and family courts, advocacy groups, community-based service providers, and the general public)?
23. If we were to imagine that there is a real time (the time experienced by the people whose lives are being processed as a case) and an institutional time (the time it takes to move the case from one point of case processing to the next and the time it takes to complete a given task or meet deadlines prescribed by rules or regulations), does the gap cause problems from the standpoint of maintaining the safety and well being of women and/or children? What are those problems?
24. In what ways is the worker organized to assume that there is a universal battered woman, mother, parent, father, child, abuser, victim, and so forth? What are the consequences of this type of organization of information? [9]

We had not constructed the questions *a priori*, but, rather, started with a notion of how to direct our information gathering efforts. We used the graphic in Figure 1 to orient our inquiry, which helped us to focus continually on how workers are institutionally organized to think about and act on a case. Given this orientation, we were able to avoid analyses that locate problems in the individual attitudes or personal beliefs of workers.

[9] These questions came from an accumulation of questions over several years of auditing, but first appeared in this form in the report we prepared for El Paso County, Colorado.

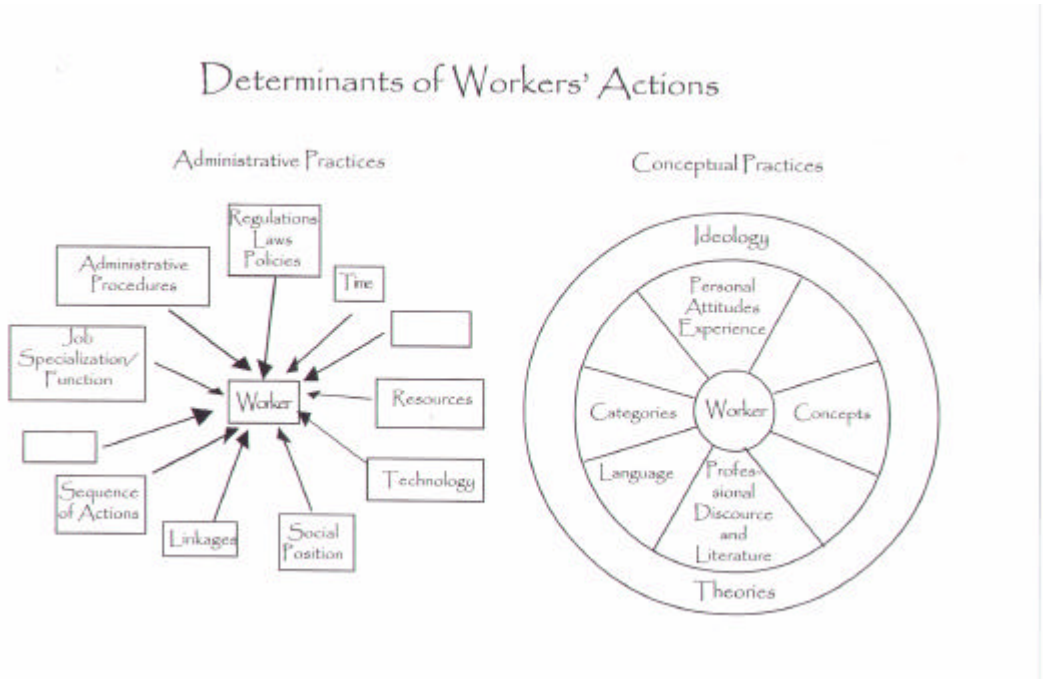

Figure 1

The analysts began with the case-planning phase of the processing and attempted to identify the structural problems that prevented effective intervention in these cases such as:

- An inability to intervene effectively with male abusers in the family;
- Poor linkages between the workers, the direct service providers and the court;
- Plans crafted with limited knowledge of the totality of circumstances;
- Documentary and assessment practices rooted in problematic theorizing about causes of the violence and the responsibilities of various parties to act in specific ways to protect the children;
- Unrealistic expectations of women to control the violence of their batterers;
- A lack of time and resources for child protection workers to intervene in these cases; and

- The promotion of generic parenting, family counseling, or personal counseling programs by community agencies in cases where domestic violence is a significant force in the relationship, without the recognition that the power dynamics between the couple are linked to the use of intimidation, coercion, and violence.

Each case or case file we examined helped us understand new aspects of the system and the way in which it operated in the lives of battered women as mothers. We spent our time examining the service plan process, the use of psychological reports, the documentation process, the use of parenting assessment forms, the limits of tools available to workers in these cases, the use of community-based services and the lack of quality control over them, the disjuncture between what women ask for and what the worker can provide, and the conceptual practices inherent in the different processes. The process we were using ultimately built connections among scholars, CPS administrators and workers, domestic violence experts, and child advocates.

THE CRUX OF THE PROBLEM

The primary issue in the majority of cases we chose to review was the presence of a father, stepfather, or boyfriend, who uses intimidation, coercion, and violence against his intimate partner. As a result, the mother was compromised in her ability to provide a safe and nurturing environment for her children. The harm that the men caused their partners and children, as well as their lack of motivation to change, was the core of the problem.[10]

[10] Of course we realized that these cases did not involve more complicated situations for CPS such as cases where the mother is being battered but is also sexually or physically abusive toward her children.

Because none of the men in the cases we reviewed were actively working to stop their violence or abuse, the CPS workers leaned more and more on the women whom the men were abusing to control the violence. The more the worker looked to the woman to control the man's violence, the more absent the man became from the file and the case. Although he was central to the case, he disappeared from sight and any real intervention plan. It was as if he were not on the CPS' radar screen.

Consequently, the mothers were left with almost full responsibility to undo the harm to their children, not because the workers were victim blamers, but because they were not institutionally organized to directly intervene with male offenders. The worker's role was to police the mother. Thus, the relationship between the mother and the worker quickly became hostile, adversarial, or punitive, negating any chance of building an effective alliance to protect the children.

The following hypothetical statements express the disjuncture between the domestic violence advocacy and the child protection communities. We might imagine an uncensored advocate making the first statement, a CPS worker making the second.

1. *"Child protection workers blame mothers for not protecting their children even when mothers are not being abusive or using physical or sexual violence against their children. Because they are unable to stop their batterer from harming the kids, mothers are punished by the system, with the primary punishment being the threat or reality of having the children removed from the home. This plays right into the hands of violent abusers, who routinely threaten women by saying, 'I'll call child protection on you and you'll lose your kids.'"*

2. *"Domestic violence advocates want to think that if women are okay, children will be okay. And in a way we agree. When we step in, we often realize that the man is not going to turn things around for the children. And so our best bet for protecting*

children is to help the woman get her act together, get help, get him out of the home, and reach a way of living independently from him with her children in a safe and nurturing environment. So, yes, we concentrate on the mother, because our only other option, and the safest option, is to place the kids."

The case files indicate how the overarching problem comes about from an accumulation of concrete practices:

1. Files are opened under the mother's name and the investigation proceeds as a scrutiny of how the mother did or did not protect her children from the abusive or violent behavior of the father/adult male. Over 80% of the contacts by social workers in the cases we examined were with the women, each of whom was battered by her partner. The worker had to make a determination as to whether the mother could take responsibility for providing a safe and nurturing environment for her children. If not – and even when only the father was putting the children at risk – the worker had to act on the children's behalf by assuming custody. One worker equated this process to intervention with alcoholics. "If a parent is a severe alcoholic, the worker will look to the non-alcoholic parent to determine if the children can be left in the home and cared for properly. If the non-alcoholic parent is unable to care for the children, then they will be placed in foster care." However, we found that there was no meaningful intervention with any of the men in these cases or any effective challenge to their use of violence. Both the way the workers are organized to think about their role with the offending parent and the lack of tools to intervene directly with him seem to be at the root of this and many other problems we uncovered.
2. Even though assessments had been conducted, workers reported that often there was little information in the files to indicate the presence of domestic violence in the

homes. Tools such as guidelines, screening and intake forms, the use of categories (definitions), case service plans, and assessments were generally not designed to identify and account for domestic violence. Consequently, there was little emphasis placed on aspects related to violence in the homes and yet, decisions regarding children's well being were based on these reports. The absence of this information also led to case planning that was inadequate to meet the needs of the victims and hold the perpetrator to minimum standards of accountability.

3. Simply teaching workers to recognize and document the presence of domestic violence was not useful because that recognition simply translated into her failure to take protective action toward her children by ending the relationship with the abuser. The assumption here is that ending a living arrangement with a batterer ends the children's exposure to the violence and that it is the mother's responsibility, not the state's, to take such a hostile action against the offender\batterer.
4. There was no discernable relationship between the worker and any of the children in the cases we analyzed. As one analyst noted, "We are child protection workers but we do almost no real social work with children." While the children's safety was the purpose of state intervention, there was very little specific assessment and few services provided to children. The files had next to nothing about the children for whom the actions were being undertaken. It was impossible to put together a clear picture of details such as: a) how much violence the children were exposed to; b) how much violence or sexual abuse they had actually experienced; c) how any of these children were being affected by the violence they were living with; d) what specific

help they received from services that were provided; and e) if those services made a difference for them.

a. Some analysts favored a position that the intervention should be on behalf of both the mother and the children through an order for protection filed by the CPS worker. By using the protection order in this way, the state can remove the offending party (whether the biological parent of the children or not), monitor that party's compliance with court exclusion orders, and incarcerate those who fail to obey the orders. Yet, no county had oriented its intervention in this direction. Instead, counties have used the power to remove children from their homes as a club to obtain cooperation from one or both parents. Because the threat of removal of children from home is typically a more effective weapon against mothers, it is used disproportionately against them. There is no mechanism built into the child protection case processing system for a child protection worker to directly intervene with male batterers.

b. The above argument evokes fears that such a paradigm shift would lead to the state's intervening with adult women on the same basis as it does with children, giving women no autonomy or decision-making authority – an undesirable outcome, to say the least. However, the discussion about shifting the intervention focus to the abuser needs to occur because the current notion of "I'm here ONLY for the children" was ineffective and its negative impacts on the parent-child (specifically, mother-child) relationship has to be taken seriously.

5. While most of the analysts agreed that we need a paradigm shift that holds the predominant aggressor in the family responsible, we also all recognized that for most

children, their fate was the same as that of their mothers. We know that simply shifting all our attention on keeping abusers out of the house or "fixing them" won't be enough. If a mother is unable to "get on her feet," then it is inevitable that the children will either be continually exposed to abuse or have to come under the protection of CPS. Undoubtedly, women are being held overly responsible for the violence of their male partners. Nonetheless, some analysts took the position that women who are not actively engaged in harming their children should not be required to participate in any services offered. This was not a majority position, but one that was passionately argued. The majority were concerned that intervention with men must occur in a way that, most likely, would result in their stopping their violence. If necessary, the abuser should leave the home. Interventions with battered women who are not violent toward their children should be designed to meet their specific needs. Women should not be labeled as a harmful parent because of their use of these services or their inability to stop their batterer's violence.

6. The conceptual orientation of CPS tends to utilize psychological discourse to analyze problems. Thus, poverty and issues related to economics, housing, gender dynamics, racial oppression, and various other factors that create many of the conditions of violence are not addressed in assessment processes or as part of a plan to assist families. In the cases we examined, the CPS workers' analyses almost always located the problems within the individual and the solutions offered overwhelmingly required counseling. CPS as an organization is structured to view violence against women in the home as the result of women who make poor choices, couples having difficulty managing stress or conflict, or abusers being unable or unwilling to handle their anger

in non-aggressive ways. These constructs all call for counseling and leave the deeper social causes of violence in families and against women unexamined. In the cases we reviewed, the child protection progress reports showed a correlation between the mothers' continuing therapy and the worker's assessment that she was "cooperating with CPS" and showing improvement. Yet, there was no link between this measurement of progress and a mother's claim that she was actually being helped nor documentation that her attendance changed the conditions in which her children were living.

7. No comprehensive domestic violence assessment tools were used at any point of case-processing that could inform CPS workers, service providers, and decision makers about the level of violence experienced the by women in these cases. In Minnesota, the development of the Family Risk Assessment of Abuse/Neglect form could inadvertently lead interveners even further away from understanding how dangerous a specific case might be, and therefore, what kind of intervention is called for.[11] This risk assessment process and others like it are not based on the specifics of a family's situation, nor will they uncover those specifics. In addition, there is no method built into case documentation practices that would help generate a true domestic abuse assessment process. However, even if such an assessment tool were developed and incorporated into the existing structure, given CPS' current orientation toward psychological explanations of problems and its requirement that the mother protect the children from her abuser, it would not serve the interests of battered women and their children.

[11] See Attachment C for the assessment form and instructions to CPS workers on how to use it.

The disjuncture between the generic tools of assessment used in child protection cases and the realities of relationship dynamics present in these families was apparent. For example, in some cases, psychological reports were ordered on one or more family members and in other cases, the women were court-ordered to individual psychotherapy with progress reports written by therapists. In general, the psychologists who conducted interviews and tests made either weak or no connections between test and observation results and the violence being used by the father or adult male in the home. Testing battered women in the midst of being abused and threatened with the removal of their children is likely to produce the profile of a dysfunctional adult – even of women who are coping remarkably well in their difficult situations. Without underscoring the connections between the test results and the violence, we are left with a series of "professional evaluations" that obscure more than they explicate. Below are some observations and questions regarding the use of psychological evaluations:

a. When conducting their evaluations, none of the psychologists involved in the cases seem to have a comprehensive picture of the violence.
b. One CPS worker remarked, "Psychological reports have become a routine measure used by the courts, guardians *ad litem*, and in custody cases, by the attorney to bolster his client's case. They are occasionally ordered because someone is showing signs of mental illness or disturbance, but that's the exception, not the rule."

c. Another worker noted, “As a worker I have rarely found them [evaluations] helpful except to use when I want to remove children. They help make a case for removal, but at the same time, they are so unfair in that regard.”

d. A third CPS worker told us, “In many ways we are not considered, as workers, capable of rendering a ‘professional opinion’ to the court even when we are much more knowledgeable about the cases than the psychologists paid to test and report to the court. They are expensive and not very helpful, but judges want them, especially if the court is likely to place children or limit a parent’s visitation rights.”

e. Every aspect regarding the use of psychological evaluations must be reconsidered. Is there any added value to their usage? When should these be ordered and for what purpose? Do these evaluations produce credible and appropriate information for the court, the intervening worker, or others to better protect children? What guidelines should be followed in ordering, conducting, and interpreting these evaluations when there is a history of violence involved in the case? What should be the relationship between a thorough domestic violence assessment and a psychological evaluation? Could these evaluations be culturally biased against battered women? What are the annual costs of these evaluations to the county and does their ubiquitous use create an unwarranted drain on limited intervention resources?

8. The parenting assessment tools often used by CPS not only framed the issue as a parenting problem, as noted earlier, but seemed irrelevant to the kinds of issues about parenting that were being raised in domestic violence cases. Notions of “normal”

parenting that underlie these forms were not only unhelpful in explicating the strengths and weaknesses of each parent, but in fact, served to obscure the harm that was being done to the children. For example, in one case, a local family service agency was contracted to conduct a "Parent Skills Evaluation."[12] To conduct the evaluation, the evaluator observed each parent separately, interacting with the children. Each was scored on a scale ranging from 1 to 5 in categories listed on the form. Surprisingly, even though the narrative in the file clearly demonstrated that the parenting skills of the mother and father could not be compared, their evaluation scores were almost identical, making it appear that their skills were equivalent. It should be noted that this evaluation was conducted at a time when the mother's social worker was repeatedly scolding her for leaving the children alone with the father. The social worker seemed to believe that the father was not fit to be even a babysitter for the children, let alone a parent. In addition, we noted that there was no method built into the process to allow the social worker to challenge an evaluation made by an independent agency, even though it seemed inconsistent with the worker's knowledge of the case.

9. Parenting assessment evaluation tools are used in many cases because the system is set up to intervene in families when a child is being treated abusively by one parent, or by both. The forms used to conduct this assessment are meant to build a picture of the way in which that abusive behavior is linked to the notions of parenting skills built into the form. Such assessments are frequently conducted in the artificial environment of a social worker's office, during a two-hour observation of the parent interacting with the children. In cases where there is ongoing abuse of the mother,

[12] See Attachment D for example of the form.

even a highly skilled worker cannot use the parenting assessment form and provide a credible report to the court.

We found no connections in these parenting assessments to the kinds of problems the women faced as mothers. For example, we conducted an extensive interview with a woman who had recently used a parenting group. Lillian lived with her partner, Calvin, for five years and had three children with him.[13] She married him when her youngest child was just a few months old. Calvin began to physically abuse her after they were married. The abuse was severe but infrequent. The most recent assault was seven months prior to the interview. Calvin had hit her several times in the face and broken her cheekbone. His blows had literally punched her eye out of its socket. She required three reconstructive surgeries. Her twelve-year-old son Samuel was angry with her because she would not let his father come back home. Samuel was becoming increasingly belligerent with her and at school. Lillian was often angry with Samuel for not understanding how afraid she is of Calvin. But Samuel wanted his father home. Lillian was hurt that Samuel "wants to watch football with his father, knowing what he did to me and would probably do again." The kind of problems Lillian as a mother faced was not addressed in the parenting assessment form. Her needs would not be met in a generic parenting class, which is what she had been offered by social services. She stated that she saw no indication that her caseworker had any specific knowledge of what was going on with each of her children in relation to her. Her social worker and she had never had a discussion about each child. The intervention, as she put it, just kept focusing on "Am I going to keep him out of the house?"

[13] All names have been changed to protect the individual's confidentiality.

a. If a worker observes Calvin with his children, he [Calvin] will probably score high on the parenting form; perhaps as high, if not higher than Lillian, whom he is battering. These evaluations are used by a number of practitioners as they act on the case, including custody evaluators, CPS workers determining if children should remain in the home, and guardians ad litem in advocating for the children's interests related to visitation. The impact of Calvin's violence on his children was neither measured nor considered in the parenting form.

b. The assessment form provides a conceptual framework that the worker is expected to use in the workload of cases s/he carries. One CPS worker noted,

> *What if the form was different, as some people here are suggesting? Then I would be looking for how the father's presence in a room influences everyone's interactions. I might be looking for how he has explained his violence to his children, how his behavior is undermining his partner's relationship with the children. That kind of assessment doesn't exist. But if it did and that is what I was required to use, it would definitely get me thinking very differently about the case and about what I am observing.*

It becomes clear that not only the tool has to change but also the process. If we want to know how a person's violence is affecting a family, we need to ask the children, the mother, other close relatives, family friends, teachers, etc. One supervisor of CPS workers said of the current assessment process:

> *Unfortunately, the very things we're learning characterize a battering father's relationship to his children – such as his manipulation of the child's relationship with the mother, or his undermining of that relationship, or instilling fear in the children of what will happen to them if he leaves, or instilling fear in the woman that if she leaves she will lose the children – are not in any way picked up by these assessment tools. Yet, they are the very essence of the parenting problem in cases of domestic violence.*

The assessment tools used in the CPS system need to be analyzed with this critique in mind. Each tool provided by the institution orients workers' thinking

and organizes the information they gather. Unfortunately, these tools are not typically designed with domestic abuse cases in mind. Lillian's case file, like other files we reviewed, failed to produce any specific intervention that helped undo the harm the violence had caused to Lillian’s relationship with each of her children. Nor did it lead to a concrete plan for Calvin with which he might address the damage his violence had caused and continued to cause.

c. We discovered that a number of parenting problems identified by those in the domestic violence work were noticeably present in the families; yet, none of the parenting assessment forms or reports addressed these. Following are examples of these problems:

   i. By their behavior, abusers exposed the children to role models who demonstrated hostile attitudes and aggression toward the children’s mother as a woman.

   ii. By their behavior, abusers exposed the children to role models who exhibited a belief that they carried little or no responsibility to correct problems within the home, especially those caused by their own violence.

   iii. Abusers exhibited a wide range of manipulative behaviors and frequently drew the children into these processes.

   iv. Women adjusted their parenting styles in response to the abuse and became more restrictive in order to protect the children from the abuser’s harsh treatment.

v. None of the abusers helped the children receive counseling or therapy services. Yet, when children failed to attend therapy sessions, it was only documented in reference to the mother, but never the father.

vi. While the quality of a child's relationship to the nonabusive parent is considered to be the greatest predictor of his/her recovery from harm (Furstenberg & Cherlin, 1991), none of the workers documented any efforts by abusers to make an effort to strengthen that relationship, nor did they show how abusers might be undermining those relationships. No mention of this behavior was made in any parenting assessment.

vii. Although these parenting problems are common in fathers who batter (Bancroft and Silverman, 2002), none were addressed in any assessment, conversation, or case plan directives. We assume that many of the services to which children, men, and women are being referred are also failing to address issues elaborated above.

10. We grappled with the problem of framing these cases within a parenting discourse. One of the flaws in parenting discourse is that it artificially separates the mother's victimization from the children's. We contend that both are simultaneous victims of the same abuse. We posed a problem statement in our discussion:

> *The CPS worker is organized to think of the case (i.e., the exposure of children to domestic violence) as a problem of poor parenting shared equally by the man and woman. Yet, there is always a primary caregiver (in these cases, it is almost always the mother) and a predominant aggressor in the relationship (almost always the father/adult male). Because there is no institutional way to acknowledge that there is a predominant aggressor, the scrutiny falls on the primary caregiver, who supposedly fails to protect the child from witnessing the abuse by the predominant aggressor.*

The fact that the person who is being abused is also the primary caretaker seems to be of little consequence in these cases. Yet in every case we discussed, the two are linked: the primary caretaker is the woman and she is being battered; the abuser is male and he is not the subject of the investigation. The assessment of the primary caretaker is done as if the violence she is experiencing is not relevant to her actions. We repeatedly found case notes regarding a woman's abuse to be framed as a *poor choice* on her part to be involved or in contact with or living with her assailant. In addition, parenting issues are framed in a way that completely obscures the grave realities of these families.

11. Domestic violence advocates and CPS workers seem to suffer from weak connections with one another. The rifts between the two groups were apparent in our discussions at all three sites.

    a. We discussed the need to rethink how each intervening agent defines his or her job. One analyst used a metaphor to describe this issue.

        > *It's a bit like coming across a shipwreck in a stormy sea. Women and children are clinging to chunks of wood, shivering in the cold water, weak and barely able to hang on. Then come the rescue workers; one saying, "I'm here for the children" and another, "I rescue women, and if the kids just hang on to her real tight, they'll be OK too."*

        The fact that the women and children are drowning in the same storm somehow escapes the rescuers whose mandate is to rescue women OR children!

    b. This became a problem of greater magnitude when women themselves were abusive to their children. For example, in one of the cases we reviewed, the battered mother had physically disciplined two of her teenaged children. The discipline did not meet the CPS definition of abuse, but the shelter had a rule of

zero tolerance for violence and stopped providing services to her. She lost her victim status by slapping and grabbing her children. She returned home to her abuser with her children. In our discussions, CPS workers expressed a significant degree of frustration with shelter workers' no-gray-area attitude. Women were not simply victims or offenders; nor were they clearly either protective or non-protective. It seemed to CPS workers that shelter workers were unhelpful in working on the cases in which women crossed the boundaries between victim and aggressor.

12. When a battered woman is successful at obtaining a protection order and "keeping him out," there is a general assumption that this is a successful outcome. In the cases we reviewed, the men either continued to harass the women once they left the home or moved into new families with children without the monitoring of offenders. Without the monitoring of offenders, CPS is not protecting children from abusive parents but protecting certain children in certain circumstances. As one analyst commented:

    "It's sort of like telling a shoplifter he can't go into Target anymore because that's where he shoplifted. But he can go into Kmart or Shopko. We're just switching which kids get exposed to him."

13. We discussed the use of protection orders, filed by CPS workers, and requirements that CPS workers monitor offenders' compliance to these orders. (This would be instead of monitoring non-offending mother's compliance with children's safety plans and her own service plans.) Two major obstacles emerged: the prosecutors and the judges. None of the CPS workers participating in our discussions felt that they could count on the courts to consistently enforce a restraining order on an offending

party. Because of this uncertainty, the CPS workers felt safer removing the children from their homes. Most also said that the county attorney, who is in effect a major policy maker, would not use a dual approach of using juvenile and criminal courts on these cases. One CPS worker remarked:

> *If I thought that I could file a protection order and count on the police to arrest him [abuser] when I found him there, count on my county attorney to back me up, and count on the court to put him in jail when he violates, then I'd do it. But I'm almost sure that's not what will happen. In most of these cases it's not the presence of the man at any given time but the fact that he is living there everyday and everyone is exposed to his explosiveness.*

Indeed, it was safer to coerce the woman to take steps to keep the abuser out, and if she did not comply, to remove the children, than it was to rely on the players in the system to coordinate their interventions with the offender. Thus, children were removed not so much because their mothers were failing to protect them from violent fathers or step-fathers but because workers anticipated that, if left to the state to act, it would fail to arrest, convict and jail the abuser.

14. Workers are trained to document events of institutional significance that may happen in case processing. The framework for documentation results in very particular ways of seeking information, observing, recording, and making sense of it all. After reading the summaries of the cases (one spanned fifteen years and involved twenty-one files being opened) and then reading all of the workers' case notes, we found a number of disturbing documentary practices.

Caseworkers are trained to document with an eye toward providing a rationale for removing children, should that become necessary. In all cases we reviewed, it was obvious that the social worker viewed only the mother as a possible ally in the effort

to ensure ongoing protection of the children. Consequently, the mother seemed to be under constant scrutiny. This gave rise to a rather punitive environment in which the worker policed the mother.

We saw dozens of notations about parenting "flaws" of the mother, but no equivalent documentation of the work these mothers were doing to hold their fragile families together. There was no documentation of how abusers, landlords, creditors, or others were creating specific harmful conditions in which these mothers were parenting their children. Below are some influencing factors contributing to such documentation practices:

a. Workers had no time to do a thorough investigation, but needed to make a decision quickly about whether to place the child in protective custody. In interviews with workers we found that the initial decision to open a case and to place a child in protective custody was based on very brief interviews – often just 10 or 15 minutes with the child, the mother and sometimes the father\stepfather. Several workers assigned to the case long term said that what they knew about the history of domestic violence came from the documentation of that initial interview. Because of this constraint, the documentation often produced incomplete or misleading assessments of danger and in several cases produced a naive approach to the violence.
b. There was no balance in the worker's expectations of the mothers and fathers (or male adults in the home) to provide for the children's safety. Thus, most of the documentation on failure to protect was focused on the mother (designated the

primary caregiver), not on controlling the father or adult male whose behavior was typically the primary source of risk to children. Often these reports were harsh criticisms of the mother's judgment regarding the father's behavior; e.g., the mother's decision to run errands, leaving the children in the care of their father who then fell asleep, was perceived as bad judgment on the mother's part.

In one case, a family services department petitioned to remove the children from the home because the children had witnessed their mother's partner abusing her on five documented occasions. The petition noted, "Jill Evans has exposed her children to on-going domestic violence in the home and has continued her relationship with the perpetrator of the abuse. Ms. Evans had admitted that she has been involved in this relationship for the past ten years." This petition further states, "On July 7, the social worker received information that Ms. Evans would not file an order for protection against Dwayne because this 'would make him more angry.' " There is no indication in the file that the worker tried to find out what Ms. Evans thought would happen if she filed for a protection order, despite the fact that we know violence can significantly escalate in severity when a woman leaves her abuser. Ms. Evans obviously thought filing for a protection order would actually make matters worse, but her reluctance was translated in her file as her being "uncooperative." Later, when she did file a protection order to prevent the removal of her children, her partner sexually attacked her, seriously injuring her – just as she had anticipated two months earlier. These kinds of policing encounters come to characterize the relationship of the worker to the

mother and thwart the possibility of the two forming a collaborative relationship to protect the children.

c. At the same time, case workers did not attempt to encourage the men in these families to share the load of household and childcare work, despite what appeared to be huge imbalances in the workload.

15. This policing role consumes the worker, leaving little or no time to do what one CPS worker called “any real social work.” In our analysis of files, we made notes of each time a woman asked for concrete help and the response to those requests. We found that, in most cases, the worker was not able to provide what the mothers requested.
16. Equally troubling was our inability to find any evidence that the services offered to women and their children actually met their specific needs. The generic set of services offered to women, men, and children seemed geared to meet the system’s need to document reasonable service delivery efforts. It was difficult to see that they were actually aimed at fulfilling the client’s specific needs. Moreover, the outsourcing of services to private non-profits or medical facilities has created a web of community-based services that the counties have no effective way of monitoring for quality or, in domestic violence related cases, appropriateness. Not only has this led to social workers having less intimate knowledge of the cases, but also to uncertainty about the exact nature of services that clients received. Yet, CPS workers were compelled to verify that the county did, in fact, make reasonable efforts to assist families in reuniting in cases where the children had been removed, and that the parents had been given opportunities to change before removal was recommended. One analyst commented, “Most counties have a list of vendors that workers can use

to help families. Workers can decide not to refer to places from which they individually get poor feedback, but there's no real way to ensure that these vendors are set up to provide the specific help their client needs. I doubt that anyone ever actually goes and observes what goes on in these services."

17. In one of the communities, we focused our attention on the intervention with male batterers as parents. A number of the men we interviewed stated that parenting issues were missing in their court ordered batterer groups. Most said they would like to have the opportunity to spend more group time on their relationship with their children. The batterer rehabilitation programs had a significantly underdeveloped notion of working with the men as fathers, even though the majority of the men in their groups were fathers or living with women with children. The CPS workers also had little knowledge and training about the issue of batterers' intervention services. Furthermore, we found that when criminal and civil courts ordered abusers into these programs, the courts frequently did not enforce their participation, even though it was mandatory.
18. In Minnesota, the initial treatment of risk was based on statistical analysis rather than on what actually was happening in a given family. With high liability risks for intervening agencies, there was a reliance on risk assessments and structured decision-making tools to identify high-, moderate-, and low-risk cases. However, statistical probabilities seemed to replace lived experiences. Although it may not work for families, consistent application of the same set of standards shields an intervening agency from vulnerability to a lawsuit. For example, in one case, there was a twelve-year-old boy, who was the biological son of the father only, sleeping in

the same bedroom as his four-year-old half-sister. They had bunk beds and both used sleeping bags as blankets. Because of the number and ages of the other children in the household and the number of bedrooms, there were few alternatives to this arrangement. There were records that the twelve-year-old boy had been sexually abused as an infant. Because of this, the worker told the mother that he was a high risk to his sister's safety, and required that the children sleep separately. An "error in judgment" was documented on the (step) mother's safety plan, but not on the (biological) father's. It appears that the worker had no details about the nature of the previous abuse that occurred ten years earlier in a different county. With no place to provide separate rooms for the boy and his sister, the parents decided to send him back to his biological mother. It appears that no attempt was made by the worker to determine if such a move was in fact safe for the twelve-year-old.

In discussing Minnesota's structured decision making process, a CPS worker commented, "It's sort of like statistically it exists, therefore it does exist. We don't have the time or information to see if it is really happening here, but to minimize risk, we will assume it probably is occurring, or at least it could easily occur." And so in Minnesota the statistical information that children living in homes with four or more children are more likely to be abused than children in families with fewer children required the worker to automatically give additional risk points to large families. Once a case reached a certain level of risk, the workers were compelled to open a case file. An over-reliance on statistical probability without the proper assessments presents a number of problems related to class, race, and gender fairness. It is

appropriate that a full examination of all these case-processing steps would show a myriad of ways in which biases are institutionally structured into workers' case processing routines.[14]

19. With the exception of El Paso County in Colorado, in the locales where we reviewed cases there were no financial resources available to the social worker or the mother to offset the high transportation, housing, and child care costs created by the violence and the intervention. For example, in one of the social worker's notes, the mother had asked the social worker if she could look into some free daycare services for her. The worker noted that she had done so, but there was none available. There was nothing more in the file about this need, except frequent requests by the mother for help or complaints about stress, migraines and exhaustion. El Paso County workers and advocates reported positive results when resources were funneled to families for such needs.

    In another case, the family home was declared unfit for children with reports of high lead levels, missing windows, plumbing problems, and roach infestations. In the file was a letter from a social worker from Family and Children Services, but no letter from the CPS worker assigned to the case. This letter states that the mother contacted five different agencies to help fix her house, and Family and Children Services was trying to help her secure funding for assistance. The social worker assigned to her case stated in her notes that the family was given 60 days to fix the home. AmeriCorps volunteers helped to clean the dwelling, but lead removal was beyond their capacity. The worker told the mother that she must "fix the problem before the

[14] See Attachment C for Minnesota Family Risk Assessment of Abuse/Neglect form.

children can live in the house or suffer the consequences." The worker, like the mother, was most likely stumped about how to solve the problem. So, she simply reverted to her policing role.

In both of these cases the eventual cost to the county for temporarily removing children was very high compared to the rather limited requests these women made for assistance.

20. Even when only one parent or adult was using violence, the social worker was expected to maintain official neutrality toward both parents. Several women asked for help in protection order hearings and related attempts to obtain help. As one worker observed,

    "I can't appear to be siding with one parent, so I couldn't really go with a woman when she gets a protection order."

    The inability of social workers to advocate for battered women begs further discussion. By failing to structure such a role for the worker, opportunities for advocating for the child's safety are repeatedly lost.

    a. In one case, the five-year-old daughter had complained to the mother that her dad touched her "privates" during one of their visits. The First Witness program conducted a videotaped police interview in which the officer conducting the interview and the First Witness program staff concluded that there was a high probability that the girl had been sexually abused.[15] The mother was "advised" by the worker to file a protection order. She did so immediately. However, during the

[15] The First Witness Program is a non-profit organization which provides abused children a safe and respectful environment to tell their story and trains investigators in techniques to conduct interviews with children.

civil court hearing, no representative from Family Services, the police, or First Witness appeared on behalf of the mother or her daughter. Consequently, no one knowledgeable in interpreting these interviews was present in the courtroom. The judge denied an order for protection for the mother and her daughter after learning that the mother was involved in a custody case with her ex-husband and stated his suspicion that the child was saying these things to please her mother. The judge's memorandum states,

> *Children who are involved in divorce of their parents are placed in a troublesome situation, one in which the need, conscious or unconscious, to please each of the parents becomes very strong. In this case, the almost immediate statement of allegations against the respondent by the child. . . suggests that she knew, whether coached or not, what she needed to say to please her mother. . .*[16]

When we interviewed practitioners involved in this case they noted that most of the professionals working on the case disagreed with the judge's ruling, but they were neither present at the hearing nor institutionally organized to advocate for a child by calling for a review of the case.

b. In a second case a woman had called and asked her social worker if she could accompany her to court for an order for protection hearing and bring some CPS records. The worker responded that she could not go because it is not related to child protection. Three days later, when the woman inquired once again, the worker documented that she had already told this woman, "Since Russ [the abusive partner] is my client as well, it is not ethical to choose sides for court." We observed a confused notion of what it means to be neutral in every case – workers under the mistaken notion that the manner in which they were acting was

[16] See Attachment E for the judge's full memorandum.

neutral, when in fact it really was not. Additionally, these workers were not clear on whether neutrality was actually appropriate in order to promote the children's well being.

Despite the long tradition of social workers acting as advocates for their clients' needs, there was almost no such advocacy conducted in the cases we analyzed. We noted a number of requests that women made to their workers that were deemed inappropriate, pursued in superficial ways, or not responded to at all. We also noted the number of ways in which the workers could have acted as an advocate for the women, often even more effectively than a domestic violence worker.

21. Even when they are convinced the child faces continued harm, the hierarchy of opinions and actions in the system precludes workers from pursuing a course of protective action on behalf of children. In one of the cases mentioned above, when the judge denied the mother a protection order that she had filed on behalf of her child, neither the social worker nor the officer were able to continue the case – although both believed that the child involved had been sexually abused. We noted that in several instances, the specialized nature of institutional intervention and hierarchical relations within the institution led to a situation in which the issue of a child's safety was subsumed by the institutional hierarchy of rulings.
22. Although there is no universal mother, battered woman, abuser, or child of an abuser, policies and standardizing tools are, by and large, written to fit a generic representation of these roles. Many of the tools used in processing cases (including

the parenting assessment form, the standardized language in the service plans, and the psychological evaluations) organize workers to impose a uniform cultural norm on all of the families they work with. Furthermore, the standard against which these families are being measured is middle-class and European-American.

23. Many of the workers we encountered were operating from conceptual notions and theoretical bases that we, as analysts, found problematic. Following are some examples:

    a. In one case, a progress report from Children and Family Services Counseling Center states, *"This worker [Angelina's therapist] then began to go over the genogram done by Case Worker 1 on Ms. Herrig with the client in a separate session. Ms. Herrig's background indicates the origins of issues with perfectionism and control, which are affecting the couple's relationship and her parenting."* Such theorizing is common in the case files. Often, they are disturbing in their lack of contexts. Many of the conclusions (e.g., "issues with perfectionism") were never backed up by any objective data. The professionals who were doing the categorizing did not seem to be accountable to the individuals they categorized.

    b. Another example in the same progress report makes the following observation about the mother and her partner, *"This couple has the potential to grow into a couple relationship which meets each of their needs, with each functioning in a more positive manner toward the other and the world. Their complimentary styles are actually a good match, with each one needing someone similar to the other to function to their fullest as a couple."* Even though the social worker viewed the

relationship as having "potential" to be successful and to keep the family intact, it was less than six months later that a petition was filed to remove their children from the home. It states, *"Angelina Herrig is unable or unwilling to protect the children from further exposure to domestic violence or the risk of physical harm by Russ Herrig. Ms. Herrig has been ambivalent about whether to divorce or remain separated from Russ Herrig."* Even though it seems that the worker is still trying to "figure out" if Russ could change, when Angelina goes through the process of not being sure, it is seen as an issue of unwillingness to protect her children. At the same time, Angelina repeatedly wanted to discuss her partner's behaviors with the worker but was stopped from doing so. The worker inevitably responded to her attempts to talk about how to deal with her abusive partner by issuing new instructions regarding her responsibilities or the repetition of old instructions.

c. In one case, the child protection worker had spoken with both an advocate at a battered women's shelter and the staff at a hospital crisis nursery. The worker had noted that there were concerns about the number of times the woman had tried to seek shelter. The worker wrote,

> *Tara (the advocate) stated that Rachel hadn't presented the current domestic abuse issue very well, other than to say she felt unsafe at home and was going to a motel. Tara stated that Rachel has enlisted [the shelter] in her "ploy" to engage the system in providing her service when she so desires. The concern they had was that Rachel repeatedly uses the shelter system without trying to make changes in her personal life…Tara stated that Rachel has been seen at the shelter's advocacy office ten times, and that her coming there has not always been for having been abused.*

The fact that Rachel (a mother of nine who was being abused and facing eviction) frequently used emergency services could be viewed positively, as an effort to protect her children. Instead, she was categorized as manipulative, engaging in ploys, and using the system.

d. In Rachel's case, the social worker repeatedly characterized her as "uncooperative" and "difficult." This worker compared notes with the advocates at a local shelter, who also agreed that she was "uncooperative." Rachel is quoted many times in the worker's notes as being angry at CPS' involvement in her life and the fact that it required so much of her. She had refused to give CPS the information they asked of her in a phone interview. She called her social worker a month later and said that she saw no basis for CPS' inquiries and that she had declined to give CPS the information. It appeared that her "uncooperative" behaviors began after her child died of SIDS in foster care, after years of CPS involvement. The CPS worker noted that after a visit to Rachel's home, "I asked Ms. Chapin to show me around the house, telling her it was a necessary part of my assessment. She declined to do this saying, 'Not unless you're a city inspector.' "

Rachel's adversarial stance was not viewed as warranted even though she has a very painful history with CPS. We noted in her file that when her teenage sons Jabar and Tim were removed from her home and placed in foster care, they had a series of "run-ins" with police over a six-month period. This was their first contact with police for "delinquent" behavior. They were returned to Rachel's

home because the foster parents were unable to control them. Even though her situation had not changed, Jabar and Tim's behavior apparently did. The caseworker had noted, "Tim, Jr. and Jabar have not engaged in delinquent behaviors since their return to the home." Again, there were no interviews with the children to bring deeper understanding to this transformation nor any specific credit beyond the above statement given to Rachael's positive influence on her children

e. How the worker balances the issue of foster care for children, versus children remaining in less-than-desirable home situations, was not explicated in these files, in the court transcripts, in agency directives, or in interactions with the family in assessment and evaluation reports. Still, the question of when to remove children is germane to all of the cases. The negative impact of foster care or potential sangers to children were not addressed in any of the field we reviewed.

f. In two cases, Jill's and Angelina's, both women were completely without support in regard to childcare. Both resisted obtaining protection orders against their abusers because they needed help with the children. No provisions were made by the workers or court to allow the women to obtain protection orders while continuing to use the fathers as sources of childcare. The reality of the situation for many women, including Jill and Angelina, is that they must balance their fear of their abusers with their need for help in caring for their children. Jill and Angelina both resisted obtaining protection orders against their abusers because of this need.

Eventually she tried to argue that the solution was for her partner to move out and still be available to provide childcare for their children. At one point, Angelina's worker told her to get a protection order. The file notes that Angelina asked, "Can I just kick him out of the house, because I may still need him to baby-sit?" The worker's response was, "That will not suffice." However, soon after, Russ obtained permission from the court for unsupervised visitation with his children.

Is it not possible for CPS workers to engage in solving these problems with women by either providing assistance with childcare or structuring protection orders in a way that allows a father to be responsible for childcare? One of the major reasons why women in two of these cases continued to see their abusers after a separation was because they needed help with caring for their children. One analyst remarked,

> *It reminds me of when I was a child and bill collectors use to call my mother and start harassing her. I'd hear her say 'I don't have the money but I'll make a partial payment,' then the bill collector would shout and yell and then she'd say, 'OK, I'll put the check in the mail for the full amount tomorrow.' Then everyone would hang up. Of course, she never put the full check in the mail, but it got rid of him. Eventually she just stopped answering the phone and whenever it rang she'd say, "If that's a man, I'm not home."*

There were dozens of similar exchanges in these files: unrealistic demands, followed by resistance, followed by threatening postures, followed by compliance, followed by a retreat from punitive posture, followed by non-cooperation with an agreement that was never really a mutual decision. Again, the lack of communication and mutual problem solving between the workers and the women was striking.

24. CPS workers were not conceptually organized to consider power dynamics and women's vulnerability to continued violence when they act on these cases. For example, when one woman was told to file a protection order against her husband, she responded that this would only make him "more angry." Her response was documented but not fleshed out. What did she think might happen? Would it be dangerous for her to file an order? How? Dangerous to whom? What makes her think so? A few months later, a CPS assessment states, "Jill obtained an OFP against Dwayne." One month later, there was a police call to the home because Dwayne had threatened Jill. The police report was forwarded to CPS and the worker wrote a note to the file, "In this worker's opinion, Jill has not demonstrated that she has an understanding of the risk to her children based on her most recent poor choices and decisions." However, there was no discussion or notation in the file about the potential danger a protection order might pose to a woman in Jill's position.

    The weak connections many workers make between their observations and the violence the woman is experiencing has prompted reformists to want to place domestic violence advocates in child protection offices to engage as case consultants. Our team of analysts began to generate a list of "understandings" about domestic abuse cases that ought to be incorporated into the ideological framework of CPS work. These "understandings" would inevitably replace the existing ideological framework.[17]

[17] See Attachments I and J, articles by Ellen Pence and Coral McDonnell on philosophical frameworks and building safety of women and children into policy and procedure.

CONCLUSION

The approach that we used to analyze these case files and to interview focus groups led to three important accomplishments: first, we discovered a way to move beyond the limited notion of cross training between domestic violence workers and CPS workers as a "primary" solution for poor CPS case outcomes for battered women and their children. We replaced this discussion with a more complex one about rethinking CPS' institutional organization regarding its work to protect children. Second, we identified a significant number of the structural problems that need to be remedied at the local, state and even national levels. And third, we found a process of analysis and policy discussion that allowed us to bypass the rifts between advocates in the domestic violence field and child protection caseworkers and administrators. The deep changes that the problems at hand require us to make leaves no room for the strongest allies of women and children to be at odds. Unfortunately, in our analysis and recommendations, we have not yet been able to avoid the ever-increasing pressure in today's society to frame social problems as failures of individuals to act responsibly.

As our recommendations show, we propose a shift from holding battered women accountable for their abuser's violence to the abuser himself. Because we are still enmeshed in analysis and solutions that are overly dependent on locating problems in the individual parent, we are recommending that this process be recreated at a much larger and more comprehensive scale, at either the state or national level. Such an effort would facilitate a process similar to ours involving key state policy makers, state and national

domestic violence experts, scholars, and social workers. In addition, a separate group of battered women should be organized and consulted in the process.

Each of the sites produced a report with recommendations specific to where they are in the reform process and to the questions they asked. Key points from their recommendations are found in attachments (1) (2) and (3). It is important to keep in mind that these three consultations were small, time limited and preliminary efforts. We circulate this summary report only to wave a flag of inquiry and to suggest a process that may move our collective work ahead. We end this report with the conclusion of the Minnesota report.

In the 1970's, state legislatures in every state began passing legislation to reframe ways in which the criminal and civil justice system would intervene in domestic abuse-related cases. That effort has continued for almost thirty years. It has involved changing or creating legislation in a number of key areas, including legislation which: a) expands police powers of arrest in domestic assault cases; b) creates a civil protection order laws giving victims a means to petition the court for immediate relief; c) increases prosecutors' latitude in introducing evidence; d) enhances penalties for repeat offenses; e) requires law enforcement agencies to create policies guiding officers on the use of arrest and setting standards for police documentation of cases; and e) controls the access to weapons of those convicted of domestic abuse.

During this time, millions of dollars of federal, state, private, municipal, county, and city funds have been allocated to create emergency housing and advocacy services for victims of abuse.

Every step of the criminal court system's handling of these calls, from the 911 call to the police investigation to the booking and detention proceeding through the final disposition

of the case, has been altered. New forms, assessment tools, guidelines, and protocols made every step of case-processing more attentive to the safety needs of the victim. New methods to enhance the possibility of conviction, rehabilitation, and, if necessary, incarceration have been built into the infrastructure of case processing. Training programs, a philosophical paradigm shift, and new conceptual practices characterize these reform efforts.

Today we have a new structure in which to intervene in criminal cases of domestic violence. We are still struggling with the legacy of centuries of acceptance of this violence. We are battling the backlash and what many call the unintended consequences of legal interventions, but we are not at a loss for what to do.

This cannot be said of the efforts to change the way we intervene on behalf of children when there is domestic violence. Most of the recommendations and efforts have remained at the level of staff training, increased awareness and better coordination between domestic violence advocates and CPS workers. While efforts to promote new protocols and policies are being undertaken in a number of counties, few of these efforts have resulted in a commitment to build substantive changes into the infrastructure of the state and county child protection system. As a state we have given CPS workers and the families they work with minimal new resources, limited tools to directly intervene with offenders, no agreed-upon conceptual shift, and no models for forging a comprehensive criminal, civil, and juvenile court intervention in these cases. As one analyst stated, "We have a bucket full of tools but we just keeping jumping in with the same old worn-out jigsaw." Many have found fault with what CPS is producing in the way of case outcomes, but as a state which has been a leader in criminal law reform efforts and as a country we have failed to put together a comprehensive plan and process to accomplish what no local community can or will.

To do this would require a commitment by state policy makers, the legislature, and the funding community to provide the resources to create a strategic plan that in its making garnered adequate support, credibility, and knowledge to successfully carry it out. Our

recent history in this country to transform the criminal and civil courts intervention in these cases demonstrates our capacity to envision and change a major institutional response to those who batter. Our children and their mothers deserve no less.

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Attachment A

In 1998 The National Council of Juvenile and Family Court Judges produced the report *Effective Intervention in Domestic Violence & Child Maltreatment Cases: Guidelines for Policy and Practice.* It was first published with a green cover, and has since come to be known as the Greenbook. Today that report is widely circulated in the domestic violence and child protection fields. It represents the first attempt by a national collaborative of experts to articulate what is wrong with the current responses to these cases and what principles should guide reform efforts. In brief, the report recommends that four principles guide collaboratives which are seeking to enhance intervention in these cases. They are: 1) The intervention should seek three outcomes: safety, enhancing well-being, and providing stability for families and children; 2) Efforts should keep children affected by maltreatment and domestic violence in the care of the non-offending parent whenever possible; 3) A system of services should be developed with a number of crucial characteristics. Characteristics to be considered should include: services being available as soon as problems are identified; service providers being trained to respond meaningfully to safety issues; providers collaborating; ensuring that the services provided are culturally appropriate; and adequate resources being dedicated to these families; 4) And finally, that child protection services, domestic violence services, and community based welfare services should design a differential response to a diverse range of families.

Since that report was published, the federal government has funded six communities to incorporate one or more of the dozens of concrete recommendations on how to achieve these objectives. These have come to be known as the Greenbook sites.

Attachment B

List of Facilitators:

Dorothy Smith, University of Toronto – Ontario and University of Victoria – B.C.

Dorothy Smith, Ph.D., is an Adjunct Professor of Sociology at the Ontario Institute for Studies in Education, and Professor Emeritus at the University of Toronto. She is an internationally renowned scholar whose work focuses on the application of a feminist perspective to sociology and institutional ethnography. She has written several books, including *The Everyday World as Problematic: A Feminist Sociology*, for which she received a John Porter award and *Texts, Facts and Feminity: Exploring the Relations of Ruling*. Dorothy Smith is the leading sociologist in North America in the field of institutional ethnography.

Lonna Davis, Family Violence Prevention Fund

Lonna Davis, MSW, is the Director of Technical Assistance for the Family Violence Prevention Fund's (FVPF) Children's Program. The FVPF is a national non-profit that focuses on domestic violence education, prevention and public policy reform. In this capacity Ms. Davis is responsible for providing and brokering technical assistance to states and communities who are interested in collaboration strategies between child welfare organizations and domestic violence programs. Prior to joining the FVPF, Ms. Davis was the co-founder and clinical manager of the Massachusetts Department of Social Services, Domestic Violence Unit (DVU) where she was employed for ten years. The Massachusetts DVU was the first public child protection setting to hire advocates for battered women to work directly on child abuse and neglect cases. The DVU has received numerous awards and citations for its pioneering work in the field of domestic violence and child abuse

Ellen Pence, Praxis International

Ellen Pence, Ph.D., is the co-founder of the Duluth Domestic Abuse Intervention Project (DAIP). She is the author of DAIP's educational curriculum *In Our Best Interest: A Process of Personal and Social Change* and co-author of *Power & Control: Tactics of Men Who Batter* with Michael Paymar of the National Training Project. Both are based on the work of Paulo Freire. She is currently the Director of Praxis International. Praxis International is a nonprofit corporation, which works towards the elimination of violence in the lives of women and their children.

<u>via videoconference:</u>

Susan Schechter, University of Iowa

Susan Schechter is the co-author of the Greenbook. She is a Clinical Professor at the University of Iowa in the Social Work Department. She has been the Lead Author, Consultant, and Co-Investigator on many domestic violence related projects, and is on the Editorial Board of the *Journal of Interpersonal Violence*.

List of Participants:

Media Wright, Violence Implementation	National Council of Juvenile & Family Court Judges, Family Department, Information Specialist for the Greenbook Project
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Sandra Davidson,	MN Coalition
Sharonna Lee,	BWJP (Battered Women's Justice Project)
Stephanie Avalon,	BWJP (Battered Women's Justice Project)
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Mark Nelson,	St. Louis County Social Services
Dick Pingry,	St. Louis County Social Services
Mary Ness,	SafeHaven (formerly Women's Coalition)
Mona Peterson,	SafeHaven (formerly Women's Coalition)
Earaka Holiday,	SafeHaven (formerly Women's Coalition)
Scott Miller,	DAIP (Domestic Abuse Intervention Project)
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Tina Olson,	Mending the Sacred Hoop Technical Assistance
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Julie Tilley,	Praxis International
Casey McGee,	Praxis International
Janice Wick,	Praxis International
Maren Hansen,	Praxis International
Anne Marshall,	Praxis International

Attachment C

MINNESOTA FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT

SSIS Case Name/#:_____Date Report Received:_____
SSIS Workgroup Name/#:_____Tool Date: _____
County Name/#:_____Tool Status:_____
Worker:_____Finalized Date:_____

RISK ASSESSMENT - NEGLECT

N1. Current report is for neglect	
No	0
Yes	1
N2. Number of prior assigned reports	
None	0
One	1
Two or more	2
N3. Number of children in the home	
Two or fewer	0
Three or more	1
N4.Number of adults in home at time of report	
Two or more	0
One or none	1
N5. Age of primary caregiver	
30 or older	0
29 or younger	1
N6. Characteristics of primary caregiver	
Not applicable	0
Lacks parenting skills	
Lacks self-esteem	1
Apathetic or hopeless	1
Lacks parent skills & esteem	2
Lacks esteem & apathetic	2
Lacks skills, esteem & apathetic	3
N7. Primary caregiver involved in harmful relationships	
No	0
Yes, but not a victim of domestic violence	1
Yes, as a victim of domestic violence	2
N8. Primary caregiver has a current substance abuse problem	
No	0
Alcohol only	1
Other drug(s) (with or without alcohol)	3
N9. Household is experiencing severe financial difficulty	
No	0
Yes	1
N10. Primary caregiver's motivation to improve parenting skills	
Motivated and realistic	0
Unmotivated	1
Motivated but unrealistic	2
N11. Caregiver(s) response to assessment	
Viewed situation seriously & cooperated satisfactorily	0
Viewed situation less seriously than investigator	1
Failed to cooperate satisfactorily	2
Viewed less seriously & non-cooperation	3

Total Score:

MINNESOTA FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT

RISK ASSESSMENT ABUSE

Al. Current report is for abuse	
No	0
Yes	1
A2. Prior assigned abuse reports	
None	0
Abuse report(s)	1
Sexual abuse report(s)	2
Abuse & sex abuse report(s)	3
A3. Prior CPS service history	
No	0
Yes	
A4. Number of children in the home	
One	0
Two or more	1
A5. Caregiver(s) abused as child(ren)	
No	0
Yes	1
A6. Secondary caregiver has a current substance abuse problem	
No, or no secondary caregiver	0
Alcohol abuse problem	1
Drug abuse problem	1
Alcohol and drug abuse problem	1
A7. Primary/secondary caregiver: excessive/inappropriate discipline	
No	0
Yes	2
A8 Caregiver(s) has a history of domestic violence	
No	0
Yes	1
A9. Caregiver(s) is a domineering parent	
No	
0	
Yes	1
Al0. Child in home has developmental disability/history of delinquency	
No	0
Developmental disability/emotionally impaired	1
History of delinquency	
Disability and delinquency	1
A11. Secondary caregiver motivated to improve parenting skills	
Yes, or no secondary caregiver in home	0
No	2
A12. Primary caregiver views incident less seriously than agency	
No	0
Yes	1
Total Score:	

SCORED RISK LEVEL

Assign-the family's risk level based on the highest score on either scale, using the following chart:

Neglect Score	Abuse Score	Risk Level
0-4	0-2	Low
5- 7	3- 5	Moderate
8-12	6-9	High
13-20	10-16	Intensive

RISK ASSESSMENT - OVERRIDE

Override

- o None
- o Sex abuse cases where perpetrator likely to have access to child
- o Cases with non-accidental physical injury to an infant
- o Serious non-accidental injury requiring hosp/medical treatment
- o Death (previous or current) of sibling as result of abuse/neglect
- o Discretionary override (one level)

Discretionary override reason

Override Risk Level:

- o Low
- o Moderate
- o High
- o Intensive

Override risk level approval status:
Override review/approval by:
Date:_____

MINNESOTA FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT
DEFINITIONS

Only one household should be assessed on a risk assessment form.

The primary caregiver is the adult (typically the parent) living in the household who assumes the most responsibility for child care. When two adult caregivers are present and the worker is in doubt about which one assumes the most child care responsibility, the adult legally responsible for the children involved in the incident should be selected. If this rule does not resolve the question, the legally responsible adult who was perpetrator should be selected. **Only *one* primary caregiver can be identified.**

The secondary caregiver is defined as an adult living in the household who has routine responsibility for child care, but less responsibility than the primary caregiver.

NEGLECT SCALE

N1. **Current Report is for Neglect** - "Yes" if the current report is for neglect or both abuse and neglect. This includes any problem under assessment even if not identified in the original report. "No" if the current report is not for neglect.

N2. **Number of Prior Assigned Reports** - Count all maltreatment reports, determined or not, which were assigned for CPS assessment for any type of abuse or neglect prior to the report resulting in the current assessment.

N3. **Number of Children in the Home** - Number of individuals under 18 years of age *residing* in the home at the time of the current report. If a child is removed as a result of the assessment or is on runaway status, count the child as residing in the home.

N4. **Number of Adults in Home at Time of Report** - Number of individuals 18 years of age or older *residing* in home at time of current report.

N5. **Age of Primary Caregiver** - Age at the time of assessment.

N6. **Characteristics of Primary Caregiver - Check appropriate box and *add the indicated scores*** for each primary caregiver characteristic: **a) Not applicable**: **b) Lacks parenting skills** - inability or unwillingness to care for/supervise children, uses excessive physical/verbal punishment, lacks knowledge of child development and age-appropriate expectations for children, poor knowledge of age-appropriate disciplinary methods: **c) Lacks self-esteem** - lacks confidence, is withdrawn, doubts abilities, self-disparagement; **d) Apathetic or hopeless** - appears overwhelmed, is indifferent, recent substantial decline in hygiene, energy level and/or physical appearance not related to a medical problem.

N7. **Primary Caregiver Involved in Harmful Relationships - a) No**; **b) Yes, but not a victim of domestic violence** - adult relationships outside the home such as criminal

activities which are harmful to domestic functioning or child care, or harmful adult relationships inside the home not at the level of domestic violence; **c) Yes, as victim of domestic violence** - a relationship characterized by domestic disturbances or conflicts that require intervention by police, family, or others, often involving physical violence by one or both caregivers. See also A8 definition. -

N8. **Primary Caregiver has a Current Substance Abuse Problem** - The primary caregiver has a *current* alcohol/drug abuse problem, evidenced by use causing conflict in home, extreme behavior/attitudes, financial difficulties, frequent illness, job absenteeism, job changes or unemployment, or driving under the influence, traffic violations, criminal arrests disappearance of household items (especially those easily sold), or life organized around substance use. **a) No problems**; **b) Alcohol only** - alcohol abuse but no problem with other drugs, **c) Other drug(s) (with or without alcohol)** - abusing drugs other than alcohol such as cocaine, marijuana, heroin, barbiturate, prescription. The caregiver may be poly-addicted and may also abuse alcohol.

N9. **Household is Experiencing Severe Financial Difficulty** - "Yes" if caregiver(s) cannot consistently pay for one or more basic household necessities (rent, heat, light, food, clothing). Household is not living within its means due to caregiver actions. "No" if caregiver(s) consistently pays for basic household necessities.

N10. **Primary Caregiver's Motivation to Improve Parenting Skills** - Based on worker judgment made by observing primary caregiver response to a tentative service plan or other offers of agency assistance made during the assessment. **a) Motivated and** realistic - no need to improve parenting skills, or there is a need and the primary caregiver is willing and able to work with the agency within established time frames; **b) Unmotivated** - able, but has not demonstrated a willingness to address parenting skills issues within established time frames; **c) Motivated but unrealistic** - willing to make agreed upon changes but the primary caregiver's physical, intellectual, or mental ability precludes making the changes within established time frames.

N11. **Caregiver(s) Response to Assessment** - Based on the caregiver who is least cooperative or is least in agreement with the investigator. If two caregivers are present in a household, each should be assessed separately. **a) Viewed situation as seriously as investigator and cooperated satisfactorily** - a single caregiver or both regard the situation as seriously as the investigator and are cooperative as evidenced by involvement in services planning for self/children, making safety plans for the child(ren), etc.; **b) Viewed situation less seriously than investigator** - *either* caregiver views the determined incident less seriously than the investigator or minimizes the level of harm to the child(ren); **c) Failed to cooperate satisfactorily** - *either* caregiver refuses involvement in the assessment and/or refuses access **to** the child(ren) during the assessment, etc.; **d) Both b and c** - *either* caregiver views the situation less seriously than the investigator *and* did not cooperate during the assessment.

Al. **Current Report is for Abuse** - "Yes" if the current report is for abuse or both abuse and neglect. This includes any problem under assessment even if not identified in the original report. "No" if current report is not for abuse.

A2. **Prior Assigned Abuse Reports** - Include all reports, determined or not, assigned for CPS assessment for any type of abuse prior to the current assessment: a) no prior *abuse* reports investigated; b) a prior investigated report of any type of abuse *except* sexual abuse: c) a prior investigated sexual abuse report; d) prior investigated reports of *both* sexual abuse and other types of abuse.

A3. **Prior CPS Service History** - "Yes" if a family has received CPS or foster care services as a result of a prior determined report of abuse and/or neglect or whether a case was receiving CPS or foster care services at the time of the current determination. "No" if the family' has not received CPS or foster care services as a result of a prior determined report of abuse and/or neglect.

A4. **Number of Children in the Home** - The number of individuals under 18 years of age *residing* in the home at the time of the current report, including those removed as a result of the assessment or on runaway status.

A5. **Caregiver(s) Abused as Child(ren)** - "Yes" if credible statements were provided by the caregiver(s) or others on whether *either or both* caregivers were abused as children. Abuse includes physical, sexual, and any other type of abuse. "No" if neither caregiver was abused as a child, based on credible statements by the caregiver(s) or others.

A6. **Secondary Caregiver has a Current Substance Abuse Problem** - "Yes" if secondary caregiver has a current alcohol/drug abuse problem as evidenced by use causing conflict in home, extreme behavior/attitudes, financial difficulties, frequent illness, job absenteeism, job changes or unemployment, or driving under the influence, traffic violations, criminal arrests, disappearance of household items (especially those easily sold) or life organized around substance use (if yes, check appropriate boxes). "No" if the secondary caregiver has neither an alcohol nor drug abuse problem, or if there is no secondary caregiver in the home.

A7. **Primary *or* Secondary Caregiver Employs Excessive and/or Inappropriate Discipline** -"Yes" if either caregiver employs excessive and/or inappropriate disciplinary practices, particularly methods employed to punish children in the home. The circumstances of the current incident and past practices may be considered. One standard is whether caregiver disciplinary practices caused or threatened harm to a child because they were excessively harsh physically or emotionally and/or inappropriate given the child's age or development. "No" if neither caregiver employs excessive and/or inappropriate disciplinary practices.

A8. **Caregiver(s) has a History of Domestic Violence** - "Yes" if *either* caregiver has a history of domestic violence defined as adult mistreatment of one another, evidenced by

hitting, slapping, yelling, berating, verbal/physical abuse, arguments (may involve, or be blamed on, children), physical fighting (with or without injury), continuing threats, ultimata, intimidation, frequent separation/reconciliation, involvement of law enforcement and/or domestic violence programs, restraining orders, or criminal reports. "No" if neither caregiver has a history of domestic violence.

A9. Caregiver(s) is a Domineering Parent - "Yes" if *either* caregiver is domineering over child(ren), evidenced by rude remarks/behavior, controlling, abusive, unreasonable and/or excessive rules, overly restrictive, overreacts, unfair, or berating. "No" if neither caregiver is a domineering parent.

Al0. Child in the Home has a Developmental Disability or a History of Delinquency - Score 1 if either or both exist. **a) No - no history of either; b) Yes - Developmental Disability** if there is evidence that a child has a special need including mental retardation, attention deficit disorder, learning disability, or is emotionally impaired. **History of Delinquency** if any child has been referred to juvenile court for delinquent or status offense behavior. Status offenses not brought to court attention but which create stress within the household should also be scored here, such as children who run away from home, are habitually truant from school, or have drug or alcohol problems (if yes, check appropriate boxes).

A11. Secondary Caregiver Motivated to Improve Parenting Skills - Based on worker judgment made by observing secondary caregiver response to a tentative service plan and/or other offers of agency assistance made during the assessment. **a) Yes, or no secondary caregiver in home** - no need to improve parenting skills or there is no secondary caregiver. If there is a need, the secondary caregiver is willing and able to work with the agency to improve parenting skills; **b) No** - the secondary caregiver needs to improve parenting skills but is not motivated and/or able to work with the agency.

A12. Primary Caregiver Views Incident Less Seriously than Agency - a) No - the primary caregiver views the determined incident as seriously or more seriously than the agency; **b) Yes -**the primary caregiver views the incident less seriously than the agency by refusing to be involved in service planning for self/children, refusing services, and/or minimizing the level of abuse sustained by child.

MINNESOTA FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT
POLICY AND PROCEDURES

Risk assessment identifies families which have intensive, high, moderate or low probabilities of continuing to abuse or neglect their children. By completing the risk assessment the worker obtains an objective appraisal of the likelihood that a family will maltreat their children in the next 18 to 24 months. The difference between the risk levels is substantial. High risk families have significantly higher rates than low risk families of subsequent reports and determinations and are more often involved in serious abuse or neglect incidents.

The risk scales are based on research on cases with determined abuse or neglect that examined the relationships between family characteristics and the outcomes of subsequent abuse and neglect. The scales do not predict recurrence, simply that a family is more or less likely to have another incident without intervention by the agency. One important result of the research is that a single instrument should not be used to assess the risk of both abuse and neglect. Different family dynamics are present in abuse and neglect situations. Hence, separate scales are used to assess the future probability of abuse or neglect.

Which cases: All CPS maltreatment reports assigned for an assessment that involve a family caregiver. This does not apply to institutional abuse cases.

Who completes: Social worker assigned to complete the assessment.

When: The risk assessment is to be completed prior to the time the decision regarding the disposition of the assessment is made. It is one of the elements considered in making the decision regarding this disposition.

A risk assessment is conducted when a new CPS incident occurs in an ongoing case.

Decision: The risk assessment identifies the level of risk of future maltreatment and guides the decision to close a report or open a case for ongoing services.

Low risk cases will be closed. Moderate risk cases should be considered for closure.

For open cases, the risk level guides minimum contact standards.

Appropriate completion:

Only **one** household can be assessed on the risk assessment form. In some cases (for example, joint custody cases), it may be difficult to identify the household in which the children reside. The household which provides the majority of the child care should be selected. If that fails, choose the household where the CA/N incident took place. Some

items are very objective (such as prior CAIN history or the age of the caregiver). Others require the worker to use discretionary judgment based on his or her assessment of the family.

Identifying the Primary and Secondary Caregivers

Some items refer to the primary or secondary caregiver of the children involved in the incident. First, identify the primary caregiver. The primary caregiver is simply the **adult** (typically the mother) **living in the household** who assumes the most responsibility for child care the majority of the time. When two adult caregivers are present *and* the worker is in doubt about which one assumes the most child care responsibility, the adult legally responsible for the children involved in the incident should be selected. If this rule does not resolve the question, the legally responsible adult who was a perpetrator should be selected. The secondary caregiver is defined as an **adult living in the household who** has routine responsibility for child care, but less responsibility than the primary caregiver.

Each scale (abuse and neglect) is completed regardless of the type of allegation(s) reported or assessed. All items on the risk assessment scales are completed. *The assigned social worker must make every effort throughout the assessment to obtain the information needed to answer each assessment question.* However, if information cannot be obtained to answer a specific item, score the item as "0."

Following scoring all items in each scale, the assigned social worker totals the score for each scale and determines the risk level by checking the appropriate boxes in the risk level section. **The highest score from either scale determines the risk level.**

Policy Overrides

Policy overrides reflect incident seriousness and child vulnerability concerns and have been determined by the agency to be case situations that warrant the highest level of service from the agency regardless of the risk scale score. If any policy override reasons exist, the risk level is increased to intensive.

After completing the risk scales, the assigned social worker indicates if any policy override reasons exist. If more than one reason exists indicate the *primary* override reason. Only one reason can be selected. All overrides must be approved in writing by the supervisor.

Discretionary Overrides

The assigned social worker also indicates if there are any discretionary override reasons. A discretionary override is used to increase the risk level by one increment in any case where the assigned social worker feels the risk level set by the scales is too low. All overrides must be approved in writing by the supervisor.

Attachment D

Family Services Center
Parent Skills Evaluation
Conducted by Independent Counseling Agency

PERSONAL GROWTH		
1) Regular attendance		
a) attends scheduled meetings		
b) keeps appointments		
2) Shows willingness to change behaviors by:		
a) accepting suggestions from the staff		
b) integrating behavioral changes into daily living		
c) following case plans		
FAMILY MANAGEMENT		
3) Provides adequate physical care for child/ren including:		
a) appropriate, safe housing		
b) sufficient food		
c) appropriate clothes		
d) medical/dental care		
e) adequate hygiene		
f) management of household finances		
4) Provides secure, stable environment necessary to meet emotional needs of child/ren by:		
a) maintaining control of household		
b) maintaining orderly schedule,		
c) providing for personal needs as well as child's needs		
d) minimizes child's exposure to advlt/parental conflict		
PROTECTION AND SAFETY		
5) Shows ability to make appropriate choices for self and child/ren including:		
a) choosing appropriate living space		
b) choosing appropriate friends/companions		
c) ability to protect child/ren and self from harmful people and/or situations		
6) Provides for child's safety by:		
a) choosing appropriate caretakers.		
b) child-proofing home		
c) supervising children		
SUBSTANCE AND NURTURING		
7) Shows an attachment to child/ren by:		
a) speaking respectfully to and about child/ren		
b) using gentle touch with child/ren		
c) responding appropriately to others praising child/ren		
d) spontaneously talking to child		
a) praising child's qualities and/or behavior		
8) Shows realistic expectations of child/ren according to age and ability by;		
a) providing age appropriate toys and experiences		
b) encouraging developmental progress		
c) encouraging child to explore child's environment		
d) rewarding for positive behavior		
9) Shows appropriate knowledge of parental role by:		
a) initiating play with child		
b) not intruding on child's play without reason		

c) not teasing child		
10) Responds to child's distress by:		
a) attempting to sooth child both verbally and non-ver6ally		
b) maintaining control in response to child's distress		
c) refraining from making negative remarks to child or to observer		
d) showing empathy for child		
e) using alternative ways to discipline child		
DISCIPLINE		
11) Demonstrates range of responses to child's misbehavior		
a) diverting child's attention by playing games, introducing now toys		
b) allowing for appropriate choices		
c) refraining from making negative remarks to child or others about child		
d) refraining from yelling at child		
e) refraining from slapping, hitting or spanking child		
12) Parent's style of Interaction with child /ren shows:		
a) behavior that is not harsh or punitive		
b) behavior that is not overly permissive		
c) willingness to negotiate choices		
d) understanding of difference between discipline and punishment		
13) Uses appropriate methods of behavior management Including:		
a) limit setting		
b) choices		
c) time outs		
d) re-direction		
e) appropriate consequences		
COMMUNICATON		
14) Parent demonstrates the ability to communicate effectively by:		
a) talking to and listening to the child's request for attention		
b) giving appropriate responses to the child's attempts to communicate		
c) praising child's positive behavior		
15) Parent demonstrates ability to:		
a) express their needs and concerns to others		
b) understand information		
c) apply information appropriately		
d) maintain control of emotions during stressful situations		
1) Almost never (0-5%.of time) Parent demonstrates no competence in this area.		
2) Seldom (5-25% of time) Parent is inconsistent. Seems unable to follow through		
3) Sometimes (26-50% of time) Parent is able to be consistent part a the time		
4) Often (51-75% of time) Parent is consistent and puts forth effort		
5) Most of the time (75-98% of time) Parent provides consistent care		

Attachment E

MEMORANDUM

This is a proceeding on a petition for an Order for Protection alleging domestic abuse within the meaning of Minn. Stat. §518B.01 subd. 2. In this case, the only allegations of domestic abuse are those which fit in the definition of 518B.01 subd. 2 (3), specifically criminal sexual conduct within the meaning of §609.342, 609.343, 609.344, or 609.345. The allegations, if true, constitute criminal sexual conduct.

While much of the evidence related to other conduct of both of the parents and presumably addressed the question of the best interests of the child, in this case the only issue before the Court is whether domestic abuse has occurred. Even if the Court were to find domestic abuse, the court in the marriage dissolution proceeding has determined temporary legal and physical custody and no contact between the respondent and the child if an OFP is granted. That court also specifically provided that if an OFP was not granted, that *ex parte* temporary order would be vacated and the temporary custody provided in the earlier order resumed until final disposition of this matter which is set for trial on June 30.

This Court's findings demonstrate the reasoning for being unable to attribute sufficient credibility to the testimony of the child as observed in the videotape of the forensic interview to support petitioner's burden of proof of domestic abuse. By those findings the court does not mean to suggest that the child was necessarily coached before making her statements in the forensic interview or in the interview for the sexual abuse evaluation at the Clinic. Children who are involved in a divorce of their parents are placed in a troublesome situation, one in which the need, conscious or unconscious, to please each of the parents becomes very strong. In this case, the almost immediate statement of the allegations against the respondent by the child at the beginning of each interview without having been asked about that subject matter suggests that she knew, whether coached or not, what she needed to say to please her mother who had brought her to each of the interviews and was waiting for her while she was being interviewed.

The allegations her are most serious. The evidence, however, did not rise to the level that this Court can make a finding of domestic abuse. There being no finding of domestic abuse, the petition must be denied and no further action is necessary by this Court. – Judge

Attachment F

The McKnight Project: Developing a Minnesota Strategic Plan to Protect Battered Women and Their Children Who Are Harmed by Domestic Violence October 2002

Recommendations

Our work has opened the doors of discussion between the Duluth advocates and key administrators at St. Louis County Social Services. But as we discussed earlier, very little of what we found problematic in these case files is a function of local policy. We are therefore recommending that the McKnight Foundation help facilitate a process similar to ours involving key state policy makers, state and national domestic violence experts, scholars, and social workers. In addition, a separate group of battered women should be organized and consulted in the process. Any plan would involve a great deal of discussion, but we feel compelled to present a number of suggestions that came from a brainstorming session on how to move this process to the next level.

1) Call a meeting of key policy makers from the state legislature, the Department of Human Services, the Minnesota Coalition for Battered Women, the Hubert H. Humphrey Institute of Public Affairs, several representatives from our collaborative, and representatives of communities whose children are over-represented in the foster care system to discuss this report and our findings.
2) Replicate this process by
    a) Calling together a statewide think tank with a number of national advisors to expand on this analysis.
    b) Obtaining 40 to 50 case files from ten Minnesota counties.
    c) Hiring consulting academic(s) familiar with the process described here to prepare the files and facilitate the discussion.

d) Developing a five-year strategic plan that addresses the legislative, policy, procedural, training, and conceptual changes that need to be put into place. Below is a preliminary list of what that plan might address.
    i. A paradigm shift in how we recognize responsibility in protecting children from abuse and exposure to domestic violence.
    ii. A legislative agenda that will allow this paradigm shift to occur in the intervention in these cases.
    iii. The development of new assessment and evaluation tools for CPS and related workers.
        1. This process will likely involve the development of a set of guidelines regulating the use of psychological evaluations and ensuring that those that are conducted contextualize the evaluation within an understanding of the role violence plays in family members' profiles.
        2. This will undoubtedly also involve creating a completely different method of evaluating the impact on the children of a parent who is either battering or being battered. Parenting assessment skill evaluations should look markedly different in a reformed system.
        3. Assessment tools must not assume a universal notion of good parenting that serves to engage in cultural impositions that have nothing to do with the protection of children or battered women.
    iv. The development of a case processing plan that maximizes the likelihood that the CPS worker will be able to form an alliance with the non-offending parent in the protection of the children and in that process determine at what level CPS workers can advocate for victims of battering who are on their caseloads.
    v. A determination of how the state should view the role of parents who are being battered in protecting their children from their batterer.

1. Determine the best strategic use of limited resources and strike a balance between the distribution of funds that are made available to mothers, fathers, children, and intervening agencies.
2. Determine how a CPS intervention can use the juvenile, civil, and criminal courts to protect children. Enhance the use of the criminal court as a powerful tool of intervention in these cases.
3. Determine how the resources now going to foster parents could be funneled to parents who are battered and need temporary additional resources help their children deal with the impact of the abuser's violence.
4. Determine how CPS intervention can deal with the totality of circumstances that create the conditions of violence rather than be limited to individual psychological interventions.
5. Develop a quality control process for community-based services offering services to families as part of the reasonable efforts standard.
6. Develop a plan to ensure that social workers have an authentic relationship with the children on their caseload and that children become visible parties in the processing of these cases.

3) Develop a funding strategy employing private, state, and federal dollars to implement this plan.
4) Test new strategies in three sites by securing funding and special legislative permission if necessary before proposing statewide implementation of new strategies.

Attachment G

Report on the Praxis Consultation on the Use of the Safety and Accountability Audit in the El Paso County Greenbook Initiative

Recommendations

COORDINATION OF AUDIT PROCESS: FIRST STEPS

The group suggested that the first task of the new Domestic Violence Specialist should be to provide oversight and coordination to conduct an audit in El Paso County. Praxis proposes a number of steps for the site to further this analysis:

- Select a coordinator (the Domestic Violence Specialist) to facilitate this process e.g. prepare the materials, interview and observe workers, arrange and facilitate meetings and prepare case files;

- Select a team of analysts (a cross section of Greenbook partners) that will provide the analysis and develop new procedural changes based on their findings. In order to keep momentum the team should meet as regularly as possible; and

Schedule a 1½-hour videoconference or audio conference between Praxis and the team to map out a strategy for the audit process.

Responsibilities of Audit Coordinator (Domestic Violence Specialist):

(The Audit Coordinator is responsible for the coordination of the audit team and its efforts; however there may be duties that are delegated to members of the audit team).

- Develop a confidentiality form to be signed by everyone participating on the audit team;

- Develop a list of procedures and rules of participation for team members;

- Prepare and distribute to the team a list of all rules, laws, or policies that influence the investigation phase of a child protection case;

- Arrange for a group of battered women who have had child protection cases investigated spend a day going through a case using the format designed with Praxis. Use an adaptation of the "Angelina" case or a case not from El Paso County. Provide a summary of their conclusions to the audit team;

- Observe and interview 5 different social workers to determine:

    - Current procedures used by workers to investigate child protection reports, such as how information is collected, how are reports verified, coordination with law enforcement, home visits, and who is interviewed and why ;

    - Problems encountered during the investigation phase; and

    - Time constraints and influences on the worker during the investigation phase including how long s/he has to make a determination by law policy, and/or judicial mandate as well as case load time considerations.

    - How each of the determinants depicted in figure 1 produce problematic interventions.

- Prepare a written summary of the information obtained through the observations and interviews of the social workers and distribute to audit team;

- Prepare a summary of any literature on the investigation phase in child protection cases pertinent to domestic violence cases and distribute to the audit team;

- Review approximately thirty cases that have incidents of both domestic violence and child maltreatment. The cases to be reviewed should be a mixture of those that were substantiated and went forward after investigation and some that were unsubstantiated. Assure that the cases are a mixture of both DHS originated and DIVERT originated. Choose 5 – 7 of the substantiated cases to bring to the team immediately and 5 -7 of the unsubstantiated cases to be looked at later.

- Change all the names of all the people involved in the case, but not the names of the agencies involved.

- Summarize or make notes of everything in the file and prepare 1-2 page bulleted summary of each of the case files in chronological order for team members.

- Prepare a one-page summary for the team of an interview with each of the workers who involved in investigating in each case. (This may not be practical if you choose to not review local cases or cases that are older than one year.)

- Have one representative of social services review the files completely and be present at the meeting to respond to questions.

- Design with Praxis a format for analyzing the cases. (Many of the questions outlined in Attachment 4 can help in the analysis.)[18]

Responsibilities of the Audit Team:

- Review all materials prepared by the Audit Coordinator prior to the first meeting.

- Prepare for the first session to be focused on one case file. The first case should be the most detailed and the group should spend the most time on it. At the conclusion of the first day there should be a next-step action plan conducted to determine how to proceed with the remaining substantiated case files and to evaluate whether this process is taking the group in the direction it needs to go.

- Focus each team member on an intervener, e.g. law enforcement, advocate, etc. As you go through the case, continuously stop and discuss what the team thinks <u>is</u> happening now and what they think <u>should be</u> happening from their perspective.

- Use the questions outlined in Attachment 4 and others developed by Audit Coordinator and Praxis to guide the analysis.

- Document all changes the group agreed on, debated, or did not agree upon, as follows:

    1. The activity discussed.
    2. How is it potentially problematic for battered women or children's safety?
    3. What are the relevant concepts, theories, or assumptions related to this discussion?
    4. What administrative or conceptual practices might need to be added or changed?
    5. At what level/s is change required to address the issues raised by the group?
        a. Shift in thinking? (How)
        b. Legislative change? (What)
        c. Procedural shifts or changes? (How)
        d. Change in text? Change in form? (How)

[18] Note: the list of questions from Attachment 4 of the El Paso report have been modified and are found on page 8 of Building Safety for Battered Women and their Children into the Child Protection System.

e. Changing how a worker is linked to others? (How within child protection, within the courts, within the community?)
f. Skill development change?

6. Repeat this process with the unsubstantiated cases.

At the conclusion of reviewing all the case files, the audit team should have a fairly solid information to make policies that determines how a case moves forward in the system. Training programs can be designed for domestic violence workers, child protection workers and other service providers. The analysis will lead the audit team into Phase Two of the audit looking at the case planning phase. This will create a process for ensuring that community services are providing more appropriate and pertinent services to the men, the women and the children involved in these cases. Everything that comes out of the review of these case files will create an agenda for the Domestic Violence Specialist to work with CPS workers, other domestic violence workers and people who are actively working on the various committees of the Greenbook Project.

Praxis recommends that two or three of your key people participate in the Safety and Accountability Audit training. Praxis is conducting an in-depth five-day training in May 2003 for people who are coordinating institutional safety and accountability audits in different settings (e.g. visitation centers, criminal courts, civil courts and child protection). As a recipient of VAWO funding, the training is provided free of charge to anyone in your group. In addition, Praxis could participate in monthly conference calls to help guide this process in the formative stages.

Attachment H

St. Louis County Greenbook Initiative

Site Visit Recommendations[19]

Finding #1:

DFS and court staff admit that there is often little in their files that indicate that domestic violence is present in the home. Tools such as guidelines, screening and intake forms, the use of categories (definitions), case service planning and assessment were not designed to identify and understand domestic violence. The absence of this information often leads to case planning that inadequately meets the needs of the victims and holds the perpetrator to minimum standards of accountability.

Recommendations: DFS, Juvenile Court & Advocates

1.1: Develop a domestic violence-screening tool and require its use as a standard intake practice. An example of this might be having a set of standard questions that are asked of every mother at every screening/intake, such as:

- Tell me about your relationship.
- Have you ever been afraid of your partner?
- Would you say your partner is very jealous or tries to control what you do?

1.2: Implement policies and practices to ensure that workers routinely inquire about domestic violence throughout investigation, assessment, and case planning. It is recommended that the tactics of abuse described on the Power & Control Wheel be used as an outline for discussing the nature and severity of the violence. A copy of the Power and Control Wheel is attached.

1.3: Review and modify all currently used forms to ensure workers can record and account for domestic violence adequately.

[19] These findings are based on focus groups and individual interviews. Praxis did not conduct an audit, but a pre-audit site visit.

1.4: Incorporate documentation of social risks such as poverty, issues related to economics, housing, gender dynamics, racial oppression, and other factors active in creating the conditions of violence into investigation, assessment and case planning procedures.

1.5: Implement procedures that provide for coordination between DFS, courts, and domestic violence advocacy programs when working on cases involving domestic violence.

1.6: Collaborate with domestic violence organizations in the development of policies, procedures and tools.

Finding #2:

Parenting assessments are used in many cases because the system is set up to intervene when one or both parents are treating a child in an abusive or neglectful way. The assessment is meant to provide some picture of how that behavior is linked to their parenting notions and skills. But even highly skilled workers will not capture the reality for battered mothers and their children and be able to provide a credible report to an intervening agency or court.

Participants agreed that often there is little connection in these parenting assessments to the kinds of problems the women faced as mothers.

For example, we conducted a rather extensive interview with a woman who lived with her partner for five years and had three children with him. Lillian married Calvin when her youngest was just a few months old. Calvin first physically abused her after they were married. The abuse was severe but infrequent. The most recent assault was seven months prior to our interview. He hit her several times in the face, breaking her cheekbone. His blows literally punched her eye out of its socket. She required three reconstructive surgeries. Her twelve-year-old son, Samuel, is now angry with her because she won't let his father come back home. He is becoming increasingly belligerent at school and towards her. Lillian is often angry with Samuel for not understanding how afraid she is of his father. Samuel still wants his father at home. Lillian feels hurt that "he wants to watch football with his father, knowing what he did to me and would probably do again." Lillian's kind of problem as a mother is not addressed in a parenting assessment form. Her needs will not be met in a generic parenting class, which is all she has been offered by social services. There is no indication that her caseworker has any specific knowledge of what is going on with each of her children in relation to Lillian. The intervention, as she put it, just kept focusing on "Am I going to keep him out of the house?"

If a worker observes Calvin with his children he will most likely score high on a parenting evaluation, perhaps as high if not higher than Lillian, whom he is battering. Advocates reported that these types of evaluations are used by a number of practitioners,

including custody evaluators, CPS workers, and guardians *ad litem's*. The impact of the father's violence on the children is neither measured nor considered in this parenting form- regardless of the decision being made (e.g. custody, removal, visitation).

The assessment form provides a conceptual framework that the worker is expected to use in work on the case. One CPS worker noted:

> *What if the form was different as some people here are suggesting. Then I would be looking for how the father's presence in a room influences everyone's interactions. I might be looking for how he has explained his violence to his children, how his behavior is undermining his partner's relationship with the children. That kind of an assessment doesn't exist. But if it did and that is what I was required to use it would definitely get me thinking very differently about the case and about what I am observing.*

Recommendations: DFS, Juvenile Courts and Advocates

2.1: DFS should develop a parenting assessment tool that could capture the following information, but is not limited to:

- The nature and severity of violence;
- The protective strategies used by the non-abusive parent;
- The impact of the offender's violence on the children, the non-abusive parent and other significant relatives, friends, teachers, etc.
- The ways in which the children are being used by the offender;
- The harm that the violence is causing to the relationship between the non-abusive parent and the child/ren;
- The self identified needs of the non-abusive parent; and
- The undermining of the non-abusive parent's authority.

2.2: Collaborate with domestic violence organizations in the development of tools.

Finding #3

In most situations, DFS workers felt the non-offending parent is left with almost full responsibility to protect children from on-going abuse and to undo the harm caused by the violence. Because the workers are not institutionally organized to directly intervene with men and fathers, (particularly men who use violence who may not even be a legal party to the case), the workers naturally focus on the role and responsibilities of mothers. Additionally, discourse and training provide a conceptual framework that expects the social worker to maintain official neutrality toward both parents, even when only one parent or adult is using violence.

Under the current practice, the worker assumes the role of policing the non-abusive parent because she is the parent that the workers have access to and she is viewed as the one most likely to change. Because victims are not responsible for the violence and are granted very few avenues for stopping the violence perpetrated against them (e.g. hiding in shelters and inconsistent legal remedies), the relationship between worker and non-offending parent can quickly become hostile, adversarial, or punitive and allows for little opportunity to build trust and an effective partnership in order to enhance the families safety. Additionally, the victim's fear of losing custody of her children presents a significant obstacle to the ability of DFS and courts to gain accurate information from her regarding the history of the domestic violence. The role of the social worker in domestic violence cases needs further exploration.

Recommendations: DFS, Juvenile Courts and Advocates

3.1: Policy guidelines should be created to enable DFS social workers to advocate for parents who are experiencing violence. For example, a policy statement integrating the best interests of children with the best interests of their mothers in domestic violence situations may help workers have more clarity and flexibility in their practice. Such a policy guideline can improve DFS and court practice by providing direction for all actions throughout the case process (e.g. , who is named as abusive or neglectful, separate interviewing practices for victims and offenders, formulating an assessment of the family, separate service plans, decision-making etc.).

3.2: Develop procedures that ensure each client have access to a domestic violence advocate working in conjunction with the social worker on these cases.

Finding #4:

When asked about psychological exams performed on battered women involved in domestic violence and child protective services, workers reported that, in general, psychologists who conduct interviews and testing do not adequately address the relationship of their findings to a context of violence and abuse. In some cases, domestic violence is not identified at all.

Testing battered women in the midst of being battered and feeling threatened with the removal of their children is likely to produce a profile of a dysfunctional adult even for women who are coping remarkably well. Workers reported that psychological evaluations are a routine intervention that is most often helpful in the legal arena and less likely to be useful in getting a true picture of how domestic violence affects children or parenting.

Recommendations: DFS, Juvenile Courts, Advocates and Psychologists

4.1: The role of psychological evaluations in cases of domestic violence and child maltreatment needs to be explored by a multi-disciplinary group of providers. The following questions can provide some focus for discussion:

- What's currently useful about psychological evaluations?
- When should they be ordered and for what purpose?
- Are they producing credible and appropriate information for the court, the intervening worker, or others to better protect children?
- What guidelines should be followed in ordering, conducting, and interpreting these evaluations when there is a history of violence involved in the case?
- What should be the relationship between a thorough domestic violence assessment and a psychological evaluation?
- Are there ways these evaluations are culturally biased and biased against battered women?
- What is the cost/benefit analysis of these evaluations to the county/state?

4.2 The development of a set of guidelines regulating the use of psychological evaluations and ensuring that those that are conducted include the context of violence within the family. These guidelines need to help the workers think about who, when

and why evaluations need to be conducted and help psychologists to think about how to do it differently.

II. CHILD PROTECTION ORDERS

Adult Protection Orders, although a life saving intervention in some cases, have become an overused and misunderstood tool in cases of domestic violence and child maltreatment. Problems often arise when a non-offending parent is required by DFS and/or the courts to obtain a Protection Order as a way to keep her children safe. If she is compliant, there is an assumption that this is a successful outcome. If she refuses, she is accused of failing to protect her children and faces the possibility of their removal. Finding non-abusive mothers responsible for failure to protect can often be a result of the system's inability to hold the perpetrator of violence accountable.

Finding # 5:

Participants reported that less than half of the men they see through the child protection and court system are actively working to stop their violence or their abuse.

Because of this and other previously mentioned factors, workers lean more on the mother than the abuser to stop the violence. Participants agreed the more they look to the woman to control the man's violence, the more absent the man becomes from the file and from the case. In a sense he is always there, yet he disappears from sight and therefore any effective intervention. Over and over participants from each of the focus group expressed their discontentment of the lack of batterer accountability in the system.

A participant from Juvenile Court stated:

> *As long as I've been in child welfare, the idea of holding the offender accountable has always been around, but I've never had the time to deal with it.*

Participants agreed the women were being held overly responsible for the violence. The majority were concerned about two things: (1) intervening with men in a manner that will result in behavioral change (e.g. stopping the violence and if necessary, leaving the home); and (2) ensuring that any actions a mother is required to take are designed to meet her specific needs and that by using them she is not labeled as a harmful parent. Currently, there is no mechanism built into the child protection case processing system for a child protection worker to directly intervene with male batterers. Participants all agreed that they felt powerless to do anything to make the system work in a way that would enhance accountability for abusers through current practices.

Recommendations: DFS, Juvenile Court, Advocates, and Batterer's Intervention Programs

5.1: A pilot project between DFS and the Juvenile Court to conduct a trial study on 25 cases referred to DFS where there is a concurrence of domestic violence and child maltreatment. Factors that determine if a case will be accepted into the project shall include:

- The presence of on-going physical violence being perpetrated upon a parent by another adult in the home;
- The presence of physical harm to the children; and
- An assessment by a multi-disciplinary group of people in partnership with the non-offending parent to determine if it is in the best interest to exclude the offender from the home.

The goal of the project is to use a legal mechanism to remove offenders from their homes and decrease the responsibility of the violence on the victim. The DJO worker will file a Child Protection Order on behalf of the children to remove the offending party (whether the biological parent of the children or not). DFS will design a child protection service plan that will focus on the actions of the offender and be a part of the court order. The service plan will incorporate the use of a Batterer's Intervention Program (BIP). Resources will be provided to the non-offending parent and children by agencies that are specifically designed to advocate for victims of domestic violence. The DJO will monitor the offender's compliance with court orders and bring cases back into court for civil contempt of those who are in violation.

After 25 cases have been completed, an evaluation will be conducted to examine if the project:

- Provided increase safety for the adult and child victims;
- Provided enhanced accountability for the offender; and
- Provided for the self-identified needs of the non-offending parent and children.

While this provides a basic outline for such a project, the group will need to have more discussion before implementation. It is crucial that this attempt to provide more accountability of perpetrators and less blame on victims not result in an intervention that further complicates the lives of the victims and their child/ren. Some topics for consideration might be:

- What happens if the victim changes her mind and decides to allow the perpetrator to see the children or move back home?
- What are realistic consequences for the offender if he is non-compliant?
- What economic considerations might there be for the family?
- Does this put the victim and her children in more danger?
- What feedback have you gotten from advocacy groups? From battered women?
- Are you prepared to meet the self-identified needs of the victim and her child/ren?

- How will workers get trained to explain the practice to families?
- Do you have good representation from all disciplines to carry out such a project?
- Has this been done before and what were the results?

III. ACCOMMODATING SERVICES

Families who experience domestic violence are referred to multiple local organizations for services. Because these services were not designed to assist battered mothers and their children, it is unlikely that that the services offered meet the specified needs of the families. Accommodating services to the child welfare system must be examined in order to achieve a more holistic systems reform.

Finding #6:

We found little evidence that the services offered by DFS vendors to battered women and their children actually met their specific needs. Because services are contracted out, DFS is challenged to monitor how effective or appropriate the services are.

DFS needs a mechanism to measure the performance of its vendors as it relates to services for families experiencing both domestic violence and child abuse. Reasonable efforts in these cases need to be defined by the appropriate services and interventions. DFS social workers need to know what services their clients are receiving in order to best help them and verify to the court all reasonable efforts have been made.

Recommendations: DFS, Juvenile Courts, BIP and Advocates

6.1: A quality control process for community-based services offering services to families who experience domestic violence should be developed. Contracts with agencies should include a training clause on domestic violence and child maltreatment and performance measures to help DFS monitor the quality of services

6.2: A collaborative effort between DFS, Juvenile Court, BIP and domestic violence organizations to identify and initiate new resources in the community that specifically address issues related to parents and children who have experienced domestic violence.

IV. COURT CONNECTION WITH BATTERER'S INTERVENTION PROGRAMS

During April and June of 2002, the Greenbook Initiative conducted a self-study of the systems' response to domestic violence. One of the findings that emerged from the study was that the DFS and court system (criminal, civil and juvenile) have little knowledge and training about the issue of batterer's intervention services in the area. It was also found that when criminal and civil courts ordered abusers into these programs, it frequently did not enforce mandatory participation. This finding led the Initiative to the conclusion that this area needed enhanced coordination.

Finding #7:

Information obtained by Praxis through focus groups also supported the findings of the lack of coordination between the three courts, child protection and the BIPs in St. Louis County.

The judiciary focus group members were quite candid about how little they understood the programmatic content of BIPs and in some cases were unaware of the programs entirely. Most of the participants interviewed stated they were unaware of what services BIPs provides. While participants were for the most part consistent in their answers, one probation officer stated that he was in constant contact with a BIP worker. BIP staff reported that they have little-to-no contact with the courts and often have to hunt down information to find out the circumstances of the men who use their services.

A BIP staff member noted:

> *As far as our connections with court, it's difficult to find out if they are there voluntarily or not. We request the police report and record check from the man, but we don't always get that. Probation says they can't release to a third party. That's their policy, but probably not statute. Some probation officers will send us something. The supervisors tell us they will not send us the reports.*

Recommendations: Civil, Criminal and Juvenile Court and BIP

7.1: Conduct a series of meetings between civil, criminal and juvenile court services and BIP staff to discuss coordination and collaboration.

7.2: Design a set of policies and procedures that allow for communication and coordination between civil, criminal and juvenile court services and the Association of Batterer's Intervention Programs.

7.3: Develop a set of guidelines for sentencing that includes completion of a BIP for misdemeanor convictions.

Finding #8:

Focus groups were asked if they were aware of any programming on the part of BIPs that included a parenting or fathering curriculum. Few were aware of such programming, although the participants indicated that it would be beneficial to enhance their curriculum on issues related to parenting.

DFS reported that they have included BIP as a condition of a service plan of the offending parent a few times in the past, but had no formal relationship with the BIP to know if the abuser was attending such groups. BIP staff reported they covered a little on the issue of parenting within their groups, but it was not a specific component. Men who have been violent stated that parenting issues was something that was missing in their groups and they would like to have the opportunity to spend more time on their relationship with their children.

Recommendations: BIP and Advocates

8.1: BIP staff should enhance parenting components to their current curriculum to address the impact of the violence on children. The curriculum could move beyond the impact of domestic violence on children toward helping fathers interact and make amends with their children and be better co-parents when appropriate. The Family Violence Prevention Fund can be a resource for this.

8.2: Conduct a series of meetings between DFS and BIPs to discuss coordination and collaboration.

8.3: Design a set of policies and procedures that allow for communication and coordination between DFS and the Association of Batterer's Intervention Programs in cases of domestic violence and child maltreatment.

8.4: Victims of domestic violence, BIP participants and advocacy programs should be involved in all of the steps of development and implementation.

Finding #9:

While coordination efforts are quite strong between the courts and DFS, we found advocacy programs lacked involvement in intervention practices outside their own organizations.

When asked to describe how services were provided, practitioners within any system rarely mentioned coordination with advocates or domestic violence organizations. The advocates we met with echoed this problem as they expressed a feeling of working in isolation. They reported they had little communication with court services or DFS.

Recommendations: Civil, Criminal and Juvenile Courts, DFS and Advocates

9.1: Conduct a series of meetings between all courts and DFS to discuss current intervention practices and develop new joint protocols to enhance services to victims of domestic violence.

9.2: Enhance visibility and leadership role of domestic violence organizations.

9.3: Explore the possibility of incorporating some of the elements of Coordinated Community Response by having a multi-disciplinary group (including at least two advocates) attend a 3-day training offered by the National Training Project. Many of the concepts from this training are extremely relevant to your current efforts.

V. Enforcement

Designing policies, procedures and guidelines is often not the only part of making a system work. The tracking and monitoring of policies, procedures and guidelines is a necessary component to systems change.

Finding #10:

Focus group participants were quick to point out that a central missing piece of their system is the lack of consequences for perpetrators who are ordered into BIPs.

While BIPs may report to the probation officer if there is non-compliance, it is not known how or if this information reaches the court, and if the court acts on it. In civil court there are no formal mechanisms to assure compliance. Even when a victim may bring it to the court's attention, it is rare that perpetrators are held in contempt.

Recommendations: Civil, Criminal and Juvenile Courts, BIP, and DFS

10.1: The civil, criminal or juvenile court should mandate perpetrators of violence to one central monitoring agency rather than to individual BIPs. Following the practices of the Duluth-model, perpetrators of domestic violence sign release-of-information forms naming the agencies, probation officers, judges and the monitoring agency involved in their case. The release also allows the monitoring

agency to provide certain information to the victim regarding the perpetrator's attendance and compliance with court orders. The monitoring agency conducts an interview and then assigns him to one of the on-going groups. Referral information including the victim's statement, a summary of any police report, the release of information, and the intake and referral form with background on the assailant is forwarded to the BIP. The group facilitators submit attendance reports weekly. Cases are brought back to court for non-compliance by the monitoring agency.

SUGGESTIONS FOR IMPLEMENTATION OF RECOMMENDATIONS

Multi-disciplinary committees should be involved with the implementation of recommendations. We recommend formation of the following committees or inclusion of the following categories as priority areas for a single multi-disciplinary committee:

- **Policy/Procedures**
  The task of the Policy/Procedures Committee would be to assist each agency in reviewing current policies that are relevant to domestic violence and creating policies where none exist. New policies should prioritize safety for the children and non-offending parent and should address the issues in the findings.

- **Training**
  The task of the Training Committee would be to prepare a long-term training plan for St. Louis County. This includes training on new policies and procedures, training for contracted service providers and training on roles and responsibilities of each disciplines working on behalf of families.

- **Monitoring/Evaluation**
  The task of the Monitoring/Evaluation Committee would be to set up a tracking system to ensure a high degree of compliance with changes made through the process. This committee would also work to evaluate the impact those changes have on case outcomes.

Policy Making

Practitioners are currently operating under written policies to varying degrees. Where policies don't exist, St. Louis County agencies should create written policies. Where written policies exist, agencies should update the current policies, based on the findings.

a. Make handbooks for practitioners (DFS, Judges/Court; District Attorney; Court Clerks; Probation, Law Enforcement, BIP, Advocacy Organizations, Community Group Organizations) that correspond to each policy. Handbooks should combine an explanation for the rationale of the policies; specifics on the procedures needed to carry out the policies, and information and training tips regarding unique aspects of responding to domestic abuse-related cases.

b. Put procedures in place to have practitioners from each area of the system review all drafts of these policies in order to infuse coordination and address the linkage issues that arose from the report.

c. Train practitioners from all areas of the system on the implementation of policies and consider inviting key personnel from other agencies to participate.

d. Design systems to monitor compliance of practitioners for all new policies and procedures for a period of six to 12 months following the issuance of the policies.

Training

Some of the training issues identified by the report, such as assessing risk factors, were common to all practitioners and may best be addressed through multi-disciplinary training opportunities. Other issues were more specific to different practitioners such as training for BIP staff and advocates on curriculum for parenting after violence. Cross-training with practitioners would be beneficial as would ensuring that all systems receive positive feedback on what services are provided as a result of their intervention and what practices are most effective in achieving victim safety and offender accountability.

a. Create a cross-disciplinary team of St. Louis County domestic violence experts to ensure ongoing training for practitioners at all levels of the system that respond to domestic violence cases.
b. Create a strategy for sending key personnel to the existing specialized state and national trainings on responding to domestic violence cases.

c. Ensure that for each practitioner, training includes the following:
    - The policies from his/her own agency;
    - The policies of other agencies;
    - The unique aspects of domestic abuse and child maltreatment cases;

  - Assessment for and documentation of signs of dangerousness; Effective intervention is based on knowing if you are dealing with "a slapper or a stalker." It is the cumulative process of information gathering and sharing that clarifies this, as well as assists the practitioner's ability to elicit and interpret information.
- Each practitioner's role in the coordinated community response to domestic violence and child maltreatment.
  - What every worker is able to do is enhanced or constrained by what the previous worker has done. Effective intervention involves more than any one agency's policies or practices—it includes engaging in a process where the cumulative effect of all institutional actions promotes victim safety and offender accountability.

Monitoring & Tracking

St. Louis County should develop a multi-disciplinary monitoring and tracking committee that would, on a periodic basis, take child protection cases all the way through the system and examine them in relation to the major themes and specific recommendations identified in this report.

The multi-disciplinary group could prepare a report of the above information to be distributed to practitioners and other interested parties in St. Louis County. Ongoing monitoring and reporting would promote a wider understanding of current practices and increased cooperation among all agencies.

Some Thoughts on Philosophy: Coordinated Community Response to Domestic Violence

By Ellen Pence

Adapted from Chapter Two of
Coordinated Community Response to Domestic Violence: Lessons from the Duluth Model,
by Shepard and Pence, (In press, Winter 1998)
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SOME THOUGHTS ON PHILOSOPHY

Ellen Pence

The Domestic Abuse Intervention Project (DAIP) is one project of a non-profit community based advocacy group called Minnesota Program Development Inc. (MPDI). MPDI has five domestic violence related projects: the Domestic Abuse Intervention Project; the Duluth Visitation Center; the National Training Project; Mending the Sacred Hoop, a technical assistance project to Native American tribes; and the Battered Women's Justice Project, a national library and resource center on criminal justice reform efforts. The first three projects are located in Duluth. They emerged from the DAIP which was the first project of the organization. The other projects were the creation of activists in the state who utilized our organization as a home base to do national organizing.

Having been asked to write a piece on the philosophy of our coordinated community response to domestic violence and I am wondering whose philosophy am I to write about? The board of MPDI? The staff of the DAIP and the Visitation Center? The collection of agencies which participate in the interagency effort? I wonder if I should I write about the articulated philosophy or the operative philosophy. Perhaps I could just make arguments for my own thinking and ascribe it to the project. Even if I can identify a standpoint from which to speak about the philosophy of the project, what aspect of the philosophy shall I address? Is a discussion on our philosophy equal to talking about how we think about things? What things? What we think causes the violence? What we think the role of the legal institution is in stopping or perpetuating the violence? How we think institutions work or how they change? How we think about our work with the individual offenders and victims? I realize that the prospect of clarifying things for the reader is quickly diminishing.

I will attempt to describe the philosophy of our project by discussing some of our debates in all of these areas and try to highlight the challenges the DAIP staff posed to the system. It is, after all, the role of the DAIP staff to facilitate interagency debate and

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articulate a position that holds us collectively to the goals of victim protection, offender accountability, and changing the social climate of tolerance for this kind of violence.

WHAT CAUSES THE VIOLENCE?

This question is rarely asked at an inter-agency meeting, but our conflicts are almost always rooted in our different perspectives on what causes the violence. We argue over how to interpret observations and statements, what to do about a case, the role of the victim in stopping or provoking the violence, and the content of policies or educational programs. The conflict centers on the split among those who see the violence as rooted in: a) some kind of psychological problem of the offender, b) the way the man and the woman act as a couple, or c) how the offender understands the notion of being coupled. There are countless variations of these themes and no one fits neatly into any one camp, but these camps are broadly representative of our individual points of diversion.

In many ways, how an individual practitioner conceptualizes the causes of domestic violence is not so important. As I discuss later in this article, a critical feature of institutions is that they put into place procedures, policies, categories, and language that subsume the idiosyncratic thinking and acting of individuals into institutionally acceptable responses to a case. While the thinking of individuals in the system is not always a critical determinant of case outcome, the conceptual basis for writing institutional instructions that guide their actions is a crucial determinant.

I cannot do justice to describing the conflicting and often competing theoretical notions operative in the Duluth legal system. I can, however, try to articulate some of the thinking that was already firmly entrenched in the legal discourse of the Duluth system, and then describe how the DAIP staff attempted introduce another way of thinking about the violence and the cases before the court.

Our Thinking about the People

When the project began, most practitioners in the system linked the use of violence in marriages (intimate relationships) to the abuse of alcohol, people with poor

relationship skills, or an inability of the men involved to handle stress, anger, or frustration in non-aggressive ways. These frameworks led practitioners to focus their attention on the offender's (and in some cases the victim's) lack of communication skills, their frustrations from unmet expectations, their inability to negotiate in a relationship, their self-destructive use of alcohol or drugs, their inability to deal with a partner who is destructive or mean, their lack of support for their partner, their poor parenting skills and/or lack of empathy needed to live in loving families. They believed that these deficiencies lead some men and women to erupt in violence because they were either unwilling or unable to use healthier methods to resolve these conflicts. An offender's inability or unwillingness to act differently then, was seen as rooted in his own family or personal history. In addition, there was a recognition that a certain percentage of offenders were just generally anti-social and violent in many settings.

The DAIP staff raised the question, "why, in this relationship, does the offender suddenly lose skills he seems to have in other social relationships?" If it was the alcohol, the stress, or the lack of communication skills, then why isn't he hitting his boss, a store clerk, or an incompetent barber who makes him angry? A common answer was that this relationship is different. It is more personal, more constant, more private, and both parties must know how to negotiate in the context of a deeply personal relationship. You can walk away from the store clerk, there is no building up of tensions and resentments. You simply change stores or barbers, but the home is different.

The DAIP staff agreed that it was about the nature of the relationship, but wanted to shift the focus of intervention from fixing or ending the relationship, to confronting what seems to be a sense of entitlement to use coercion, intimidation, or violence in this relationship that is not permissible in other social relationships. By making this shift, it was assumed that the whole center of attention would shift from resolving conflict to challenging the use of violence. As time went on, this line of thinking lead to focusing more attention to how to contextualize the use of coercion, intimidation and violence.

We worked on developing ways to distinguish between "slappers," those who use low levels of presumably non-lethal violence, and "stalkers," those who escalate in the types and severity of violence. It lead us to eventually distinguish between those who assaulted their partners and those who were engaging in a pattern of coercive and violent behaviors that resulted in the offender establishing a relationship of dominance over the victim (the latter we refer to as battering). We saw that not all domestic assaults were battering and not all batterers escalated to the point of seriously injuring or even killing their partners.

While the DAIP staff has argued against using causal explanations that require practitioners to assume a fairly universal psychological make-up among batterers (i.e. stress or anger control problems), we have developed some of our own truisms that also reduce complex social relationships to slogans. One was the notion that batterers use violence, coercion, and intimidation in order to control their partners. He does it for power, he does it for control, he does it because he can, were advocacy jingles that, in our opinion, said just about all there was to say.

The power and control wheel, which was developed by battered women attending women's groups, was originally a description of typical behaviors accompanying the violence. In effect it said, "when he is violent he gets power and he gets control." Somewhere early in our organizing efforts, however, we changed the message to "he is violent in order to get control or power." The difference is not semantic, it is ideological. Somewhere we shifted from understanding the violence as rooted in a sense of entitlements to rooted in a desire for power. By determining that the need or desire for power was the motivating force behind battering, we created a conceptual framework that, in fact, didn't fit the lived experience of many of the men and many of the women we were working with. Like those we were criticizing, we reduced our analysis to a psychological universal truism. The DAIP staff, like the therapist insisting it was an anger control problem, or the judge wanting to see it as an alcohol problem or the defense attorney arguing that it was a defective wife problem, remained undaunted by the

difference in our theory and the actual experiences of those we were working with. We all engaged in ideological practices and claimed them to be neutral observations.

Eventually, we began to give into the process that is the heart of the Duluth model; interagency communication based on discussions of real cases. It was the cases themselves that created the chink in each of our theoretical suits of armor. Speaking for myself I found that many of the men I interviewed didn't seem to articulate a desire for power over their partner. While I relentlessly took every opportunity to point out to men in the groups that they were so motivated and merely in denial, the fact that few men ever articulated such a desire went unnoticed by me and many of my co-workers. Eventually we realized that we were finding what we had already pre-determined there was to find. The DAIP staff were interpreting what men seemed to expect or feel entitled to as a desire. When we had to start explaining women's violence toward their partners and the violence of men who didn't like what they were doing, we were brought back to our original undeveloped thinking that the violence is rooted in how social relationships (e.g. marriage) and the rights people feel entitled to within them are socially, not privately, constructed.

We have become increasingly more able to account for the many ways that violence is used in an intimate relationship. Much of our thinking now about safety and accountability is linked to our ability to contextualize the violence, to ask who is doing what to whom? And with what impact? The DAIP still conceptualizes the violence as a logical outcome of relationships of dominance and inequality; relationships shaped, not simply by the personal choices or desires of some men to dominant their wives, but by how we, as a society, construct social and economic relationships between men and women and within marriage (or intimate domestic relationships) and families. Our task is to understand how our response to violence creates a climate of intolerance or acceptance to the force used in intimate relationships.

Finally, advocates and battered women have for decades faced the thinking that women use the police, the courts, orders for protection, and even shelters to get an

advantage over their partner in a divorce or child custody case. Advocates are constantly reminded that women lie about being afraid, about being abused, and about the impact the abuse has on their children. And because some women do it, all cases are suspect. For over a decade, the DAIP and shelter advocates reacted to this constant undercurrent of "women are liars" by arguing that "women are saints." In many ways we turned a blind eye to some women's use of violence, their drug use and alcoholism, and their often harsh and violent treatment of their children. There did not seem to be a way to acknowledge these problems and still argue that women deserved the full protection of the court or to convince people that while women were guilty of some problematic behavior, they were not responsible for the historical and culturally acceptable use of violence and sexual coercion by men against women.

Unlike children, few battered women are seen as innocent victims of abuse. The victim blaming accusations in the system, coupled with advocates false representation of women as having no agency (everything she did wrong he made her do it), plagues us to this day. But we have moved beyond many of the impasses of our first decade. Our work with women who assault their abusive partners attests to our growth in this area.

Our Thinking About the System's Response

A second and equally contentious set of debates is centered on addressing the question of why the criminal justice system's response to these cases is so ineffective at stopping the violence. The standard response in 1980 was that the victim was ambivalent about what she wanted to do. Some practitioners were extremely sympathetic to the horrendous dilemma victims faced when trying to end this kind of violence, others were impatient, frustrated, and generally hostile to victims of domestic violence. Many moved from various forms of sympathy to victim blaming.

Again the DAIP staff introduced a new spin to the same old facts. The system isn't ineffective because women don't react to being beaten properly. It is ineffective because it handles cases in a generic way which doesn't account for this unique crime and the distinct response it requires. While other advocacy groups were arguing that we

should treat this crime like stranger assaults or barroom fights and criminalize the offense, Duluth advocates used a different argument. We maintained that assaulting your "wife" is not like assaulting someone in a bar or at a party or in a social setting where the victim and offender have no familial or economic or emotional ties to each other. In a barroom fight if a victim pursues a conviction by cooperating with the prosecutor, the case will likely go forward; if the victim does not want to cooperate and expresses a strong desire to have the whole case just disappear, it will likely be dropped. But, applying that same standard to domestic assault cases is problematic for many reasons, most importantly, it gives the offender who has control over the victim, control over the state's intervention.

In our first five years of working toward new policies, we were conviction-driven which made us face a philosophical dilemma. We knew that most battered women had legitimate reasons for not wanting to have the state engage in a hostile criminal proceeding against their partners, yet we pushed prosecution as a means of holding men accountable and protecting victims. On one hand we recognized that the system was too slow, too adversarial, too inconsistent, too incident focused, and too unwilling to follow through on its own orders to be of predictable help to victims of battering. On the other hand, we thought that continuing to simply dismiss these cases would only reinforce abusers notions that they can safely use violence in their intimate relationships.

The DAIP staff asked the question, "Why should a woman cooperate with a process where there is very little in it for her?" The DAIP tried to argue from the standpoint of the woman: she does not want to testify at a trial that is taking place months after she was beaten; she knows the court will focus on one blow and not all of the abuse she is experiencing; she has nightmares of a courtroom scene where a defense attorney will subject her to a sophisticated and legalistic version of her abusers attacks on her, during which she will not be free to argue back; she sees that her abuser has an attorney but she doesn't; she knows that the none of the results are particularly helpful to her, whether it is a fine, a jail sentence, or an order telling him not to break the law again.

The arguments that ensued could not be reduced to any one or two points but one important difference between practitioners and activists was that practitioners in the system argued that victim's responses to violence caused the violence to continue and DAIP staff argued that the states response to offenders both caused the violence to continue and in a much broader sense contributed to batterers sense of entitlement to use violence in their private intimate relationships. The DAIP staff shifted the whole discussion about the violence from a focus on types of offenders and victims to a discussion about the broader social implications of the criminal justice system's laissez faire approach to these cases and the connection between that approach and the prevalence of domestic violence. It should be noted that the DAIP staff argued that the private lives of women are shaped not by the men they marry or live with as much as by the institutions in our society which define and shape intimate relationships.

Advocates from the Women's Coalition (the battered women's shelter) and DAIP first moved to strengthen the protection order process, then pursued a fairly aggressive criminal court intervention process. The civil protection order process was faster, less adversarial, more consistent, more focused on the pattern of abuse than an incident and, most importantly, it resulted in practical court ordered reliefs relevant to the needs of victims; housing, child support, enhanced police protection and, in Duluth, rehabilitation services for abusers. So we pursued a criminalization path to change the climate of tolerance and create a general deterrence to battering and a civil process to address the immediate needs of victims.

This approach left us with the question of what to do when victims failed to cooperate with our criminalization agenda. We often liken this dilemma to that of civil rights activists trying to desegregate lunch counters, schools and buses in Jim Crow states. When the first children walked into previously all white schools those children did not get a better education. As we have all seen in news stories of those tense days African American children walked through crowds of screaming threatening white adults. They entered empty classrooms. The victory was for those who followed. When the civil rights movement used those children to change a basic inequality in society, it secured an

agreement from the government to call out the national guard to protect them. The challenge to those of us who argue that we need to criminalize this violence, even when the victim wants us to back off, is to put into place the safeguards equivalent to the national guards protection of black children desegregating southern schools.

The compromise was to pursue cases even when a victim does not want it. However, we would stop short of endangering a victim or punishing victims for not cooperating with these intervention efforts. The DAIP staff talked about the need for every institution in the community to examine its role in creating a climate in which domestic violence was both normalized and kept private. The DAIP staff saw the legal system as a starting point for community confrontation of domestic violence. Unfortunately, DAIP has failed to expand its institutional reform work to other community institutions (religious, economic, medical, media, education) which in fact have a much more powerful impact on creating social norms than does the reactive institution of criminal law.

We vehemently argued our points about institutional responsibility to confront abusers and our historic duty to criminalize what for centuries has been a problem screened out of the criminal justice system. However, we were also painfully aware of how little the criminal justice system's use of conviction and punishment and rehabilitation had to offer many women who were being beaten. This has also meant that we have had to address the reality that the systems' response does not have the same meaning across class, race, and gender lines. We have had the luxury of working in a community where, as these issues and contradictions are raised, key practitioners in the system take them up as legitimate institutional concerns. We have worked to figure out what to do about battered women who use violence, how to build a program that is rooted in a recognition of Native American self determination and the impact of colonization on Native American family systems, how to design educational programs that respect the culture and personal histories of each man and woman who enter the groups, how to recognize the many ways that class and gender bias is built into everyday work practices in the criminal justice system.

CHANGING INSTITUTIONS

The Duluth Model has been hailed as an organizers miracle. The DAIP staff who present workshops in other cities are constantly asked, "How did you get the police to.... Why did the prosecutors agree to... How do you get past the secrecy of every agency... Did you have a coordinating council and who ran it... How did you involve judges when?" It is hard to say to what we owe our success in working together. When we all discuss it we agree that there have been a variety of key factors. Here I would like to just briefly list some of them in order to help contextualize the discussion on our philosophy or thinking about institutional change. Keep in mind that in 1979-80 there were no police departments in the country that were voluntarily agreeing to an arrest policy. There were no coordinating councils or inter-agency agreements to bring as examples to agency directors.

What We Did to Create Institutional Change

1) The DAIP staff (project organizers) spent eight months learning all aspects of the system from practitioners in each of the participating agencies. The project organizers consisted of three women. Shirley Oberg was one of the original organizers of the shelter and well known and respected by all of the agency directors. Her reputation and ability to talk about being abused without being dismissed opened all of the key doors for us. Coral McDonnell, had been a volunteer at the shelter. She had considerable experience in office management and made us look far more professional than we actually were at the time. I was the third, an outsider from Minneapolis whose father was a salesman and mother a Catholic. My specialty was selling guilt. We were funded by several Minnesota foundations to create a model community inter-agency response to domestic violence cases and had the luxury of a full planning year before we had to produce actual results.

2) Agency directors took a cautious but still open approach to the DAIP staff requests for them to join the inter-agency approach. Each agreed to participate in new procedures if they were approved by their staff attorney's, if all agencies

participated, and if the project was time limited and evaluated. Agency directors gave us a rather informal nod to begin talking to agency staff about these cases. This willingness to try something if others joined was not something we as organizers did. I always think that the DAIP is not an organizing miracle as much as the city of Duluth was an organizers miracle town. The willingness of nine agency directors to simultaneously try something new speaks to an intangible that has always been a part of this project. It was luck perhaps that we chose a community like Duluth to design a model. We chose it because the shelter was interested in the project, the police were open to an arrest policy and it was smaller than Minneapolis or St. Paul where there would have been a lot more politics to deal with and a lot more people to bring on board.

3) During the first four or five months of the project DAIP staff met with individual police officers and administrators, probation officers, prosecutors, therapists, judges, dispatchers, court clerks, jailors and defense attorney's to understand from their perspective: a)What would improve the system's response? b) What kind of resistance would there be to different proposals? (i.e. mandatory arrest) c) Why would that resistance be there? d) Who are the key leaders to sell on trying something new? e) How could proposed changes backfire on the project and on battered women? f) What kind of training in proposed changes would be effective?

4) These meetings were informally held in coffee shops, over lunch, and in squad cars during ride-alongs. We got to know how people in the system think about their work, their relationship to cases and other agencies, rules and regulations, and the issue of violence in families. These informal sessions created a beginning point of dialogue which were later carried into more formal meetings to discuss new policies and protocols.

5) All of the informal meetings with front line workers gave DAIP project organizers a practical way of approaching agency leaders to begin to discuss the

design of the new approach. All initial discussions about policies such as mandatory arrest or a no-drop prosecution policy were kept general and focused on what might be accomplished for the agency and for the protection of victims. These discussions focused on what their workers saw as part of the problem. None of the proposals that we began to formulate suggested that there would be absolute policies with no room for exceptions or applying good judgment when special circumstances were present.

6) The DAIP agreed to raise money to pay for all of the training costs associated with the project and the evaluation.

7) In each of the participating agencies project organizers found one or more practitioners who were for different reasons very active in helping to bring their departments into the project in a positive way. These practitioners often faced a rather cool reception from their co-workers and in some cases they faced open hostility. They were usually the people the agency administrators appointed to work with us on preparing draft language for a policy. In many ways our staff became a support system to them.

We took a low key non-confrontational approach to policy development. We focused almost exclusively on writing policies and designing training sessions to teach the basics of the new policies and gain practitioner support for the changes in the approach to these cases.

Our Thoughts About Institutional Change

Our thinking in the 1980's was that to use the criminal justice system effectively we had to identify what it is about this crime and this offender that made it difficult to successfully place controls on the offender. While this isn't directly synonymous with getting convictions it is close to that. We had this idea that a primary objective should be to shift the burden of confrontation of abusers from the victim onto the system. This meant police could no longer ask the victim whether or not she wanted him arrested, thus

our mandatory arrest policy. We had to neutralize the offenders' ability to control the process by getting the victim to ask to have the charges dropped, thus the no-drop policy. We wanted judges to sentence offenders to either jail or rehabilitation groups or both and immediately revoke probation when the offender failed to complete rehabilitation groups or reoffended. We needed an arrest policy that based the decision to arrest on the presence of probable cause and the presence of danger to the victim. We needed a quick civil process that overcame the gaps in a divorce action and a criminal action.

Our first decade focused on broad policy issues, networking and developing support systems for victims and rehabilitation programs for offenders. In our second decade we have deepened our understanding of how institutional practices can marginalize or centralize attention to victim safety. I think it would be fair to say that somewhere down this long road to change we came to the realization that even if we could hand pick every police officer and judge and prosecutor we would still not eliminate the bad case outcomes that continued to occur after we had changed almost every policy. We had attributed the failure of the system to effectively address victim safety to individual attitudes and poor training. We began to see an institutional ideology that was embedded in work practices which standardized practitioners' actions regardless of their personal idiosyncratic work habits or beliefs.

The project was a local project. Case processing routines were established and carried out in a local setting but these work practices were linked to conceptual practices that were not produced locally. Much of the masking and obscuring of victims experiences occurred as their experiences were made into cases prepared through a complex set of administrative procedures which made the violence something institutionally recognizable and actionable. Beginning with the administrative methods designed to accept a victims call for help, continuing with the way police officers are institutionally organized to respond to and document an assault call and ending with the closure of that case weeks or even years later, each practitioner is guided to think and act on cases in ways that are institutionally prescribed yet often appear to be the result of an individuals objective review of the facts.

In the past five years we have made a significant organizing change in how we think about institutional change. In the past we might ask the question; "Why did this practitioner take this action?" Now we ask, "How was this practitioner institutionally organized to take this action?" Instead of seeing actions as the result of what's going on in the head of a judge or probation officer or police officer we see it as the result of what is going on in the work practices (i.e., forms, rules, regulations, documentary practices, communication networks, technology limitations, insurance rules, etc.). Ways of thinking about the violence are built into those practices. For example, probation officers making sentencing recommendations are guided to think about appropriate sentencing for offenders in domestic violence cases based on the presentence investigation form used in their interviews and presentation to the court. Imagine the difference in thinking that would develop over a ten year period if we had twenty probation officers use a pre-sentence investigation form that emphasized documenting the pattern of abuse and violence the offender had used in this and past relationships; another twenty officers documenting the offenders criminal and work record, and a third group of officers documenting the conflict in the marriage that proceeded the assault in question. To uncover how routine practices tend to compromise or marginalize attention to victim safety we have developed an institutional audit which is fully described in the manual The Duluth Safety And Accountability Audit (Pence and Lizdas, 1998). That process has directed our examination of how texts used in processing cases act to compromise victim safety.

When a woman who has been beaten by her intimate partner dials 911 for help, she activates a complex system of agencies and legal proceedings which constitute the state's legal apparatus of ruling. It is in turn linked to other systems of ruling, particularly the mental health and social service systems. These agencies of social control are themselves coordinated and controlled through administrative processes and regulating texts increasingly present in the mundane but vital processes that manage our daily lives. Few activities that occur in the processing of a case are not textually mediated. Texts are

the primary instruments of implementation and action in this system and as such are a focal point of our

The number 911 is the first in a series of texts that will coordinate, guide, and instruct a number of practitioners who will participate in processing as a criminal assault case a woman's experience of being beaten. The dispatcher who receives the call does not use her/his own discretion in accomplishing each of the tasks in this highly specialized system. She/he instead follows a written script in the form of computer screens which mediate the discussion first between the caller and the 911 intake worker and then between the dispatcher and the police officer who will respond to the call (Wahlen & Smith, 1994). These screens constitute the second text in the management of a domestic assault case by a community's police and court system. They are not, as D. E. Smith (1990) notes, "without impetus or power" (p. 122). These texts and the hundreds that will follow are active. They screen, define, prioritize, schedule, highlight, route, mask, and shape.

The woman's actual experiences becomes a "case" when the dispatcher begins the process of inscription and is institutionally resolved through a series of processes or organizational occasions. Cases move from one occasion to the next through a series of practitioners who do something—take action—and then textually record those things needed to move the case to the next occasion for action. Much of what the practitioner does is guided by texts such as administrative forms, rules and regulations, screening devices, intake forms, and report-writing formats. The text the practitioner produces is designed to hook up and assist the practitioner at the next occasion for institutional action. As such the text, like the practitioner, is doing something. Much of the ideological work of the system is buried in the text. Therefore to incorporate a principle such as prioritizing victim safety into the infrastructure of the system, changes must occur at the level of the text.

A case record or file becomes a key organizational element in taking action; it is the institution's representation of the "incident" (here the incident is an assault on a

woman) which precipitated the opening of the case. As an institutional representation, it reflects the concerns of the institution. It is like a medical chart telling the reader who did what, when, and for what purpose. Although some organizational occasions are recorded, case files rarely contain verbatim transcripts of what occurred. Instead they contain documents that are organized to record what "of institutional significance" occurred at each processing occasion.

Members of the institution are trained to read and write in institutionally recognizable ways. The reader is linked to the writer of a document in such a system not only through the text but through the legal discourse which organizes their professional training. Professionals are trained to translate what they see and hear and gather from the everyday world into professional discourses about that world. The professional discourse in reports and documents appears to be the objective work of an individual responding to a specific set of circumstances, yet this is far from what actually happens. Battered women's lives are twisted into preformulated categories created not in the lived experience, but in the professional discourse.

CONCLUSION

The understanding of how power works through conceptual practices buried in a textually mediated legal system is a key to our current organizing efforts. It will not hold all of the remaining answers to our community's long experiment with reform. We are committed to a process of change and a focus on safety and accountability. Our goal is to create a different social climate, not to promote certain courses of action.

The overall organization is incorporated (1979) as Minnesota Program Development Inc (MPDI). The non specific name reflects the intentions of its original organizers. We wanted to create a vehicle for ourselves as a group of activists to work on progressive social change projects that focused on the economic, political and social issues facing women in the state. We imagined ourselves working on a variety of social justice projects one of which would be confronting violence against women within marriage. At that time we were also envisioning working on other issues concerning

welfare, child custody, housing, credit scams, and a host of issues one or more of us were interested in pursuing. Today every project of MPDI is focused on domestic violence. As one board member stated "when the DAIP thing took off so fast everything else just sort of went on a permanent back burner."

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Developing Policies and Protocols in Domestic Violence Cases

by Ellen Pence and Coral McDonnell

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DEVELOPING POLICIES AND PROTOCOLS

Ellen Pence and Coral McDonnell

The Duluth model's major contribution to the national legal reform effort has been its method of negotiating agreements with community agencies which intervene in domestic violence cases. Included in this interagency effort are victim advocates, law enforcement officers and administrators, prosecutors, probation officers, court administrators, mental health providers, policy makers, and in a limited role, judges. The model focuses on ensuring that practitioners respond to domestic violence cases in a consistent manner and that their response centralizes victim safety.

While coordination is a method to reach the overall goal of victim safety, it is not in itself the primary goal of the Duluth model. When reform efforts focus on coordinating the system rather than on building safety considerations into the infrastructure, the system could actually become more harmful to victims than the previously unexamined system.

If we measure success by counting increases in arrests, conviction rates, or a reduction of repeat cases entering the system, coordination may seem to be the key to an interagency effort. However, if we use the criteria of insuring victim safety, holding offenders appropriately accountable for their violence, and changing the climate of tolerance for this type of violence, we see that coordination is merely a means to far more complex objectives.

Many cities adopt a strict mandatory arrest or a no-drop prosecution policy on domestic violence cases, as if apprehending and convicting batterers is the only goal of intervention. This course of action is shortsighted and ultimately fails because typically the victim is the biggest obstacle in convicting the abuser. The victim then, who may or may not be helped by a conviction, is seen as the problem. From there the reform effort

shifts from a critique of the institution's ability to hold an offender accountable to a critique of the victim. Ineffective intervention strategies and structural problems with the law fade from view as objects of inquiry.

Examining and amending our policies and procedures to build in victim safety has been an ongoing process at the Domestic Abuse Intervention Project (DAIP) in Duluth. In 1981, we negotiated agreements with nine key agencies to simultaneously enact policies directing practitioners to follow certain procedures when responding to domestic assault cases. In the nearly two decades since adopting those policies we have continued the process of examination and change.

Our primary task in intervening in domestic violence cases is to transform the way the system is structured to respond to domestic violence. While existing procedures may serve the purpose of processing other misdemeanor crimes, they are often not effective in domestic violence cases. Several structural realties of the criminal justice system make processing domestic assault cases difficult. Problems with the structure include the slow processing of cases, victims being placed in an adversarial position to the offender, practitioners attending simply to single incidents instead of the overall use of violence, and texts (regulations, forms, procedures, and reports) that are not designed to direct practitioners to give attention to victim safety and to the collective goal of placing controls on offenders. Another significant problem in the criminal justice system is its fragmentation. Each practitioner in the system is highly specialized and tends to pay attention to their own function rather than to the collective work of the entire process. Dispatchers or responding law enforcement officers must see the relationship of their work during the first hour of a case to the work of other practitioners who will later intervene in the same case. Prosecutors, sentencing judges, probation officers, rehabilitation specialists, protection order judges, and custody evaluators read initial police reports looking for guidance on key decisions they must make in a case. Each practitioner needs to see how they are linked with others in the system.

Each practitioner is part of an organizational network. In order for the network to function properly each player must be consistent in their actions and be aware of what others in the system are likely to do in certain circumstances. Although very little of what practitioners do is at their personal discretion, they do have discretion whether or not to screen a case out of the system and to determine the appropriate level of intervention. Once those decisions are made the practitioner typically complies with standardized procedures in processing the case.

For example, once a law enforcement officer decides to arrest a suspect, the procedures for arresting, transporting, booking, and filing a report are routinized. Consistency in carrying out these tasks is ensured through the use of administrative procedures, standardized forms, instructions, training programs, departmental policy or procedural guidelines, and employee supervision. To achieve consistency and attention to safety, institutional procedures must be linked together and practitioners must be cognizant of the special problems these cases pose. When a practitioner's response is unpredictable, the best policies and procedures can still lead to failure. In designing an effective response, methods must be in place to ensure a high degree of practitioner compliance because, for a battered woman, an unpredictable system is like playing Russian roulette—a game with which she is already far too familiar.

Practitioners' actions are restricted by regulations including federal and state laws, case law, insurance regulations, agency and department policies, and local interagency agreements. These regulations must be scrutinized relative to victim safety and offender accountability objectives. To centralize safety, the response must take into consideration the risk the offender poses to this and other victims. Therefore, a law, a policy, or a procedure must be constructed in a way that allows the practitioner to account for the probability that offenders who are batterers are likely to retaliate against their victims because of actions taken by the state/community. Policies need to account for the likelihood that most offenders will pursue another relationship in the future. The intervention approach must shift the burden of confrontation from the victim to the

institution to whatever extent possible and without coercing victims into a certain course of action. While the approach assumes that most offenders who batter will use coercion and force in any intimate relationship, responses must not be designed under the assumption that all assaults in intimate relationships constitute battering. Not every person who assaults his or her partner is engaging in a ongoing pattern of coercion, intimidation and violence. To assess risk, the collective work of practitioners must be directed toward understanding the pattern and history of violence as well as the power differences between the victim and the offender. Because it is so important to understand how the violence is being used in a relationship, the task of documenting and assessing for levels of danger must be built into the work routines of practitioners and seen as the collective work of all interveners.

SOME ASSUMPTIONS OF DULUTH'S REFORM EFFORTS

In Duluth we work to hold batterers accountable. The term accountability means to be held responsible for one's actions. This is a long and complicated discussion when used in relation to battering. We can only highlight some of the assumptions we use in the Duluth response to domestic violence cases.

First, we do not assume that all violence is the same. The person who is physically and sexually abused over a period of time and uses illegal violence as a way of stopping the violence is not doing the same thing as the person who continually uses violence to dominate and control a partner. Similarly, a person who engages in abusive behaviors, including grabbing and shoving his or her partner, is not to be treated the same as the person who threatens to kill his partner and uses actions to terrorize her. All of these parties should be held accountable but the response must attempt to treat similar cases in a similar fashion. Therefore, policies and procedures should help standardize responses while allowing the system to respond to the specifics of a case.

In order to hold offenders accountable and to protect victims we need to understand how the violence is used by a person and how victims are impacted by the violence. Harsh sanctions are not necessary with people who have used minimal force in a relationship, show potential for rehabilitation, and are entering the system for the first time. More jail time does not always mean more justice. On the other hand, we cannot be naive about how dangerous and deceptive many batterers can be. Offenders must be held accountable accordingly.

In Duluth we assume that most victims of ongoing abuse (intimidation, coercion, and violence) are safer if the state/court has some level of control over the offender. For example, convictions and probation are preferred over deferred prosecutions and two years probation is recommended when abusers reach a level of abuse which indicates an escalating pattern of violence. Completely dropping a protection order is discouraged if a couple wants to live together again. Dropping the exclusion order but keeping the restraining order gives the system leverage if the abuse resurfaces. Cases are processed so that the system can respond quickly to renewed violence.

We assume that using violence against a child's parent adversely affects the child. Interventions must not pit the interest of the child against the interest of a parent who is an ongoing victim of the violence. We continue to debate the role of the abused parent in providing safety for the children.

SOME RULES OF POLICY MAKING

In Duluth, policies evolved and developed over a long period of time. The changes and some of the corresponding conflict came in phases, with many inactive periods between the more active periods of reflection and change. Policy making is as much about the process as it is about content. We have learned over the years that the process needs to be inclusive and based on dialogue, not debate. It must also be attentive to practitioners' knowledge, research findings, and experiences of victims. Finally, the

process must be open to scrutiny and evaluation. We list here some of the lessons we have learned during the almost two decades of policy development in Duluth.

Mind Your Politics

In the early 1980s we worked in an atmosphere of distrust, defensiveness, and finger pointing. Shelter advocates challenged agencies and institutions who often responded with hostility. Battered women's advocates were usually seen as "pushy, single issue, and inherently biased outsiders."

Internal conflicts existed within and among agencies: police thought prosecutors were dropping the ball; prosecutors pointed to the weak response of judges; judges claimed a lack of appropriate resources for sentencing; and clerks were tired of all the prima donnas in the system. Dispatchers were concerned about a pending decision to move from the police department into a county-wide 9-1-1 system. Police officers were split internally over the appointment of a new police chief while most of these conflicts were not rooted in problems related to domestic violence cases; they were part of the political climate surrounding the domestic violence reform work in process.

Over the years, defensiveness to the criticism from outsiders, in this case, activists in the battered women's movement, has significantly diminished. Today our system is not perfect; in fact it is still far from it. But now as many issues of concern and proposals for solutions are raised by practitioners as by battered women's advocates.

The number one rule of policy making should be that the change must simultaneously deal with domestic violence while considering the political realities of the multi-agency response. Community members wishing to initiate successful institutional reforms should anticipate resistance, be inclusive rather than exclusive, and avoid slogans and rhetoric. They should create an atmosphere conducive to dialogue in order to sustain relationships through the difficult discussions. Advocates must give up the notion that only they care about battered women and that practitioners in the system are personally

responsible for failures in the legal system. Practitioners need to give up the myth that they as professionals have been trained to be objective and fair (as opposed to advocates) and recognize that bias is built into their training and discipline. Finally, administrators must prioritize the protection of victims over the protection of the agency.

Assess Current Practices Relative To The Primary Goals Of Intervention

The Duluth model owes much of its progress to the willingness of practitioners and policy makers to work with advocates and activists in the battered women's movement. These practitioners and policy makers relied on battered women's advocates to help identify problems in the system, participate in sessions to develop solutions, and to evaluate the impact of new procedures. Visitors to Duluth are amazed at the extent to which agencies have been open to having their handling of cases be scrutinized by others. The attitude among agency directors in Duluth is that such scrutiny improves their services rather than hinders their ability to operate. A good system is refined by scrutiny; an ineffective system is replaced by it.

Initially, shelter workers drew up lists of obstacles that women faced when using the criminal and civil court for protection. It was these lists that shaped the agenda for reform. Most of the reforms that came from the process in 198 1—1984 were what we might consider macro level changes. New policies were implemented in each agency that led to significant change in procedures—for example, dispatching policy required dispatchers to send a squad to all domestic-assault related calls and to give domestics involving assault the highest priority coding. Police policy required officers to make arrests when there was probable cause to believe that a misdemeanor level domestic assault had taken place which had resulted in an injury to the victim. Police policy also required officers to write a report on every domestic-related call. Probation policy required probation officers to request a revocation hearing if an offender committed another assault on a victim. The agreement with the judiciary made it routine for judges to order pre sentence investigations on all domestic violence related offenses, no matter how seemingly minor. The agreement with counseling agencies required that counselors

work with offenders in groups or classes and not offer marriage counseling as a method of reducing violence. All of the policies required new methods of documenting cases and sharing information with other practitioners, including victim advocates.

Later policies were altered on a more micro level as laws changed or experience highlighted problems. We conducted a series of low budget evaluations of specific aspects of the intervention process. We then used that data, as well as cases where practitioners or advocates felt the system failed to protect victims, as the source for ongoing refining of policies. From 1984 to 1994, we continued to make revisions but focused more on procedures than major policy changes. For example, criteria were established for police to distinguish between self-defense and assault. A protocol was developed for police clerical staff to provide victim advocacy agencies access to police reports on misdemeanor cases. We developed a curriculum for abuser classes and designed an interagency communication network which eventually became known as the Domestic Abuse Information Network (DAIN). We developed a program for victims of ongoing abuse who had been arrested for assaulting their abusers. We opened a visitation center offering supervised visitation and exchange of children for parents in cases where offenders were using visitation as an opportunity to continue the abuse. Native American activists reviewed each policy for its impact on Native American families and developed separate advocacy services and programming for the community.

In 1995, we began a new process for assessing our practices by employing the research methods of Canadian sociologist, Dorothy Smith (1990), to investigate how procedures and daily routines in the system affected certain institutional goals (safety, accountability, and changing the climate of tolerance for violence). Based on her work, we developed a method for auditing our system that examined each step of case processing. From that audit, we uncovered many practices in our system which contributed to the inadequate outcome of cases and provided an agenda for change that will take another five years to fully implement.

The audit procedure is fully documented in a manual entitled The Duluth Safety and Accountability Audit: A Guide to Assessing Institutional Responses to Domestic Violence (Pence & Lizdas, 1998). The audit process involves an interagency team which includes staff from the police department, probation department, prosecutor's office, court administrator's office, and a victim advocate. The team observes each processing point and interviews the practitioners involved. Such an audit provides a community a full picture of where changes need to be made in the rules which guide practitioners' work and the daily routines used to carry out institutional objectives.

Build Practice Into Every Day Work Routines

It is well known that large bureaucracies are coordinated by paperwork. Beginning with 9-1-1, most transactions and actions are textually mediated (paper driven). When a 9-1-1 call is made, the conversation between the caller and the dispatcher is guided by how the dispatcher is required to respond to and record the call. When a law enforcement officer arrives at the scene he or she goes through certain steps to determine if an arrest is to be made and documents what happened in the incident. The strategy of reform has shifted over the years from "change the attitude" to "change the text." Simply stated, if you expect a practitioner in a heavily burdened court system to consistently do something, look for something, or think about something, then request the information on the form the practitioner uses to process the case. Do not leave safety or accountability to the whim, memory, or personal commitment of hundreds of people. During our audit, we found dozens of places in our system where normal institutional practices failed to account for the safety needs of victims and left prosecutors in a weak position to obtain convictions even in serious cases. Below is an account from one of the workers involved in conducting the audit of our system. It graphically illustrates how a gap in the system is discovered in the audit process.

THE LITTLE GREEN FROG STORY

> While we were conducting an audit at the jail, a suspect was brought into the jail. I observed the jailer as he told the man to take off his bootlaces, belt, tie,

and all the things he could possibly hang himself with. The jailer then told the man to take everything out of his pockets. Items in his pocket include $5.85, a tiny green plastic frog, a small Swiss army knife, a comb, and a few other items. The jailer put all these items in a plastic bag and wrote down everything that he took: the green frog, the Swiss Army knife, the $5.85, the belt, and bolero tie. After writing down what had been put in the plastic bag, he told the inmate that he would put the bag in a box behind his desk and that he would get these items when he was released. The jailer then had the inmate sign a paper that stated what items had been taken from him.

You can see that the jailer was making it clear to the suspect that all his stuff was his, no one was going to take it, and that he would get it tomorrow. They documented everything to avoid a dispute later about what the man had with him when he was brought in.

This process is well thought through, particularly in terms of the potential for future lawsuits. That strange thing was that during the time they were going through this process, the guy was very angry and yelling and was threatening his wife saying, “Someday I’m going to kill that fucking bitch. She knew this would happen. I can’t believe this. Every time I walk into the house she tells the kids to dial 9-1-1. She’ll pay for this!”

The he was then carted off to his cell. I told the jailer that I noticed he had recorded every item that he had taken from the man but I wondered if there was any place he recorded the threats that the man had made against his wife. He said no. I asked if there was a form for recording these kinds of threats. The jailer indicated that they did have an incident form on which they could report threats. I asked to see the form, and the jailer dug around and finally found the form. I asked him why, in this case, he hadn’t recorded the man’s threats? He said he was only obligated to report serious threats. I

asked him how he knew the difference between a serious threat and a not very serious threat. He said that this guy had been in jail plenty of times and that he always blew off steam like that, so he knew it wasn't serious. I questioned the jailer more and he asked me if I worked at a shelter or Battered women's program and I told him that I did. He asked me if women ever came to the shelter and told us that their husband had threatened to kill them. I told him they did. He asked if we called the police and told them that. I said we did. He then asked if we called the police every time a woman told us that her husband had threatened her, and I responded that we didn't. He asked when we did call, and I told him we called when it was serious threat. He asked how we knew it was a serious threat. I said, "I just know."

This example helped us see the need to carefully examine what seem to be perfectly adequate procedures. Two major tasks of an audit are to locate where safety and accountability can be built into the system and to translate safety and accountability into concrete practices such as a new jailer form or a new 9-1-1 response to a first call for help.

The following is a description of the first 24 hours of processing a misdemeanor domestic assault case in Duluth. Changes which have been built into the infrastructure of the system are bolded.

Victim calls 911 to report that her husband has assaulted her and violated the protection order. He had slapped her and grabbed the keys to her house. He left the house heading towards the east end of town in a blue 1985 Toyota pick-up truck. The dispatcher gives the case a **priority call**, dispatching one squad to the house and alerting all other squads to the description of the vehicle and the alleged offender. The dispatcher **directly quotes the woman's** description of the assault on the CAD (computer aided dispatcher) complaint report form.

Officers respond to the house, conduct an interview **using a checklist format**, asking about **history of prior violence** by the suspect toward her or others, ask about and **document the involvement of children** in the incident, and **overall abuse**, give to her a **referral card** to the shelter/legal advocacy program, and **file a complete report**.

Two hours later a second squad pulls over a 1985 blue Toyota truck and identifies the woman's husband as the driver. After conducting an interview with him officers determine they have **probable cause to make an arrest and do so**.

When the suspect is booked he makes several threatening remarks towards the victim which are recorded on the **jail incident form and turned over to the arraignment court** the next morning. After placing the suspect in his cell, the **jailer calls the shelter** and gives the name, phone number and address of the alleged victim. The jail **holds the suspect** until arraignment court the next day.

The **shelter sends a trained on-call volunteer advocate** to the house to talk with the woman. The advocate provides advocacy and information on the shelter services, protection orders, what might happen in court, and asks for her permission **to forward information regarding the history of abuse to arraignment court. If the victim gives permission, the advocate fills out a history form, a statement regarding the wishes of the victim regarding full, limited, or no contact with the offender, and obtains the name of a person who can reach the victim at any time**.

Domestic assault arrest police reports given **priority by the word processing department. A copy of each report is distributed to**

- **the Domestic Abuse Information Network**

- **the shelter advocate assigned to follow up on the case**
- the probation officer and judge at pre-trial court
- the court administrator
- the detective bureau for follow up on enhancing the charges
- **the suspect's probation officer (suspect has a previous conviction)**
- **the domestic violence file**

The next morning an employee of the city attorney and probation department prepares a file on the case which includes the arrest report, any past police arrest or investigative reports on this offender, CAD printout (Computer Aided Dispatch - 911) reports, risk assessment form completed with women's advocate, photos of victim injuries, copies of past and current protection orders, any pending court cases, probation information, past DAIN involvement, any prior victims known, criminal history, to be available in all future considerations of the case by the prosecutor, judge, probation officer, rehabilitation program, etc.

The suspect is arraigned and the probation officer appointed to this offender is sent the file to determine if he/she should ask for revocation of probation regarding the previous conviction.

All of these changes are the result of years of modification to the way our courts process these cases. Most changes represent many hours of discussion and debate. Others just seem to happen following one meeting on the subject. Effective policy development is a process that requires a commitment to the long haul.

Beware of Categories

There are several problems inherent to generalized policies and regulations. They often fail to account for the multiple social positions of those to whom the policy is being applied. For example, the arrest of an immigrant man recently arrived in this country could have devastating effects on him and his family. The use of a sentencing matrix which bases the decision to incarcerate an offender on past convictions rather than dangerousness to the victim will result in indigent men being sentenced differently for battering than wealthy men. Obviously, the threat of a conviction has a different meaning to men of different social classes and men from communities with different historical relationships to police and the courts.

Generalizing rules and regulations force interveners to apply broadly defined rules to individual cases in which more effective responses could be made by verifying the specifics. Let us use the example of the Minnesota law which divides assaults into two broad categories—felonies and misdemeanors. An assault becomes a felony if the assailant used a weapon or the assault resulted in permanent bodily harm or a broken bone to the victim. A misdemeanor is a less serious offense and is treated differently in several significant ways; most notably a misdemeanor carries a lighter sentence. Judges often sentence misdemeanor cases without requesting pre-sentence investigations.

Statutes are a set of generalizing rules which tend to group different situations together and treat them as if they are the same or similar. Let us look at how victim safety was compromised in a case involving a double arrest in one Minnesota community. State intervention is based on the notion that felony assaults (assaults involving the use of a weapon or permanent bodily harm) are more serious assaults than misdemeanors assaults (no weapon and no permanent bodily harm). Following is an excerpt from a police report documenting the arrest of a woman who had been physically and sexually abused by her husband for seven years.

I asked Diane Winterstein to tell me what occurred, she said her husband Phillip had come home after drinking at the Y&R bar and was becoming very belligerent. She said he told her that people were “reporting on her.” I asked what he might have meant by that and she said that he acts like everybody is his personal watch guard over her and that he makes up affairs she was supposed to have and then says his reporters saw her with someone. She went on to say that Phillip started pushing furniture around I noted that a chair was pushed over in the dining room. She then went into the kitchen and got out a steak knife and threatened to “poke his eyes out” if he didn’t leave the house immediately. I asked her if she was in fear of grave bodily harm at this point and she said no, she thought he was going to leave. Then according to Diane he started to call her names like “whore” and “bitch” and “cunt” at which point she lunged at him and “poked him in the right hand with the knife.” She said when he saw the blood he started to cry and she called him a “big baby,” at which point she says, “he grabbed me by my hair began pulling me toward the bathroom and kicking me.” She stated that he kicked her three or four times in the legs and right hip area. I asked her if there were any bruises. She showed me the area of her right hip which was red and swollen and beginning to bruise. I asked her if he did anything else to assault her and she stated that he threw her up against the wall and told her that this time she had gone too far. I asked her if she had been violent to him in the past and she said that she often threatens him to get him to leave her alone. . . She said that he slapped her across the face twice and then spit in her face. . . conferred briefly with Officer Dickie and a decision was made to arrest both parties. I informed Diane that I was placing her under arrest for 2nd degree assault and took her into custody without incident. Officer Dickie placed Mr. Winterstein under arrest for 5th degree assault (see Officer Dickie’s report for more details). . . Officer O’Keefe took pictures of both parties’ injuries. Both refused medical treatment. I placed a kitchen knife

shown to me by Diane Winterstein as the one she used to stab her husband into evidence. (Pence, 1996)

In this case Diane Winterstein faced a prison sentence often years. She eventually pled guilty to second-degree assault for "stabbing her husband with a deadly weapon." Since it was her first offense, she spent only 11 days in jail and was ordered to attend classes for offenders. The case against Philip Winterstein was eventually dropped in exchange for his agreement to cooperate in the prosecution of the more serious case, the felony against Diane Winterstein.

It is the generalizing character of the law that impedes practitioners from intervening in this case in a way that will protect Diane from future assaults. In fact, it is quite possible that she has actually been made more vulnerable to her abuser by this state intervention than had the police never arrived at her door. Yet each practitioner in this case did their job.

Reformists must consider these potential problems when attempting to use generalizing rules, policies, laws and regulations in order to enhance victim safety. Of course it would be impossible to manage a large bureaucracy without these generalizing texts. The implementation team must pay close attention to how redrafts of regulatory texts can backfire on certain groups of people. There is no universal battered woman: race, class, age, and gender positions result in differing impacts of the same treatment.

<u>Use Policies To Control The Screening Of Cases</u>

We have had to grapple with the difference between our rhetoric and the realities of people's lives, for example:

•Not every case of domestic violence is best resolved in a courtroom.

•Every act of domestic violence does not necessarily lead to a serious attack on a victim.

•When victims call for help they are not calling to activate a long hostile criminal proceeding. They are usually calling to make something happen immediately.

•Many individual victims will not be helped by a prosecution.
•Some cases in which an assault did occur are almost unprovable in a courtroom using the standard of proof required in a criminal trial.
•Most offenders who are arrested for assault will not be with the woman they abused after five years.
•With no intervention (sanction and or rehabilitation) most offenders will continue to be violent for many years.

Who determines the significance of such "facts"? Should the responding police officer decide which case should end up in a courtroom? If so, should the officer have full or only partial discretion to make that decision? The first question posed by a policy is to the extent to which a practitioner can exercise discretion when a specific course of action has been prescribed. The loss of discretion is the single biggest source of staff resistance to interagency policy development. Policies should not turn practitioners into robots, mechanically applying a few predetermined actions to a case.

Instituting policies such as Duluth's mandatory arrest policy does not mean that officers stop thinking, evaluating, or making judgments. In fact, the opposite is true. The Duluth police policy states the officer must decide when and if an arrest is appropriate, providing no injury has occurred. If the case has reached a level of violence in which someone has been injured and there is probable cause to believe that the suspect assaulted the alleged victim, the decision on whether or not to arrest is moot. This policy has increased officers' use of professional judgment and skills in these cases. In the past if a case was difficult to sort out or the victim was reluctant to proceed with a criminal case the officer simply advised and left a brief report, or possibly no report. Currently, the officer is required to conduct a thorough investigation and question the parties at the scene in order to determine whether there is probable cause to arrest, to ascertain if any party was using self-defense, to document any action taken, and to gather evidence needed to prosecute these very difficult cases.

Change Takes Time

The changes we discuss here have been in process for almost two decades. Sometimes rigid policies are needed to change long-held beliefs and traditions in an institution. Eventually the new practice becomes the routine. The policies can begin to give back a degree of discretion that may have been important to limit for the first five to ten years of reform given the prevailing thinking about the problem.

Staff turnover affects change. For example, in the early 1980s when we worked with police officers designing new policy, there was considerable resistance to changing long-held practices. Officers were opposed to giving up discretion on when to arrest. Currently, nearly all of the Duluth police officers comply with and are supportive of the arrest policy and report writing guidelines because most of them became police officers after the policy was enacted. They were trained as rookies to use these methods of responding to domestic assault cases. We recently introduced the notion of not making double arrests when there is a primary aggressor and two assailants. Officers again resisted. Some of us thought the officers would appreciate the ability to use their discretion to determine which party to arrest, but instead officers argued strenuously for the application of existing arrest criteria in all cases.

Use Policies to Control for Appropriate Levels of Responses

The criminal justice system cannot treat every assault as if it will become life-threatening. Policies and protocols must guide practitioners in determining the level of response to cases based on their perception of the level of danger. With few exceptions, every practitioner has her or his own way of prioritizing these cases.

Policies should dictate the basis for which a practitioner should screen a case out of the system, respond as if it were an emergency situation, or take some action in between. Standard response has been established for domestic violence cases for all responders. Procedural checklists of actions to take on all domestic assault-related cases have been developed. For example, we recently developed a method for practitioners

(i.e., prosecutors, probation officers, rehabilitation programs) to alert the sheriffs warrants division to cases which do or do not involve an immediate risk to the victims. The DAIN monitors the attendance of all offenders court ordered to nonviolence classes. If an offender fails to attend court-ordered classes and is harassing or threatening the victim, the DAIN asks for a court hearing to find the offender in contempt of court. The sheriffs department is then notified that this is a high risk situation. If, on the other hand, an offender fails to attend classes and the victim does not know where he is, has not heard from him, and is not aware of his whereabouts, the DAIN notifies the sheriffs department that this is not a high risk situation. The sheriffs department then prioritizes the first case over the second in determining how aggressively to look to serve someone. This is necessary in situations in which the warrants division is too overburdened with warrants to look for a person beyond two or three attempts.

We have agreed as a matter of principle not to use scales in determining levels of danger and corresponding levels of institutional action. Instead, in cooperation with practitioners, we discuss and think through the types of cases that would constitute a standard, elevated, or emergency response. An example of this is the sentencing recommendation matrix, (chart 1, attached) developed by the probation department in consultation with the shelter advocates and the DAIN staff. This matrix shows how probation officers use information gathered in their pre-sentence investigation, which includes a domestic violence supplement form, to make a decision about an appropriate sentence to recommend. The sentencing recommendation matrix is most effective when it is part of a coordinated community response to domestic violence.

Another example is the development of the emergency response team. In 1996, we organized a process by which any practitioner in the system can call an emergency response team meeting. If a practitioner feels that an offender poses imminent danger to a victim, he or she can call a meeting of all of the agents or practitioners involved in the case (e.g. child protection worker, police officer, shelter advocate, probation officer). Either a telephone conference call or an emergency meeting takes place to discuss a

response to this case. The recent development of guidelines for jailers to use in alerting the shelter and victims about threats made by suspects in custody is another policy-driven procedure.

Use Policies To Link People Together

Duluth agencies have entered into a multi-agency agreement regarding sharing of information and documenting responsibilities on these cases. Every policy should guide practitioners on how and when to share information. *Chart 2* (attached) illustrates how we conceptualize each practitioner linking to others in the system.

This chart shows how the probation officer gets information from others in the system. A similar chart can be made with each of the other areas as focal points to

Provide Training And Follow-Up

When developing procedures for handling cases, we recognize that most practitioners, whether advocates, probation officers, judges, or police officers, are average people. Forms, procedures, screening tools, assessment forms, and curriculums need to be user friendly. Practitioners should not be overwhelmed trying to decipher what the tools require, or these recording devices will probably be tossed in the wastebasket and people will go back to using easier methods of dealing with the case.

Training on policies should focus on case examples so that practitioners can apply the guidelines or rules. The DAIP has developed a training curriculum for police officers, probation officers, rehabilitation providers, advocates, and other practitioners in the system. All of the training curricula use case examples and apply policy and procedures to these case examples. For example, in the police training, there are a series of short videos of police officers responding to different cases. Each video is intended to elicit discussion with police officers about a particular aspect of investigating the case such as identifying the primary aggressor, determining probable cause, distinguishing self-defense from an assault, recording the history of violence, etc. Each of the training points

are centered around actual case studies and practical dilemmas that practitioners face in their everyday work. Similarly, for probation officers we provide a packet containing ten cases and ask probation officers to place each of these offenders on the sentencing recommendation matrix. Probation officers then discuss why they placed certain defendants at a level one, two, three, or four on the matrix. In conducting training in this way, we come to an understanding together of how to apply written regulations and rules that we have collectively designed. This style of training has been very effective because it engages practitioners in a process that allows them to understand the intent behind each rule, regulation, and policy, as well as understand the actual requirements on their part. It also leads to discussions that demonstrate how practitioners are linked to others in the system. It helps to identify the problems that practitioners will probably have in applying these procedures and provides them an opportunity to enhance the process by discussing other information or resources needed to carry out a particular policy, regulation, or procedure.

Recognize That victims and Victim Advocates are Allies not Enemies

It's important to recognize that victim advocates, although they may sometimes seem unreasonable, biased, and maybe even hostile toward the court system, are in fact the most valuable allies that administrators can find if they are truly trying to improve their system's response. Victim advocates are obviously going to be your most vocal critics, but can tell you where the problems in the system exist. It's important to incorporate ways to listen to the experiences of battered women who have looked for safety and justice from the court system.

In the Duluth system, we have been fortunate to have had a group of battered women who from the beginning volunteered to serve on a policy committee for the shelter and the DAIP. The Battered Women's Advisory Committee consists of seven to twelve women who have used the system within the previous four years. The committee meets six or seven times each year to review and discuss any suggested changes that are being proposed in the system and ask how they believe those changes would have

impacted them when they were in the process of trying to use the legal system. The committee is made up of women whose class, background, ethnicity, personal history, and experience in the court system differ. Most of the BWAC's meetings center around a two-hour informal discussion and pizza dinner. Besides this input from victims' perspectives, victim advocates meet on a monthly basis to discuss issues in the legal system and frequently invite supervisors of different agencies to talk about problems in the system. We believe that without such input from victims and victim advocates, policy reform efforts would not achieve their goal of victim safety as effectively.

CONCLUSION

We end this discussion on policy making by providing a template we use as the outline for any new policy and a checklist we use when thinking through a policy. This template provides an overview of items that should be covered in a complete policy. It is provided with a warning: If you want practitioners to know what is in a policy, keep it brief and to the point. A policy should have two versions—the practitioner version and administration version. The practitioner version includes I and II. The administration version includes I, II, and III.

I. The intent and rationale for the policy

II. Guidelines for processing cases

a) What should practitioner do and under what circumstances

b) Using procedures, forms, etc.

c) What, when, and how information should be shared with others

d) Applicable laws, definitions, authority

III. Supervision/monitoring

a) How will policy be monitored by agency

b) Steps to ensure compliance

c) Record sharing for external monitoring (how, with whom)

The following checklist can help policy makers examine how a policy will organize workers to think about and act on the unique features of criminal cases.

Focus on changing the institution, not the victim

Balance between the need to standardize and the need to be attentive to the particulars of a case

Focus on building cooperative relationships

Focus on practices not people

Recognize that nobody owns the whole truth

Build in methods of ensuring compliance with procedures in policy

Link practitioners to those beyond the next worker in the system

Account for the offender's level of danger

Assume that a victim will be vulnerable to consequences if she or he participates in confronting the offender

Assume that the offender is likely to batter in future relationships

Document the pattern and history of abuse when and wherever possible

Account for how

a) categories help and hinder the understanding of a case
b) practitioners will get around the intent of the policy
c) offenders will get around the intent of the policy
d) the policy/response will be used against victims of battering
e) different levels of dangerousness and risk require different levels of response
f) punishment/sanction will have an impact on the offender
g) rehabilitation/programming could be used against victim
h) victims use violence against their abusers
i) slowness will impact victim safety
j) children are affected by violence
k) offenders could use children to control victims
1) institutions send double messages about children's exposure to violence

Determine who needs information, when, and how they will get it

Distinguish between differing impacts of intervention depending on the social status of victim/offender

Put it in on the form—don't rely on memory

Develop standardizing procedures that focus on safety (i.e. matrix, police report form, control log, dispatching screen)

Don't expect practitioners to be robots

Provide training that focuses on why and how to carry out new practices by using case studies

Focus the assessment of institutions on what frames a practitioner's response:

a) rules and regulations

b) administrative forms and procedures

c) resources and technology

d) linkages to others in the system

e) training and ways of thinking

Make sure the policy covers:

a) what to do under specified circumstances

b) guidelines to put cases into appropriate levels of response

c) methods to ensure practitioner compliance (tracking)

d) guidelines for making exceptions to the policy

e) how to document actions

f) how and with whom to share information on a case

If the policy is for the greater good, then it should be carried out in ways that protect the individual victim as much as possible.

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Smith, D.E. (1990). Texts, facts and femininity: Exploring the relations of rulings. New York: Routledge.

For information about any of the Domestic Abuse Intervention Project training programs, call or write the National Training Project- 202 E. Superior Street—Duluth, MN 55802 (218) 722-2781.

Domestic Violence–Related Misdemeanor Sentencing Recommendation Matrix

Category one	Category two	Category three	Category four
The offender commits an offense against the victim but there is no evidence to suggest the offender is battering the victim. The offender has no history of battering.	**The offender** engages in battering behavior against the victim, but there is no indication that the battering is escalating in severity or frequency, or that this offender has battered another person.	**The offender** has established a clear pattern of battering with this or past victims. The PSI indicates the battering will likely continue and possibly escalate in severity and frequency.	**The offender's PSI** demonstrates that the heightened, obsessive, and/or unrelenting nature of the battering poses a high risk of serious harm to this or other victims.
This category may include offenders who commit an act uncharacteristic of their typical behavior. It may also include victims of battering who use illegal violence or activities to control or stop violence used against them.	**This category may include** batterers whose histories include using low levels of violence and activities which threaten or intimidate the victim.	**This category may include** batterers whose histories include multiple domestic violence–related contacts with the police; demonstrated harassing behavior* toward the victim; violation of an OFP; or repeated threats or assaults against this or other victims. The victim may be in fear of serious bodily harm.	**This category includes** offenders with histories similar to those of category 3 offenders but may also include stalking behavior,* threats to seriously harm or kill; use of weapons or threats to do so; and injuries that require medical attention.
Considerations: If the offender in this case is experiencing ongoing battering by the person assaulted, the probation officer considers safety measures for both parties. Specialized programming is recommended, and the probation officer does not consider executed jail time unless the assault is severe.	**Considerations:** Recommendations focus on victim safety and rehabilitation programming rather than sanctions.	**Considerations:** Victim safety recommendations are combined with more sanction-oriented sentencing, such as the maximum probationary period, some executed jail time, and rehabilitation programming.	**Considerations:** Recommendations include the strongest victim safety measures possible, including working with child protection on children's safety. A substantial jail term and long-term probation may be combined with programming if offender is amenable.*

Incarceration or other correctional programming*

30 days stayed jail	60 days stayed jail	60 days stayed jail 10-30 days executed jail	60-90days stayed jail 20-30 executed jail	30 days stayed jail 60 days executed jail or 90 days straight time

Gross misdemeanor incarceration or other correctional programming*

	91-120 days stayed jail 0-45 days executed jail	91-120 days stayed jail 45-120 days executed jail	120-180 days stayed jail 120-180 days executed jail	180-365 days stayed jail 180-365 executed jail

Probation duration (Gross misdemeanor convictions routinely receive 2 years probation

1 year	2 years

Chart 1

Chart 2

Sources of Information for Presentence Investigations