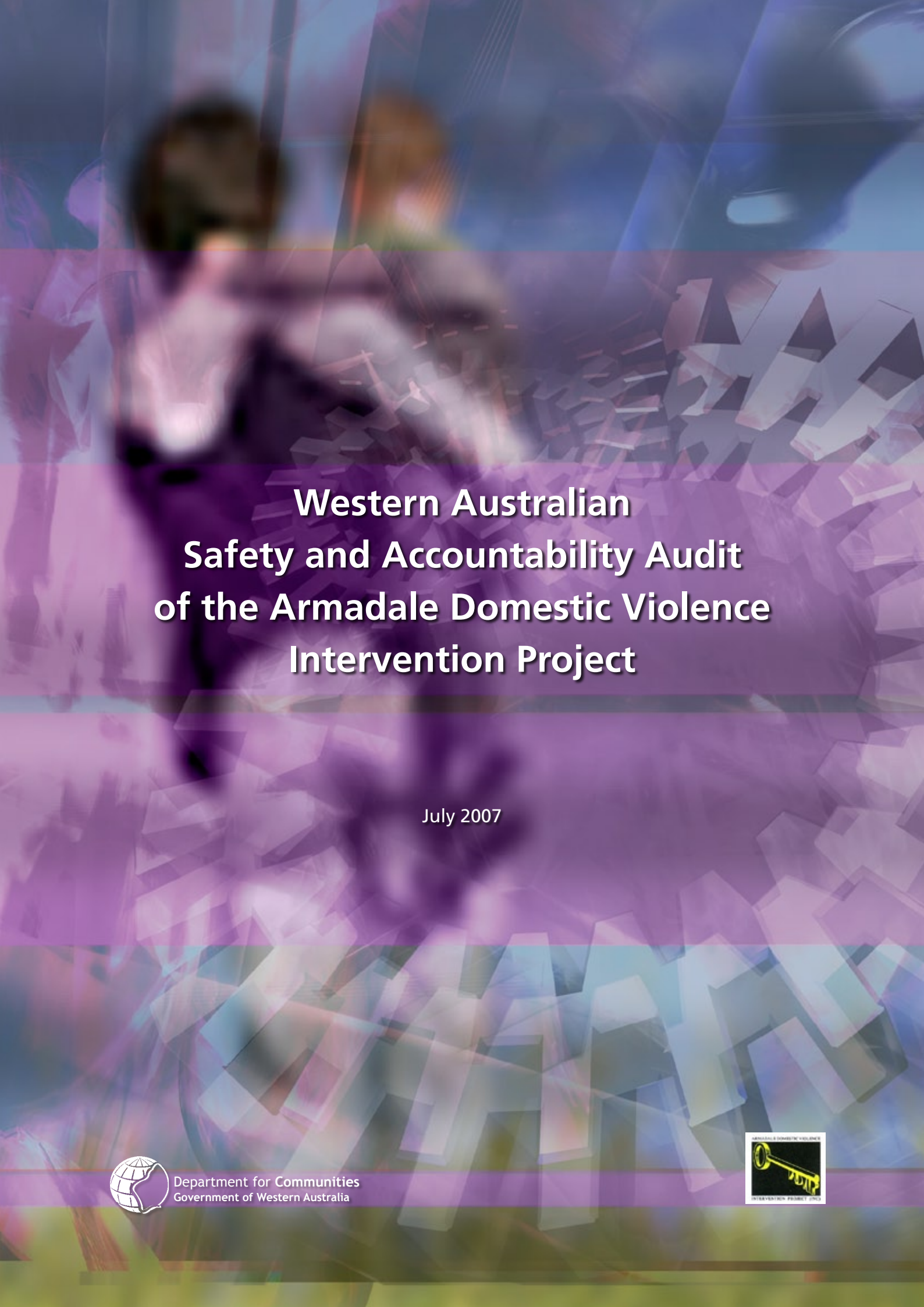

Western Australian Safety and Accountability Audit of the Armadale Domestic Violence Intervention Project

July 2007

Department for **Communities**
Government of Western Australia

Prepared by: Dr Ellen Pence, Ms Sherrilee Mitchell and Ms Arina Aoina for the Family and Domestic Violence Unit and the Armadale Domestic Violence Intervention Project.

Pence, E., Mitchell, S., Aoina, A. (2007). *Western Australia Safety and Accountability Audit of the Armadale Domestic Violence Intervention Project,* **Perth Western Australia: Western Australian Government.**

Foreword from the Minister

Family and domestic violence is a serious issue for the people of Western Australia. The complex nature of domestic violence continues to challenge us; calling for more effective approaches and coordinated effort.

The Domestic Violence Safety and Accountability Audit allowed us to look closely at our responses to family and domestic violence and provides clear directions on how we can improve in this area.

As a result of the audit the Government of Western Australia will now develop an interagency system for gathering, documenting and sharing information on family and domestic violence cases that will allow government and non-government workers to intervene in timely and effective ways.

This will be supported by common definitions and understandings of domestic violence which will ensure that the abuser is held accountable for their violence. Supporting policies will also be developed to ensure police, courts, child protection and related human service providers do their work in ways that ensure that *the safety* of victims and their children is their central priority.

The audit's success required the commitment of many service providers and I applaud their willingness to open their practice to this scrutiny. I am confident that their commitment will now ensure that the findings of the audit are translated into meaningful improvements to practice that will enhance the safety of all victims.

I commend this report to you as we work together to reduce and ultimately eliminate family and domestic violence.

Sue Ellery MLC
Minister for Child Protection; Communities; Women's Interests; Seniors and Volunteering.

Foreword from Hon David K. Malcolm

In my capacity as Co-Patron with Mrs Ruth Reid, I am pleased and privileged to have been asked to contribute this foreword to the *Western Australia Safety and Accountability Audit Report 2007.* The authors of the report have significant qualifications and experience in the area of domestic violence.

The report is extremely comprehensive. I have studied it carefully with great interest.

I agree entirely with and fully support the recommendations. The first recommendation underscores the importance of "gathering, sharing and using information that makes visible who is doing what to whom and with what impact".

The importance of this aspect cannot be over-estimated in the understanding of the dynamics of a domestic relationship. I agree that its implementation will require an unprecedented level of communication and co-operation between agencies. It will also require a strong commitment to information exchange, including the sharing of all relevant information and strategies to prevent or deal with situations in relationships to make victims and potential victims safe from violent harm.

I note that the second recommendation flows from the first, although it is more far reaching in its implications for change. I am very impressed by the recommendation to fundamentally changing the current intervention paradigm in child protection cases, as there is a co-occurrence of child abuse or neglect and domestic violence. It is noted that this change would transfer the responsibility of controlling an offender's violence from the parent who is being abused, to the intervening agencies and the offender.

I noted that the third and fourth recommendations were identified, but not fully articulated by the Audit team due to the limited time available and that the full recommendations have been developed from the information gathered for the preparation of the report. The recommendations call for An examination of methods to address building adequate systems of accountability into interagency work on domestic violence-related cases. Further work is required to make transparent the theories, concepts and assumptions that underline current and proposed practices. The need for all agencies to adopt an agreed approach on a consistent basis is significant. While recognising that it may be impossible to reach consensus on all of the philosophical aspects of cases, it will be important to reach as broad a consensus as possible for the working groups to be established.

In particular, I have noted with great interest that the Audit Team adopted with their recommendation a call for three changes within the Armadale Domestic Violence Intervention Project (ADVIP), namely:

1. Change the Core Group purpose from solving problems on individual cases to using problems in individual cases to identify and resolve structural problems in interagency case-management processes. The goal here is to create a structure and working process that emphasises identifying problems that occur in a number of cases and are not unique to a specific case, analysing the cause of the problem, proposing solutions, and then providing leadership and help in implementing the proposed changes. While the Audit team did not suggest that ADVIP abandon the work it does on individual cases, it is suggested that the current emphasis on problems known to individuals who attend ADVIP meetings is far too narrow a focus for substantive change to occur.

2. The recommendations include a call for a tracking system for all cases involved in domestic violence that come into the civil and criminal system. This tracking system would be an effective tool for uncovering systemic problems. It could be used to monitor, for example, changes in arrest, prosecution or sentencing patterns, or the compliance rate of offenders to court orders and subsequent court action to achieve compliance.

3. It is also noted with approval the recommendation that ADVIP better utilise the "tremendous resource" it has in its membership. It requires the maximum use of the potential power of the ADVIP Interagency Safety Committee if there were more overt use of its capacity to effect change. I know it will involve linking with other regional policy forums. It envisages ADVIP expanding its involvement to regional and state levels, whenever intervention at those levels is required in order to make necessary changes as to reach goals of safety and accountability."

I fully support the implementation of the recommendations. I agree that the recommendations in the report provide ADVIP with five immediate and concrete ways to respond to the findings of the Audit. I am very confident that ADVIP has the capacity to change the operating procedures of the ADVIP Core Group and that the ADVIP Inter agency Safety Committee will modify the relevant procedures so as to provide an effective forum through which to guide agencies to implement the recommendations of the report.

The Hon David K Malcolm AC QC KCSJ
Professor of Law
University of Notre Dame Australia
Fremantle
Co-Patron of ADVIP

Acknowledgements

The Domestic Violence Safety and Accountability Audit[1] (Audit) represents the best of collaborations among government, non-government organisations, and people who are victims of one of this country's most common and devastating crimes: domestic violence. No part of society escapes the reaches of this form of violence, and no single effort can stop it. For more than 14 years, the Armadale Domestic Violence Intervention Project (ADVIP) has engaged in an interagency partnership process to change what has, for more than 100 years, been a 'hands off' approach to domestic violence. ADVIP's process and efforts have long been regarded as exemplary practices of interagency collaboration in this country. It is not surprising then, that it was this community—domestic violence agencies, government agencies, and the victims themselves—who sought a process to take those efforts to a deeper level.

Acknowledged here are those who have made this Audit project the success it has become and those who have been a part of ADVIP since its inception and contributed to its work.

Institutional change occurs most readily when people have a vision of change, and when those who control the political and economic resources to make the change share that vision. This Audit would not have been possible without the sponsorship of the Family and Domestic Violence Unit (FDVU) of the Department for Community Development (DCD or the Department) and the Department of Corrective Services (DCS, formerly the Department of Justice).

Nor would it have been possible without the endorsement of the Hon. Sheila McHale MLA, former Minister for Community Development, and the Hon. Sue Ellery MLC, Minister for Child Protection; Communities; Seniors and Volunteering; Women's Interests. The government departments that gave their support by agreeing to participate are thanked—Department of Corrective Services, Armadale Health Services, Western Australia Police, Department for Community Development—and the invaluable contribution of the non-government agencies is acknowledged.

Agency leaders are thanked for being open to allowing the Audit team to observe workers at many points of case processing, interview workers from all parts of their agencies, read case files and records, examine administrative documents, and put each of these agencies' actions under the microscope. In this vein, thanked are:

- Senior Sergeant Gordon Fairman, State Coordinator Family Protection, Major Crime Division, Western Australia Police
- Mark Glasson, Executive Director, FDVU, Department for Community Development
- Michael Hovane, Managing Solicitor, Child Support Legal Unit, Domestic Violence Legal Unit, Legal Aid WA
- Camille Inifer, former Manager, Gosnells Community Legal Service
- Matt Keogh, Chairperson, Starick Services Inc.
- Paul Maher, District Manager, Armadale District Office, Department for Community Development
- Lex McCulloch, former Executive Director, Community Development and Statewide Services, Department for Community Development

1 Based on the process designed by Praxis International: <http://www.praxisinternational.org/>.

- Terri Riley, Chief Executive Officer, Relationships Australia WA
- Sue Senior, former Manager Corrective Services, Department of Corrective Services
- Mal Shervill, former Assistant Commissioner, Specialist Crime Portfolio, Western Australia Police
- Jackie Tang, former Deputy Commissioner, Community and Juvenile Justice, Department of Corrective Services.

Thanks are also extended to the Hon. Sheila McHale and District Superintendent Shayne Maines, Western Australia Police, for participating, with Dr Ellen Pence, in the discussion of the significance of the Audit findings and how best to implement the corresponding recommendations.

Several practitioners and workers were observed at work, interviewed and followed around including:

- ADVIP Interagency Safety Committee and Core Group
- Armadale Court staff
- Mr Malley, Stipendiary Magistrate

Department for Community Development:

- Crisis Care Unit (CCU) Men's Domestic Violence Helpline and Women's Domestic Violence Helpline staff and Crisis Care staff
- Armadale District Office staff
- Cannington District Office staff

Department of Corrective Services:

- Damian Hart, Family and Domestic Violence Services Consultant and Coordinator

Relationships Australia WA:

- Marian Crossman, Women's Group Facilitator

Starick Services Inc:

- Starick House Refuge residents
- Anne Muir, SPEARS Court Support Officer
- Stephanie Hastings, Coordinator
- Wendy Watson, Housing Officer/Advocate
- Virginia Blackwell, Relief Advocate

Armadale Health Services:

- Dr Donald Coid, Director of Medical Services, Armadale Health Services

Western Australia Police:

- Senior Sergeant Chris Cassidy, Officer in Charge, Cannington Police Station
- Armadale Police, including the supervisor and patrol officers
- Senior Sergeant Gordon Fairman and Sergeant Pat Utley, Police ride-along
- Police Operations Centre
- Gosnells Police Station Officers

- Senior Sergeant Phillip Tonkin, Police Prosecutor
- Senior Sergeant Lance Ulrich, Family Violence Coordinator, South East Metropolitan District Family and Domestic Violence Unit
- Constable Cassie Ross, South East Metropolitan District Family and Domestic Violence Unit
- Senior Constable Kim Greenwood, South East Metropolitan District Family and Domestic Violence Unit.

The following individuals were involved in observing, interviewing, questioning, thinking and debating; for six days they left their busy schedules to conduct an Audit of institutional processes that have a huge impact on the safety of victims of abuse and on the likelihood of offenders changing their behaviour. They are:

- Arina Aoina, CEO Starick Services Inc., Chairperson ADVIP
- Sue Bradshaw, Health Promotions Officer, Armadale Health Service
- Holly Carrington, Manager Preventing Violence in the Home, New Zealand
- Dr Donna Chung, Senior Lecturer and Research Degree Coordinator, University of South Australia
- Daphne Cross, Team Leader, Department for Community Development, Armadale
- Trevor Davis, Inspector, Assistant District Officer, Western Australia Police
- Huia Gibbs, Domestic Violence Advocate, Starick Services, Inc.
- Michael Hovane, Managing Solicitor, Child Support Legal Unit, Domestic Violence Legal Unit, Legal Aid WA
- Ben Johnson, Research Officer, Planning Policy and Review, Community and Juvenile Justice, Department of Corrective Services
- Evan King-Macskasy, Group Administrator and Facilitator, Relationships Australia WA
- Dr Gaye Mackenzie, Audit Week Coordinator
- Sherrilee Mitchell, Senior Policy and Engagement Officer, FDVU
- Helen Stamp, Domestic Violence Solicitor, Gosnells Community Legal Service
- Cynthia Thom, Coordinator of Domestic Violence Programs, Relationships Australia WA
- Sergeant Pat Utley, Project Officer, Family Protection Unit, Major Crime Division, Western Australia Police
- Angie Wragg, Coordinator, ADVIP.

The Audit week was preceded by a tremendous amount of work by those who provided primary support for the Audit process and team. Literally hundreds of planning hours went into preparing for the Audit, including gathering material, scheduling interviews and observations, removing names, addresses, and dozens of other identifying notations from case files and records. The bulk of this work was done by:

- Dr Gaye Mackenzie, Audit Week Coordinator
- Arina Aoina, Chief Executive Officer, Starick Services Inc., Chairperson ADVIP
- Sherrilee Mitchell, Senior Policy and Engagement Officer, FDVU.

Consultant Dr Ellen Pence spent a week with the Audit team and Amanda McCormick helped prepare and analyse the primary texts used in the Audit process. Together, they brought extensive knowledge to the Audit team and guided the process to a successful and informative conclusion. The work of Canadian Adjunct Professor of Sociology Dorothy E Smith, who established the sociological field of institutional ethnography that Pence and McCormick draw on for their work, is also acknowledged.

In particular, the members of the reference group, who shared the vision for the Audit project from its inception, are acknowledged:

- Arina Aoina, Chief Executive Officer, Starick Services Inc., Chairperson ADVIP
- Julie Dixon, Manager Policy, FDVU
- Jennifer Gardiner, Department of Social Work and Social Policy, Curtin University of Technology
- Mark Glasson, Executive Director, FDVU
- Kedy Kristal, Chief Executive Officer, Patricia Giles Centre
- Sherrilee Mitchell, Senior Policy and Engagement Officer, FDVU
- Anne Oades, former Manager Community Engagement, FDVU.

Finally, the women who allowed the Audit team to use their case records, interview them, and observe them talking about the most intimate details of their struggles to protect their children and break free of the violence and abuse that defined their lives are acknowledged. Unfortunately, these women cannot be named here because the simple act of helping puts them at further risk of harm. Their case records and discussions highlighted the all-consuming nature of an abuser's capacity to inflict harm. The team became aware of the havoc abusers can wreak in the lives of their victims, particularly in a community inadequately organised to protect.

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Executive Summary

The Armadale Domestic Violence Intervention Project (ADVIP), established in 1993, is the first interagency effort in Western Australia to bring the criminal justice system, child protection agencies and community-based advocacy organisations to a collaborative process of intervention into cases of domestic abuse. In 2003, ADVIP and the Family and Domestic Violence Unit (FDVU) worked in partnership to explore the concept of conducting an Audit to determine the level of effectiveness of current responses to domestic violence.

In 2004, negotiations began with the members of ADVIP, most notably the Department for Community Development, the Department of Corrective Services, the Western Australia Police, Armadale Health Services, Starick Services Inc., Relationships Australia WA, and Gosnells Community Legal Services. In 2005, ADVIP members agreed to embark on an innovative process of self-evaluation by conducting a Safety and Accountability Audit. The Audit examined three core interventions: criminal justice, child protection and advocacy.

The Audit provided an opportunity for this community intervention project to engage its members in a comprehensive analysis of their interventions and responses to domestic violence. The Audit was designed to allow the interagency team an opportunity to select key points of institutional intervention in domestic violence–related cases to determine how the design of those processes maximised opportunities to protect adult and child victims of domestic violence while holding the offender accountable for the abuse.

The Audit occurred in five stages: preparation, information gathering, information analysis, making recommendations for change, and reporting on the process and findings.

The preparation phase included the following activities:

- determining the scope and focus of the Audit
- videoconferencing and teleconferencing with Dr Ellen Pence and Amanda McCormick, USA, Dr Donna Chung, South Australia, and Holly Carrington, New Zealand
- seeking agreements on how case files would be organised and analysed during the Audit week
- preparing case-processing maps and determining which key points of case processing to examine in the Audit week
- gathering documents, such as rules and regulations, administrative forms and case files, that related to each point of intervention that the team would analyse
- signing memoranda of understanding between ADVIP and participating agencies
- establishing the Primary Support Team
- employing an Audit-week coordinator
- forming and training the Audit team
- seeking permission from the women whose case files would be used during the Audit
- preparing the information gathered into folders for each of the Audit team members
- redacting all materials to ensure the information was not identifiable to the clients.

Information gathering began during the preparation phase as the Audit-week coordinator began to map out the system's responses to these cases and compile case files, case-processing records, regulations and administrative processes for the Audit team to review and analyse. However, the bulk of information gathering occurred during the week-long Audit.

Activities undertaken during the information-gathering included:

- interviewing practitioners most familiar with those processes
- interviewing policy makers, practitioners and victims of domestic violence
- observing practitioners in their daily work routines, including:
  - observing violence restraining order hearings at the Armadale Court
  - accompanying police on police ride-along and observing officers undertake their duties
  - conducting a focus group with women who have been drawn into these processes to understand their experience of the system's response
  - observing ADVIP Interagency Safety Committee and Core Group meetings
  - reading case files and background material on case processing.

Over the course of the Audit week, members were continually debriefed and met to analyse the data gathered. The Audit process required that the Audit team identify specific practices that compromised the safety of victims or failed to maximise the ability and willingness of the system to hold offenders fully accountable for the harm they caused. Team members were then asked to locate the source of the problematic practices in one of eight areas (see below). Workers assigned to specific case-processing steps were seen as being coordinated and organised through:

- the use of rules, regulations and directives
- the use of administrative processes and protocols designed for workers to use in case processing
- the application and availability of community and state resources to the practitioner, the process and the victims
- the use of methods to link workers to those who have acted previously on the case, as well as to subsequent intervenors
- the use of methods of teaching and training practitioners to act on and talk about the cases
- systems of accountability and supervision
- establishing a specific mission of the intervening agency, defining the function of the case-processing task at hand and specifying the specific task the worker is obliged to perform at any individual time
- embedding in policies, regulations, administrative procedures and case-management routines an authorised use of assumptions, language, concepts, and theories that shape the intervention.

These eight areas of investigation were talked about as 'Audit trails'. They provided a framework for limiting the scope of the Audit while also pushing the team to discover systemic, rather than individual, causes of poor outcomes.

During the analysis phase activities included:

- breaking into three subgroups that would investigate:
  - the intersection of child protection and domestic violence
  - the role of advocacy in domestic violence cases
  - the criminal justice system response to domestic violence cases
- organising daily Primary Support Team meetings to discuss and analyse information gathered from the day's activities
- preparing for a meeting with the Minister of the DCD, Executive Director of the FDVU and Dr Pence to raise some findings and discuss possible recommendations to address some of the problem areas identified
- preparing a meeting with the Police District Superintendent of the South East Metropolitan Region, where discussion took place on piloting a joint project with the DCD and the sharing of information
- bringing all team members together on the last two days of the Audit to discuss the findings and recommendations for Problem Areas One, Two and Five (see Section 4 – Collecting and Analysing Data).

The information was analysed by continually asking the question: Is ADVIP helping to keep women and children safe and holding offenders accountable for their violence and abuse? This question was applied to what the Audit team saw and read in the case files and other texts, information gathered during interviews with practitioners and observations of practitioners carrying out their duties.

The Audit team identified problem statements and asked the following questions: How is what we've learned a problem? What is our evidence? How is the problem produced? How do we solve the problem? The source of the problem was located by filtering the problems through the eight audit trails. Recommendations Three and Four[2] were developed in the course of bringing together the information for the writing of the report.

During the Audit week, members discussed specific problems relating to the way practitioners' daily work routines were organised. They focused on practices that could result in a lack of protection for victims or a missed opportunity to hold offenders accountable for their violence and abuse. This was done during daily debriefing sessions and during a one-day final debriefing session. A lack of time prevented an in-depth analysis that could have identified the sources of, and solutions to, all of these problems. During the final day of the Audit, five overarching problem areas were identified that seemed to link individual case-processing inadequacies together across agencies and case-processing tasks. The final problem area related specifically to ADVIP's role in intervention.

Below are the five problems areas identified:

1 In every intervening agency, it was found that information gathering, documentation and information sharing was inadequately conceived and coordinated to achieve the goals of victim protection and offender accountability.

2 During the writing of the report, Recommendations Three and Four were formulated from the information collated during Audit week and evidence sought from Audit members.

2 Interventions tend to hold victims of abuse responsible for offenders' behaviour in ways that undermine the goals of safety and accountability and frequently lead to increased, rather than diminished, risk for adult and child victims of domestic violence.

3 The current system of practitioners' accountability for victim safety is not adequately built into case-processing routines.

4 Throughout the whole system, practitioners are acting on assumptions and using theories, categories and language that are frequently inadequate to centralise safety and accountability in these cases.

5 ADVIP's current operating structure and processes are focused on across-agency cooperation in individual cases; ADVIP at times misses vital opportunities to identify and resolve systemic issues that compromise victim safety and offender accountability.

The final report is organised around these five problem areas. For each area, it identifies:

- a range of specific practices seen as problematic across a number of agencies, and
- observations and conclusions on how some of those practices were produced by the case-processing methods used to organise practitioners to do their work.

These problem areas do not include examples of individual failures by practitioners to act in protective ways. The focus was on institutional practices that compromise safety and accountability rather than on how individual practitioners meet the standards of competent interventions. The purpose was to locate problems in the system regardless of which practitioner might be handling the case.

Based on insights on how problems were being produced in case-management practices and routines, five recommendations for change or new work were made. The team felt these initiatives would move ADVIP toward solving many of the problems in the way agencies are organised that lead to missed opportunities for protection and accountability.

Each of the recommendations are task-oriented and require the formulation of new methods of coordinating workers in the legal and human service agencies. It is recommended that an interagency workgroup drawn from ADVIP's Core Group and the Interagency Safety Committee be formed to carry out the work on each recommendation. Implementing these recommendations will enable ADVIP member agencies to increase their capacity to protect victims of abuse and to hold offenders accountable.

The following recommendations can be found in Section 5, where a detailed description of how they will be implemented is included.

Recommendation One

Form an interagency working group that will design an interagency system for gathering, documenting and sharing information on cases that allows government and non-government workers to intervene effectively in domestic violence cases.

Recommendation Two

Develop new methods of child protection intervention in domestic violence cases that will shift the responsibility of holding an abuser accountable for the harm done to children from the non-abusive parent (typically a mother who herself is a victim of abuse) to the child protection and legal system (criminal and civil) and, ultimately, to the offending parent.

Recommendation Three

Produce an interagency framework and guiding principles for all government and non-government agencies to use in defining and describing interventions embedded in systems of accountability that focus attention on the intervention goals of victim safety and offender accountability.

Recommendation Four

Produce a set of guiding principles on how to account for the unique aspects of domestic violence in policy development, case-management procedures, and resource allocation in the Magistrate and Family Courts, child protection system, and related human service providers.

Recommendation Five

Restructure the Armadale Domestic Violence Intervention Project to enhance its effectiveness in identifying structural problems, analysing the reasons for the problems, proposing solutions and ensuring that changes are implemented.

The work of the Audit team has given ADVIP a blueprint for change that will take years to accomplish. The process has given those who participated in the Audit a new understanding of how institutions work in the lives of victims of abuse and how workers' daily routines can be organised to better position practitioners to centralise safety in their practices. The process has provided both the content and process for change. ADVIP and agency leaders committed to the Audit need to ensure that this investigation reaches its full potential to effect change.

List of Acronyms

AD(H)D/ADD	Attention Deficit (Hyperactivity) Disorder
ADVIP	Armadale Domestic Violence Intervention Project
CCO	Community Corrections Officer
CCU	Crisis Care Unit
CMA	Child Maltreatment Allegation
DCD	Department for Community Development
DCS	Department of Corrective Services
FDVU	Family and Domestic Violence Unit
PSI	Pre-Sentence Investigation report
RAWA	Relationships Australia WA
SMF	Statement of Material Facts
VMU	Victim Mediation Unit
VNR	Victim Notification Register
VRO	Violence Restraining Order
VSS	Victim Support and Child Witness Service

Introduction

Armadale Domestic Violence Intervention Project (ADVIP)

ADVIP[3] was established in 1993 as part of Western Australia's efforts to confront and end the widespread use of violence in intimate relationships. ADVIP's everyday work consists of fortnightly Core Group meetings to discuss problems in specific cases and to coordinate interventions in cases that practitioners bring to the table as needing special attention. These meetings feed information and direction to the Interagency Safety Committee, which meets monthly to look at more systemic issues in case processing and seeks ways to work collaboratively to promote prevention projects.

The assumptions behind the ADVIP model of interagency work include:

- Domestic violence is a patterned offence that frequently escalates in severity and frequency.
- Domestic violence is a pattern of abusive tactics that is both legal and illegal. The violence and the threat of violence is accompanied by a pattern of powerful tactics of control that work to position the abuser in a dominant role over the victim, who ends up acting not in her own interest but in that of her abuser[4].
- Domestic violence occurs in the context of an intimate relationship, where emotional, economic, and familial ties complicate an intervention process that tends to assume victims have the desire, the right, and the obligation to speak out in their own defence.
- The lingering cultural belief in a man's right to control his wife and women's subordination to men in marriage lurks in the background of these cases. Everyone involved—the abuser, the abused, and the intervenor—observes, listens, and speaks from a mindset that is connected to this historic consciousness and sensibility.
- Abusers benefit from the strong societal belief that government should stay at arm's length from the privacy of family life.

These characteristics of the crime of domestic violence require a unique approach to intervention. That approach must, at minimum, include:

- interagency communication
- protocols and policies that link a fragmented intervention system together
- the ability to talk about cases together and work collectively
- some common philosophical agreements about the basis of interventions
- methods to intervene directly with the offender to thwart his ability to use the power he has established over his victim, which shields him from the intervening system[5]
- a system of supports for victims that enhance their resilience and their ability to resist domination and abuse

3 See Appendix One: History and Structure of ADVIP
4 See Appendix Two: Power and Control Wheel.
5 Throughout this report, gender-neutral language is used when the phenomenon being discussed applies equally to each gender. Because of the gendered nature of domestic violence, 'he' is sometimes used when referring to offenders because to do otherwise (to use 'he or she') would be misleading. For example, 'he' is used here because, while a woman is sometimes the offender in a case and sometimes the predominant aggressor, it is rare that she uses violence to establish the kinds of powers to dominate being discussed.

- recognition that partnerships within interventions often have power differentials that affect the integrated response
- agreement on an understanding of the gendered nature of domestic violence, those affected by it and its effects.

The Decision to Audit

The FDVU formed a reference group with key domestic violence service stakeholders to explore the possibility of conducting an Audit to determine the level of effectiveness of the current response to domestic violence. In 2004, negotiations began with the goal of engaging in a comprehensive analysis of ADVIP's current interagency response to domestic violence cases. The goal was to determine how the community's ability to protect victims of domestic violence could be enhanced. ADVIP was selected because of its history and record of integrated interagency community response to domestic violence.

The Interagency Safety Committee agreed that the Audit[6] was an ideal process through which to examine the aforementioned questions. The committee felt that the Audit would create an opportunity to explore current practices and provide a strengthened sense of collaboration with which to move forward. In the initial contact with Praxis International, the Audit team was asked: What do you want out of this process? The team responded by saying that ADVIP wanted to know the following:

- Where are the weak linkages among intervening agencies, and how could they be strengthened?
- Are current practices keeping women safe and holding offenders accountable for their abusive behaviour?
- Is ADVIP meeting the needs of women and children who come into the system?
- Is ADVIP coordinating the responses of intervening agencies in an integrated manner that prioritises victim safety?
- What evidence is there that indicates ADVIP is effective?

Because ADVIP plays such a central role in collaborative work, it was decided to include in the inquiry an examination of ADVIP's processes, with the sub-question: Are the ways ADVIP is structured and operates effective in identifying problematic intervention practices and promoting change when necessary?

The Audit was the first of its kind in Australia. It was seen as an opportunity to pioneer a far-reaching and innovative approach to engaging both government and non-government organisations in a process of assessing the current intervention procedures of agencies intervening in domestic violence-related cases. As it was intended to centre the assessment on agencies associated with ADVIP, the inquiry was limited to interventions by the criminal justice system, child protection agencies, and associated community and non-government agencies that deal with victims and offenders of domestic violence. The Audit would not have been possible without the strong interagency collaboration that ADVIP has established over the past 14 years.

6 Based on the process designed by Praxis International: <http://www.praxisinternational.org/>.

The FDVU sponsored Dr Ellen Pence to facilitate the Audit process. Dr Pence is the co-founder of the Domestic Abuse Intervention Project, Duluth, Minnesota USA, and is credited for pioneering interagency collaborations aimed at confronting domestic abuse. She is also the creator of the Praxis Safety and Accountability Audit, which is now used in more than one hundred communities world-wide to assess multi-agency interventions in domestic abuse cases to evaluate their capacity to provide safety for victims of abuse and hold offenders accountable for their violence. The Audit process is intended to act as an assessment tool, a strategic planning tool for reform efforts, and an interagency organising tool to promote a method of working together that sidesteps much of the defensiveness and finger-pointing that can plague such collaborations.

The pilot ADVIP Audit was included in the 2004–2008 Western Australian Family and Domestic Violence State Strategic Plan[7] (Plan). The Plan was the culmination of comprehensive community and inter-government consultation to identify priority areas and focus areas, as well as high-level strategies. These would guide all government departments in future planning and implementing of policies and programs designed to increase the safety of women and children. Resourced by existing state funding, the Plan sought to identify gaps, shortfalls and overlaps in current responses. It was designed to better target funding and service provisions. The inclusion of the Audit in the Plan provided a unique opportunity to analyse current coordinated structures and facilitate a way forward in the streamlining of efforts aimed at the protection of children and ensuring the safety of women. The findings of the Audit offer a blueprint for change to strengthen existing coordinated responses throughout the state.

Normally an Audit of this scope and size would be conducted over several months. However, it was deemed to be essential to engage Dr Pence in each phase of the process, so it was decided to conduct what came to be called the week-long 'blitz Audit'. This began by the preparation of case files, scheduling interviews and observations, drawing maps of existing processes and selecting Audit team members. On Friday 25 November 2005, an eight-hour orientation and training session was held for the team members to prepare them for the week ahead. From 28 November to 2 December 2005, a number of interviews and observations were undertaken, a focus group of women from Starick House Refuge was organised, a 546-page child protection file and more than 45 police summaries were analysed, and 19 documents from the Department of Corrective Services (DCS) and 8 records of ADVIP Core Group minutes were examined.

On the fifth day of the Audit week, this information was consolidated, generating a list of more than 35 specific problematic practices which were analysed in depth. These were then categorised into five problem areas and five projects to implement new intervention strategies involving all the agencies participating in the Audit process were proposed.

Purpose of the Audit

The primary purpose of the Audit was to examine the ways in which the participating agencies of ADVIP are organised to centralise victim safety and offender accountability, with the goal of making recommendations to ADVIP on how it could enhance its interagency work.

7 See Appendix Three: Relevant Studies and Reports, Western Australian Family and Domestic Violence State Strategic Plan, 2004–2008.

The Audit Team

In the preparation stage of forming the Audit team, names were originally selected from ADVIP membership. However, to secure agency approval for participation in the Audit, negotiations were undertaken with individual agencies which agreed to nominate representatives. This resulted in a cross-section of representation that included lawyers, caseworkers, policy officers, academics, police representatives, therapists, domestic violence advocates and researchers.

The Report

This report provides a description of the Audit team's work and findings, background information on the Audit process and its underlying framework. The report is presented in six sections:

Section 1: Design of the Audit and its underlying assumptions.

Section 2: Preparation phase of the Audit.

Section 3: Information-gathering phase of the Audit.

Section 4: Analysis phase and the Audit team's findings.

Section 5: Audit recommendations.

Section 6: Appendices including background information and relevant reports.

1 Audit Design

1.1 Audit Method and Assumptions

For the purpose of this report, it was important to define what was meant by 'domestic violence'. ADVIP understands the term 'domestic violence' to encompass a broad range of acts committed within an intimate relationship and acknowledges that there are important differences in how violence within an intimate relationship is used, the impact that violence has on the victims and the implications of intervening safely to protect victims from further abuse.

Almost every case examined in the course of the Audit involved a systematic pattern of control, intimidation and domination. In sociological terms, this patterned use of violence and intimidation is referred to as 'battering'. Sometimes the victim of that abuse hit back; when she did, she also committed an act of domestic violence. There are cases where the violence is not part of a pattern of control, although the Audit process did not uncover any obvious cases of non-battering domestic violence. In most cases in this report, 'domestic violence' refers to violence in the context of 'battering'. This definition was used to develop the recommendations and is the foundation for their implementation.

When a woman who is beaten in her home dials 000 for help, she activates a complex institutional apparatus responsible for public safety. Within minutes, her call for help is translated into something that makes her experience actionable; that is, something upon which institutions can act. First, her experience will be processed as a criminal domestic assault case, but later it may be additionally processed as a child protection case, and it may eventually become a civil protection order or divorce case.

Over the subsequent 24 hours, many individuals will act on her criminal case. Over the subsequent year, the number of agencies and people who work on her case(s)—and, thereby, her safety—will increase dramatically. Police officers, court staff, emergency room doctors and nurses, police prosecutors, advocates, child protection workers, Magistrates, counsellors, children's advocates, legal advocates, education staff, women's refuge staff and support group facilitators may all become involved in a far-reaching chain of events activated by her original call for help.

In the past 20 years, many communities have incorporated criminal and civil justice reforms to improve victim safety and offender accountability in this chain of events. Laws have been changed, policies written, procedures revised and training conducted to accomplish this improvement. Nonetheless, the following questions remain:

- Are communities now safer for victims of domestic violence and their children?
- Are offenders held accountable for violence and coercion?
- Have reforms helped or hurt?

The Audit helps to answer these questions from the viewpoint of women and their children. While the Audit team is compelled to ask questions from the standpoint of women who are abused, the team itself is made up of practitioners working in the system as well as domestic violence advocates and experts. The Audit allows practitioners to look at how a woman's real-life experience of violence is retained or made to disappear in the handling of the case. In addition, it examines whether safety and accountability are incorporated into daily routines and practices of workers who act on her case.

Because it is structured to reflect the actual experiences and job functions of those who intervene in domestic violence, the Audit engages workers in the system in a practical, useful process of change.

The Audit is not a review of individual performances or effectiveness but analyses how workers are institutionally coordinated, both administratively and conceptually, to think about, talk about and act on cases.

The Audit team was charged with uncovering practices within and between systems that compromise women's safety. The team examined each processing point in the management of cases through interviews, observations, and a review of texts associated with the processing of cases, including any rules or regulations that shape workers' responses, such as administrative forms, instruments, actual case records and files.

1.2 The Eight Audit Trails

One of the assumptions underlying the Audit process is that workers do not individually choose how to intervene or engage in case-processing routines. They are organised and coordinated to engage in their work in ways that standardise workers' interventions so that, regardless of which worker is assigned to a case, the 'system' will respond in fairly consistent ways. In order to coordinate responses across individuals, agencies and disciplines, all intervenors in cases and institutions use a number of methods to organise and standardise individual practitioner's responses.

The Audit team focused its analysis on identifying and analysing those methods of coordinating workers, not their individual performances.

In this Audit, the Audit team specifically watched for eight methods[8] commonly used to standardise workers' responses in community and non-government agencies and legal institutions.[9] These eight methods became the Audit trails. Briefly, they are:

1 The use of rules, regulations, instructions and directives.

2 The use of administrative case-processing routines, such as intake processes, interviewing guidelines and report-writing formats.

3 The use of resources, such as quality of funding, materials, processes and personnel.

4 Embedding institutionally acceptable concepts and theories through the use of language, categories, matrices, case-processing administrative tools and directives, training curricula, etc.

5 Producing strong or weak links among intervening practitioners through interagency protocols, administrative case-processing procedures, documentary practices, directives, etc.

6 Articulating and enforcing an agency's mission, case-processing purposes and specific task or function in the work of an individual worker, so establishing job-function boundaries that tend to standardise what practitioners see as possible actions to take in a given situation.

7 Establishing systems of accountability, minimum standards of practice, and supervision of workers.

8 See Appendix Four: Eight Audit Trails.
9 The eight methods of coordinating workers actions are identified and described by Ellen Pence in her forthcoming book, *Making People Count: Assessing Case Management Practice in Human Service and Legal Institutions.*

8 Providing and requiring from workers minimum educational requirements, ongoing education, skills-based training in intervention practices, and the promotion of a philosophical orientation through professional journals, conferences, case consultations and staff meetings.

Below is a graphic depiction of the eight Audit trails used in collecting and analysing the data.

Figure 1: Eight Audit Trails

Source: Praxis International, *The Praxis Safety and Accountability Audit Tool Kit*.

1.3 Steps and Methods of the Audit

The Audit had six distinct steps:

1 Forming and preparing an Interagency Audit team.

2 Determining the scope and focus of the Audit.

3 Preparing case-processing maps and determining which key points of case processing to examine in the Audit week.

4 Collecting data from key points of institutional actions on a case and from linking together steps of case processing.

5 Analysing the data and identifying key findings.

6 Preparing a written report that articulates the process, key findings and their corresponding recommendations.

The Audit process is designed to be conducted by a team. Its design recognises that the team members are not researchers, academics or statisticians. Most are generally familiar with overall processes, have an insider's knowledge of the processes to be explicated and typically are experts on some particular aspect of case processing. Some are experts on working with victims and offenders of domestic violence and others bring an outsider's perspective. Each step of the process is used to help the team identify what is coordinating workers' interventions and their impact on workers' combined capacity to offer safety.

While the method draws on a form of research called 'institutional ethnography', and words such as 'findings' and 'recommendations' are used, it is important to understand this process as a method of 'seeing what is going on'. As such, it provides an analysis of how to change those practices that undermine the goals of intervention.

Internationally renowned Canadian sociologist Adjunct Professor Dorothy E Smith originally conceived the branch of sociology 'institutional ethnography'. Smith and Pence wrote a 'think piece' for the US Justice Department's Research Institute in response to inquiries about using the Audit as a method of investigation in criminal justice reform work in the United States.

Below, is an excerpt from that article[10] which describes the Audit as a method of institutional investigation:

> *The Audit's methods of investigation are straightforward:*
>
> - *focus groups with people whose experiences are being processed as an institutional case*
> - *interviews with institutional practitioners about:*
>
> *the context of the work they do in the larger process of managing the case*
>
> *the specific ways they act on cases at each institutional point of intervention, and*
>
> *the texts or reports they use or produce at each interchange between practitioners and the case in the process*
>
> *observations of practitioners actually doing their jobs, and*
>
> *analysis of all of the administrative and regulatory texts used by the institution to coordinate workers across time and sites of institutional action.*

10 See Appendix Five: The Praxis Safety and Accountability Audit — article prepared by Ellen Pence and Dorothy Smith for October 26 NIJ\OVAW meeting.

Since the focus is not on individuals, interviews and observations follow the classic field procedures of sociological ethnography (eg Spradley, 1979; Schwartzman, 1993; Emerson, Fretz & Shaw, 1995; Holstein & Gubrium, 1998). In large bureaucracies, the 'case file' is a key coordinating instrument and therefore, a primary object of inquiry. Text analysis further adds to the understanding of institutional actions, as texts are situated in and actively coordinate the work of practitioners.

Since institutional ethnography and the Audit process characterize institutional processes rather than individuals, there are no systematic sampling procedures. Instead, interviews and observations sample the work process at different points to ensure a sufficient range of participants' experiences.

This method gives reasonable confidence that the Audit locates the normal institutional function and normal range of cases that are processed. Practitioners along those points of intervention are knowledgeable about routine processes, and interviews tap into competence. The Audit design envisions most interviews and observations of practitioners to be with those who are considered competent and well versed in their jobs. The practitioners interviewed during the Audit process are co-investigators with the Audit team. Their intimate knowledge of how the institutional processes actually work in everyday practice and their first hand experience with the people whose cases are being processed supply many of the critical observations and insights of the Audit.

Established as a research procedure for sociology, institutional ethnography translates readily into participatory forms of research in which practitioners examine and evaluate how their own work processes, and the work of others, add up to outcomes beyond those they envisage. At the same time it provides advocacy groups, who often act in a coordinating role for the Audit team, with a non-hostile, methodical, in depth way of turning the attention of interagency coordinating bodies to a critique of how institutional processes serve and hold offenders accountable for their abuse.

This process folds organically into the interagency reform work already begun in so many communities but lacking focus or methods of promoting meaningful change. The process of analysing what's going on frequently points to the obvious solution. For example, let's assume that an Audit team has transcribed some twenty-five domestic related 911 calls, and then traced the flow of written information from the dispatchers, to the ongoing record of calls in the CAD (computer assisted dispatch) system, to the responding officers, to the final police report (if a report was made).

The team can now review this flow of information from the perspective of a prosecutor, who is representing the safety interests of the victim at the arraignment hearing; a probation officer determining if a defendant on his/her caseload has violated his conditions of probation; a CPS worker who uses the report to screen the case for possible child abuse; and an advocate, who decides whether or not to try and call this victim because of the level of danger she appears to be facing.

These perspectives offer meaningful insights into ways in which the ability of practitioners to centralize victim safety and offender accountability can be enhanced or limited in just the first few hours of a case.

The institutional process is assembled by means of work process and key coordinating texts (or by other coordinating mechanisms such as laws, regulations, agency directives, or the role of supervisors). Audit team members arrive at a practical understanding of the means by which institutions produce particular outcomes from the perspective of victim safety.

This attention to case management is highly useful in the measurement of safety because it does not presume, for example, that increasing the rate of prosecution alone will make victims safer. At the same time, it reveals concrete reasons for a low prosecution rate. As an investigative method, the Audit directs its users to focus on how work that is properly done can nevertheless produce undesirable outcomes – through the ways in which workers are institutionally organized to act on a case, are organized to conceptualize a case, and finally are coordinated with practitioners at different sites of intervention.

Focus on institutionalized forms of coordination, particularly texts, has two major merits: (1) because the focus is on work practices, an Audit team can identify particular problems in those practices; and (2) problematic outcomes that are caused by institutional organization can be identified.

By seeing how a particular conceptual or administrative practice compromises safety or accountability, the team is frequently pointed to a solution.

Institutions are organized and coordinated, for the most part, by means of standardized texts or standardized protocols for producing texts. Policymakers can change the protocol for writing a particular coordinating text such as a police report. On a broader scale, legal professionals can uncover organizational disjunctures, such as gaps in communication between the prosecuting attorney's office and the police. Rather than raising issues in arenas that are difficult to change (eg, public opinion or political climate), changes can be introduced at the level of direct interaction or service.

Changes at the ground level make the institutional process more likely to produce desired outcomes: in this case, enhanced safety for women abused by their partners, and increased accountability for domestic violence offenders.

1.4 Understanding Dimensions of Safety

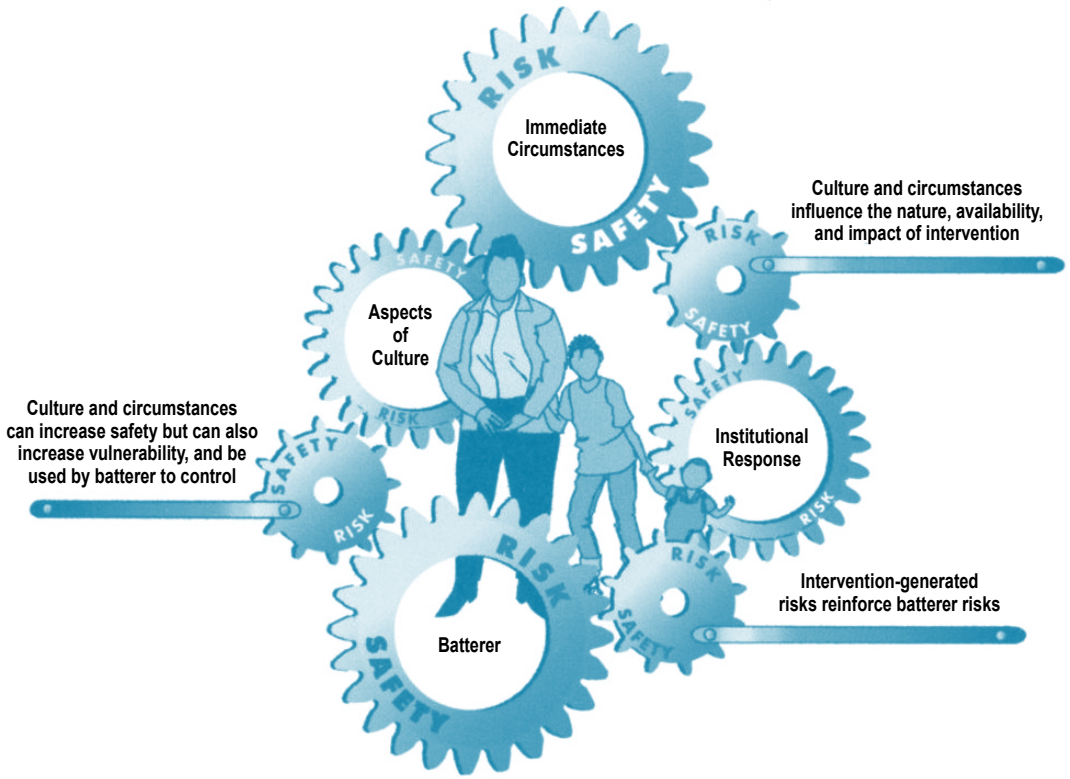
The Audit seeks to understand where, how, and for which victims of domestic violence an institutional practice is problematic. Hence, an Audit is always asking: Who is doing what to whom, and with what impact?

People's lives are complex, and the factors that reinforce or diminish safety and risk are also complex. There is no universal victim or offender of domestic violence. There is no single formula for securing a life free of danger, injury, and persecution. In other words, there is no single formula for safety and accountability. Diverse socio-economic factors (eg race, religion, class, addiction, employment, literacy, immigration status, language and sexual preference) affect safety and accountability. By using the eight audit trails, the analysis of case processing is able to reveal how institutional practices account for diversity and its implications for victim safety.

Understanding of risk assessment is often limited to the danger that an individual offender poses to his victim. In this regard, the following questions are asked:

- What types of intimidation and violence would he use in the future?
- How severe is this violence likely to be?
- What is the frequency of his abuse?
- Are there circumstances that might lead him to escalate his violence?
- Who/what helps him maintain his system of abuse?

Figure 2: The complexity of Risk and Safety



Immediate Circumstances

- Immigration status
- Limited English proficiency
- Poverty
- Lack of skills or education
- Professional or social position
- Abilities
- Mental illness
- Age
- Sexual identity
- Alcohol/drug use
- Rural isolation
- Dependence on adults
- Other

Aspects of Culture

- Race
- Nationality
- Culture norms and standards
- Childhood socialisation
- Community practices
- Belief systems
- Ethnic pride
- Language
- Class
- Religion
- Other

Batterer

- Physical violence
- Sexual violence
- Psychological cruelty and manipulation
- Economic abuse
- Damages her relationship to children

Institutional Response

- Imposition of dominant culture response or adaptation to cultural needs
- Promotion of victim autonomy or use of coercion
- Anticipate or ignore unintended consequences of intervention (e.g. arrest, deportation)
- Enhance or further damage victim's relationship with children
- Make battering visible or ignore it in custody and visitation
- Other

What is the risk?
• In the immediate situation • Of retaliation?
• Of abuse and violence? • Of unintended consequences of intervention?

Source: Praxis International, *The Praxis Safety and Accountability Audit Tool Kit.*

Aspects of culture can be a source of strength for victims of domestic violence, but offenders can also use them to control their victims. Interventions can pose their own risks when the dominant culture's institutions impose a 'one size fits all' response, which can diminish the potential safety and support available to victims. As such, the risks generated by an offender, institutional responses, the victim's immediate personal circumstances and aspects of a culture that might increase her vulnerability must be kept in mind.

The Audit team drew on the work of Jaaber and Dasgupta[11] as a framework for understanding risk and safety. They caution reformists to think in complex ways about women's safety when proposing changes to policies and procedures and provide four aspects for consideration in understanding both risk and safety. These are depicted in Figure 2 on previous page.

1.5 Who are the Victims of Domestic Violence?

Again using Jaaber and Dasgupta's work, descriptions of women who sought help from existing agencies associated with ADVIP are as follows:

- A young Thai woman; dependent on her husband's visa and severely abused by him, she stabbed him one night during an assault and was then awaiting trial for stabbing him.
- A white Namibian nurse with two teenage sons and a young daughter.
- A young Aboriginal woman with two young sons.
- A wife of a parish minister with two young children.
- A 26-year-old white Australian with a five-year-old son in his father's care and an 18-month-old son in her care.
- A Muslim mother of five children, one with a disability.
- A Malaysian woman on a temporary visa who had no income and two teenage daughters.
- A Seventh Day Adventist professional fighting for custody of four of her children.
- A Muslim accountant with young twin boys who was dependent on husband's visa and trying to avoid deportation.
- A white, English-born medical administration officer involved in a custody battle over her daughter.
- A pregnant 16-year-old, fourth-generation Australian.
- A doctor's wife; one of her two daughters was molested by a family member.

These descriptions were intended to identify the broad range of cultural, social and personal circumstances of the victims interventions were intended to protect. However, it was understood that these descriptions could not completely represent the complexities of individual lives.

The Audit team interviewed a number of these women in the course of the Audit, all of whom were experiencing significant levels of physical and sexual abuse from their abusers. At each point of intervention, the team asked: How does this process, form, rule, etc, treat differently situated cases in another way? Alternatively, does it homogenise people into a 'one size fits all' response?

11 Jaaber, Radhia A and Dasgupta, Shamita, 'Assessing social risks of battered women', in *A Guide for Conducting Domestic Violence Assessments,* Domestic Abuse Intervention Project, Duluth, Minnesota, 2002, pp 12–20.

It was assumed that a feature of modern-day institutions is to lump very different experiences into a single category and treat these variations as if they do not exist. The Audit team wanted to see when and how this assumption might occur in ways that compromised victim safety. Once such instances were identified, recommendations were made in an effort to reduce the occurrence and negative impact of such practices.

During the Audit, the team attempted to group elements of risk and safety under the headings of personal circumstance, culture, offender-posed risks and risks of institutional interventions[12]. In the course of a week-long Audit, it is difficult to grasp fully how class, race and religion cut across all aspects of risk. These factors influence every individual's interaction with an institution. While the Audit team tried to be mindful of these realities, it was not able to incorporate fully this way of thinking about safety in its work; however, the team did see the need to do so in ongoing reform work.

Figure 3: The Universal Person

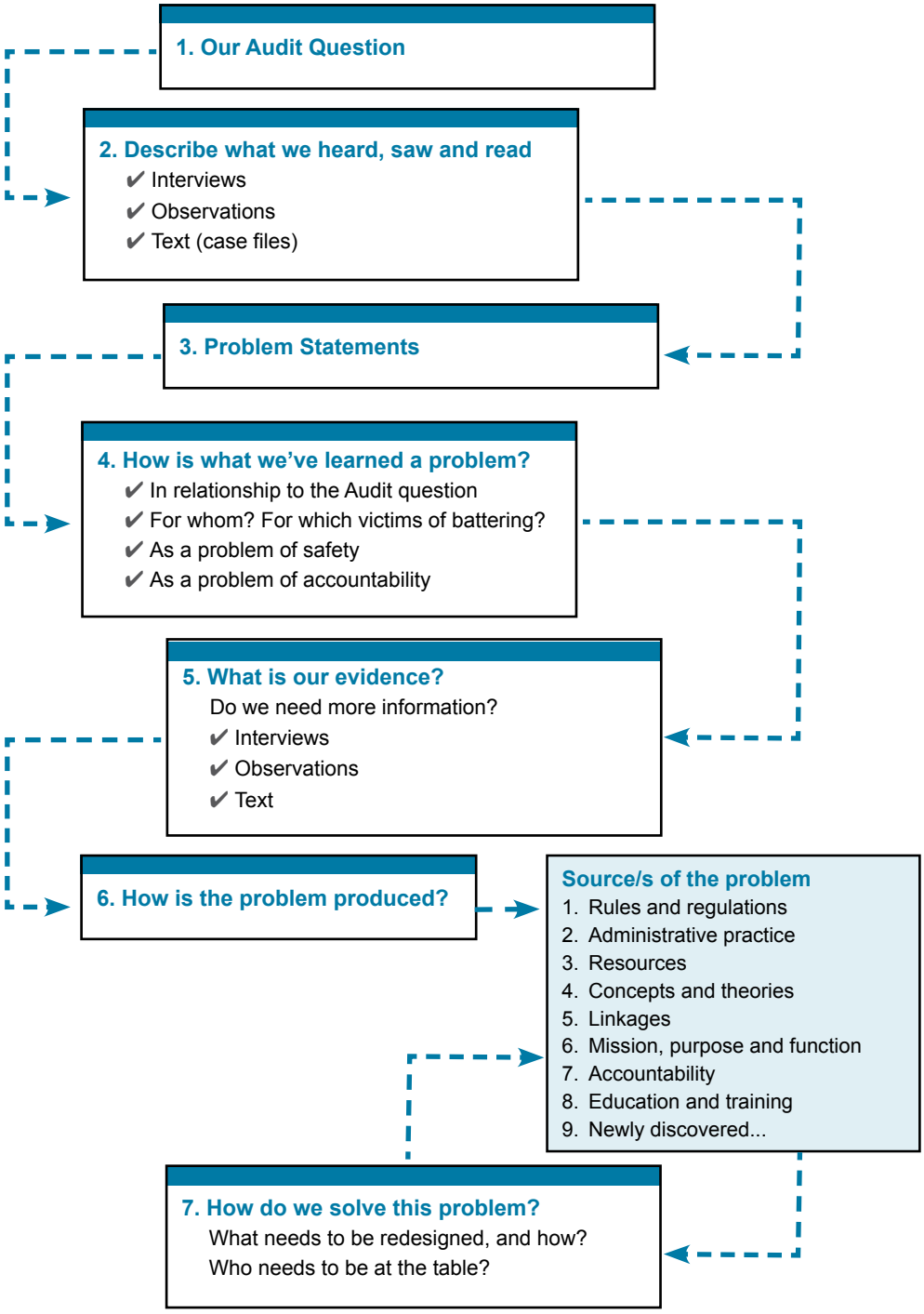
Source: Praxis International, *The Praxis Safety and Accountability Tool Kit.*

12 Jaaber, Radhia A & Dasgupta, Shamita, 'Assessing social risks of battered women', in *A Guide for Conducting Domestic Violence Assessments,* Domestic Abuse Intervention Project, Duluth, Minnesota, 2002, pp 12–20.

1.6 The Framework for Analysing Information

The following figure shows the framework used by the Audit team to analyse and discuss the information and impressions team members drew from the data available[13].

Figure 4: Safety Audit Analysis



Source: Praxis International, *The Praxis Safety and Accountability Audit Tool Kit*.

13 See Appendix Six: Example Interview and Observation Worksheet.

Assuming that the source of problems was not located in workers' skill or knowledge levels, this template gave the team the structure needed to maintain a focus on how practitioners were coordinated and organised to act in certain ways.

For each problem identified, the Audit team asked: Who is this a problem for? How is it related to safety and accountability? What evidence is there that this was a systemic problem and not simply an idiosyncratic practice of one worker? How did this problem come about [using the eight audit trails]?

This method of inquiry produced a way of thinking that diverted the Audit team from an inclination to go back to how individual workers handled a situation. This approach, rather than focusing on individual ineptitude, facilitates a substantive analysis of problematic practices.

1.7 Conclusion

The framing tools of the Audit were the:

- eight audit trails
- dimensions of risk and safety
- methods of collecting information
- framework for analysing the information.

Overall, the tools provided an unusual group of investigators with a set of instructions in the form of charts, formats and categories, while also coordinating and organising the work of the Audit team. The Audit team then set out on a course of investigation to identify and analyse the methods and tools used to process criminal, civil and child protection cases involving domestic violence in the ADVIP community. It can be argued that the best way to operate within institutions is to make these frameworks and institutional directives, which are key to case processing, transparent by asking, first, whether they serve to protect victims of abuse; and, secondly, whether they hold abusers and those who intervene accountable for the safety of victims.

2 Preparation Phase of the Audit

The Audit week was a very complex, multifaceted course of action that required agencies to work together in a way that they had not previously done. Normally, an Audit is conducted with one or two agencies and a clearly defined pathway. This Audit was going to be much more complicated. It would involve a comprehensive analysis of ADVIP's coordinated interagency response.

A core planning team formed the foundation of the Audit. This team, informally known as the Primary Support Team, became responsible for the preparation, planning and undertaking of the Audit. The Primary Support Team and entire Audit process was guided by Dr Pence, and the preparation of texts and case files was guided by Amanda McCormick. Ongoing consultations with both Pence and McCormick were crucial throughout the planning stage to ensure the success of the Audit.

One of the major obstacles encountered in the preparation phase was persuading agencies to participate in the Audit. During negotiations with government agencies, it became apparent that the information they could release was limited by legal and statutory governance, as well as by the layers of approval and support processes required in order for the agencies to engage in this Audit. Non-government service providers worked in a less constrained structure; they were also more readily able to see the Audit's potential to improve victim safety, and to make decisions on this basis. There were many instances of this difference between government and non-government agencies during the preparation phase of the Audit. For example, in terms of access to information, there were protocols regarding how information could be shared among government departments, but none to guide the flow of information from government to non-government organisations.

This lack of protocol impeded the task of persuading several government agencies to join the team and release vital information needed for the Audit. By contrast, once the cases to be analysed were identified, the non-government agencies needed only to call each client to explain the Audit's goals and ask for permission to provide information from the client's files to the Audit team.

The task became more intricate as it changed from seeking approval to conduct an Audit from agency administrators to negotiating the actual terms and conditions of the Audit's information-sharing process. Some agencies were reluctant to provide information without also selecting a person to represent the organisation on the Audit team; this representative would, in essence, ensure that the information was not used negatively against the participating agency. In some ways, this helped the Audit process because a number of experienced practitioners were assigned to the Audit team.

2.1 Bringing Together the Key Players

A videoconference, conducted by Dr Pence, was organised for ADVIP members and the Primary Support Team. Its purpose was to inform Audit members and policy makers of the Audit process and answer questions about the nature of the involvement of each participating agency.

Dr Pence facilitated a presentation on the steps of the Audit process and discussed what was required to prepare for the Audit. The Audit team planned to maintain regular contact, via teleconferencing and emails, throughout the preparation period. The objective was to ensure that the American consultants and international/interstate Primary Support Team members were kept 'in the loop'.

During the week of the Audit, the Primary Support Team was prepared to work closely to collate information, identify any recurrent themes emerging from the analysis of the three interventions to be examined and monitor the information gathered each day. The purpose was to capture as complete a picture as possible of the intersections between the pathways of child protection, criminal justice and advocacy in order to determine how effective ADVIP, as an interagency committee, was in protecting women and children and holding offenders accountable for their abuse.

2.2 Getting Everyone on Board

Due to the tyranny of distance, it was impossible to involve all members of the Primary Support Team in the day-to-day preparation for the Audit. Consequently, FDVU and ADVIP took responsibility for the tasks outlined below:

- FDVU scheduled meetings and prepared presentations for the middle and senior representatives of the government departments that were invited to participate in the Audit.
- FDVU's Executive Director sent a letter of introduction to the Executive Directors and equivalent officials of the relevant government departments. This letter requested approval for their agency's participation in the Audit and invited them to a joint presentation on the Audit process.
- The Audit became a fixed agenda item at the ADVIP monthly Interagency Safety Committee meetings, and discussions were based around which agencies were willing to 'open their doors' to the Audit. Once Starick Services was nominated to be the 'guinea pig' for the Audit, which other agencies should be involved to complete the whole picture was easily determined. Workshops, discussions, dissemination of Audit information, video and PowerPoint presentations helped to alleviate apprehension on the part of those being assessed. The Audit question that would underpin investigations throughout the Audit, 'How is ADVIP helping to keep women and children safe and hold offenders accountable for their abuse?' evolved from this process.
- The ADVIP Core Group selected five cases that had involved a minimum of three of the chosen six ADVIP intervenors. The goal was not to find a representative sample of cases in order to make quantifiable claims about what was occurring at different points of case processing; instead, it was to identify cases where most agencies associated with ADVIP had been involved and where the work done on the case was considered competent and within the scope of the workers' duties. This criterion determined what case files and related information were required from each agency.

It is important to note here that the working combination of FDVU and ADVIP was effective in that the representatives' understandings of the intricacies of the broader government and non-government systems, together with their knowledge of and insight into internal processes, helped the group to obtain the support of participating agencies.

2.3 Employment and Training of the Audit Week Coordinator

Peter Johnston, the former acting manager of the Armadale district office of the DCD, helped to develop the Audit coordinator's job description[14], duty statement and interview questions. The coordinator's responsibility was to prepare for the coordination of the Audit week, which included organising a work file on each point of case processing to be reviewed. These work files contained policies, case files, administrative forms for documenting cases and so forth. The coordinator's role would be to gather

14 See Appendix Seven: Audit Coordinator Job Description.

the information required for the Audit, which included mapping each of the participating agencies' case-processing pathways, arranging interviews and observations and drawing up schedules for the Audit week.

2.4 Mapping the System

The first part of the information-gathering phase of the Audit involved mapping[15] each interchange between a worker and a case file or the actual people involved in the case. These maps enabled the Audit team to think through: first, the scope of the Audit; secondly, who to interview regarding each time an agency took action in relation to a case; and, thirdly, what training might be necessary on each institutional process in order for Audit team members to become familiar with the working of the entire system.

2.5 Interviews and Observations

Agencies were contacted and arrangements made for Audit team members to interview practitioners, observe work routines and conduct a focus group with Starick House Refuge clients during the week of the Audit. The Audit process was explained to agencies and they were offered information on how the data would be used.

2.6 Formalising Memoranda of Understanding (MOUs)

From the point of developing the memoranda of understanding[16] to that of obtaining agency approval took more than six months. During this stage, the differing reporting processes and privacy policies of the government departments became apparent. Vigorous engagement with departments and several more meetings were required to secure approval for participation and the release of case-file information, with the exception of the DCD. Generic MOUs were used with all non-government agencies involved in the Audit. The difficulty of securing all MOUs in a timely manner had a direct impact on the formation of the Audit team.

Because membership of the team was not finalised until one week before the Audit, the team did not meet with Dr Pence as a full team until the training day, which doubled as orientation for the team.

2.7 Securing Confidentiality

At the commencement of the training, each team member was asked to sign a confidentiality form[17] to enable the team to discuss sensitive information throughout the week of the 'blitz Audit'; agreeing to the terms of the form allowed members to discuss cases openly and debate issues freely.

2.8 Determining the Scope of the Audit

It was difficult to determine the scope of the Audit until a clear picture was gained of what case-file information would be released by the agencies. The scope of the Audit was refined during the training day facilitated by Dr Pence. It was agreed three common interventions associated with ADVIP would be analysed: the criminal justice system, advocacy, and the involvement of child protection services in cases with a co-occurrence of child abuse, neglect and domestic violence.

15 See Appendix Eight: Agency Maps.
16 See Appendix Nine: Example Memorandum of Understanding.
17 See Appendix Ten: Example Audit Team Confidentiality Form.

2.9 Identifying and Collating Files

The preparation phase identified which case files and related information were required and negotiations for their release from relevant agencies were commenced. The Audit team obtained case files of selected clients from the DCD, Starick Services, and related information from the DCS. Police were able to release documentation that reflected their reporting processes, but not information related to the five cases.

Department/agency policies and procedures provided contexts for the cases.

2.10 Redacting Files

Each government department and non-government agency had their own strict policies on how files were to be redacted[18]. All files and related materials were redacted 'in-house' before they were released to the Audit team.

2.11 Getting the Basics Ready

Securing an appropriate venue

As the redacted files could not be taken off-site, it was important that the Audit room could be locked after each workday. The Gosnells Community Lotteries House provided the flexibility to meet in different room settings, depending on the day's schedule.

Catering

All afternoon/morning teas and lunches were provided during the Audit week.

Preparation of material for Audit team

Two folders were prepared: one file contained redacted case files and reports in chronological order for easy referencing, and the other had relevant background information. The background information included:

- The Praxis Audit Tool Kit on how to use the eight audit trails in interviewing and in text analysis, including sample interviews to demonstrate the different types of interviews that occur during an audit.
- Relevant legislation for each aspect of case processing that would be examined.
- Policies and procedures relevant to domestic abuse–related cases for most participating agencies (eg police and prosecution policies, domestic violence legislation, DCD guidelines, and so on).
- Maps or charts of how cases are processed in the three main areas of investigation (child protection, the criminal justice system and advocacy) and a chart of how ADVIP is structured and operates.
- A description of ADVIP's history and origins.

The Primary Support Team received additional information—including a workbook and a DVD of a lecture on how to use the eight audit trails, interviewing techniques, and text analysis—to provide guidance during the Audit.

18 Redacting refers to removing all identifying information from a document.

3 Information-gathering Phase

The information-gathering phase refers to the actual Audit week, when team members collected data from a number of sources, collated and analysed the information using the Praxis Audit methods to locate the origin of problem areas, and worked together to identify a number of possible solutions.

3.1 Audit Team Subgroups

The Audit team was divided into three subgroups, each of which focused on one of the three main areas the Audit would investigate during the week. The subgroups examined: child protection, advocacy and the criminal justice system.

Each subgroup was tasked with, first, examining the data collected in terms of their specific area of focus and, secondly, locating problem areas by filtering the data through the eight Audit trails. The Audit trails allowed the team to locate problems within a particular area of service delivery; once the source of the problem was located, it became easier to come up with a possible solution. The subgroups presented their findings to the wider group at the end of each day; it was during this large group discussion that the intersections of the three areas of focus were examined.

The Primary Support Team facilitated each of the subgroups and met at the conclusion of each day to discuss the findings and begin to 'piece together' the emerging picture. The team also drew up the following day's agenda and program.

3.2 Audit Week

Friday 25 November 2005

Dr Ellen Pence facilitated a full day of training for the Audit team in preparation for the week ahead. The training covered areas of the Praxis Audit methods to familiarise members with the processes to be used during the Audit. The team was introduced to the 12 problematic features[19] of institutional social management that members would use to analyse data collected from interviews and observations.

To prepare for the Audit week, members were asked to read the 'Jones' case[20] and to familiarise themselves with the policies, procedures and other relevant information given to them[21]. The Jones case file was chosen because all the intervening agencies were represented. To enable the reader to understand fully the context of the findings, the following is a brief summary of the Jones case (further commentary can be found in Appendix Twelve of this report):

> The case involves a family of five. Leanne, the mother, was the subject of several DCD investigations over a three-year period for neglect of her children. The father, Brian, physically abused one of the children, and two others were subjected to ongoing emotional harm as witnesses of their mother's abuse. Bobby, the six year old son, was physically injured on a number of occasions by the actions of his father. James (five years of age) had marks from his father on several occasions, while the four year old girl, Lorna, does not appear to have been

19 Appendix Eleven: Twelve Problematic Features of Institutional Social Management.
20 Appendix Thirteen: The Department for Community Development 'Jones' Case File.
21 Identifying information such as dates, locations and names have been changed to protect the individuals concerned.

physically injured at any time. Leanne was repeatedly abused and threatened during the three years covered by the case file. As she sought outside help and police protection, the severity of Brian's abuse increased. During the course of this case (from 1999 to 2003) the DCD had many contacts with Leanne. In the file, she is characterised as an unprotective mother despite numerous records of her attempts to seek help and place controls on Brian.

The DCD had few direct contacts with Brian during these periods, and in those they did have, Brian's behaviour was very threatening to workers. Leanne was frequently pressured to take action against her abuser, and she was required to engage in counselling and related services to avoid losing her children to protective custody. She frequently hid information from workers about the fact that Brian was living in the home. After Brian became verbally aggressive to workers following a home visit, and 12 months after the DCD's first contact with this family, the children were placed in foster care; a file note indicates that there were no refuge beds available at the time. The children were then placed with Leanne's parents until she arranged to fly interstate with her children to visit relatives.

In 2003, the Department received a report from the police 'concerning the welfare of the children'. The report states that the initial call from Leanne was of a 'domestic nature', with Leanne claiming that her ex-husband had been at the house and was refusing to leave. Police attended, and Brian had gone. Police then reported on the condition of the house and the welfare of the children. The Department file notes that, following receipt of the police report, 'there was insufficient information to base the decision to reclassify as a child maltreatment allegation on the observations of the home by police'.

Dr Pence also asked members to read sections of the Praxis Audit Tool Kit in preparation for the week ahead.

Monday 28 November 2005

On Monday, the team was divided into their subgroups and given a schedule for the day. It was arranged for team members to attend interviews, make observations and participate in a focus group with current and past residents of Starick Refuge. When team members were not attending to these activities, they were asked to complete group work around their area of focus. A debriefing session was arranged following the interviews/observations and the focus group, where the information gathered from these sources was discussed. Following the interviews and observations, team members were asked to complete feedback sheets where the information gathered was analysed in terms of the 12 problematic features in order to locate problem areas.

Tuesday 29 November 2005

Team members attended interviews and observations or began their group work, according to their schedules. Again, the teams were given time to debrief and discuss the information gathered from the day's tasks. Several systemic issues began to emerge from the data collection and recurrent problem areas were identified by the subgroups in their analyses of the case file, the corresponding documents, and the interviews and observations. Eventually, five overarching problem areas began to emerge.

Wednesday 30 November 2005

On Wednesday morning, Dr Pence, Arina Aoina and Inspector Trevor Davis met with District Superintendent Shayne Maines of the South East Metropolitan District Office, Western Australia Police. The purpose of this meeting was to talk about the Audit process and the types of issues being uncovering as part of that process. The remainder of the team carried on with their group work or attended further interviews and observations. Following the day's tasks and full group discussions, the Primary Support Team was able to articulate the overarching problem areas that had been identified. These were:

- information sharing
- a lack of clear accountability of service providers, or of the system as a whole, to victims of domestic violence
- the use of problematic assumptions in decision making
- too great an emphasis on victim's role in controlling their abuser's behaviour
- ADVIP, as an integrated interagency body, was not operating in a way that adequately protected victims of domestic violence or held offenders accountable for their abuse.

Thursday 1 December 2005

On Thursday, one observation was scheduled; the remainder of the day was organised around group work. The entire Audit team discussed their findings and began to identify the factors contributing to the overarching problem areas. The team then broke into subgroups and tried to answer the question: How does this problem come about? The subgroups started their deliberations by listing a number of problems relating to case management that may have had a negative impact on victim safety and offender accountability.

Each subgroup was asked to report to the full group by listing the problems identified by team members through their interviews, observations or text analyses. They then described to the full group how each problem was produced by the organisation of practitioners' work. For example, contributing factors may have included a certain aspect of regulation or policy, a particular administrative procedure or protocol, the use of a form, a specific course of action, or a problem in the current system of accountability. Members of other subgroups could easily add to the discussion because they had come across related problematic practices in their own interviews, observations and reviews of case files.

This exercise enabled the Audit team to begin to locate the origins of problems identified within the institutional methods of standardising and coordinating practitioners' work. Unfortunately, a thorough way of capturing each team's reports had not been organised. It became clear, when writing this report, that there could have been more examples to describe, had each been documented during the debriefing sessions.

Friday 2 December 2005

This was the last day of the Audit. The Audit team worked in subgroups to determine how the overarching problem areas were compromising the provision of safety and accountability. The subgroups then presented a list of possible solutions that would address the identified problems in

service response within their particular area of investigation. They then looked at the intersections of these three areas of investigation and broadly identified solutions that would promote a holistic response to victims and offenders of domestic violence.

Dr Pence, Arina Aoina, and Sherrilee Mitchell and Mark Glasson from the FDVU met with the Hon. Sheila McHale to discuss the Audit and findings. In preparation for this meeting, members of the Primary Support Team met to articulate the findings and recommendations in writing, which eventually became the basis for the way they are presented in this report. Feedback from the Minister was brought back to the Audit team.

The day ended on a very positive note, with team members highlighting how they thought the Audit process was beneficial and how the entire process made them think about their roles and responsibilities in a more 'in depth' way.

Following the Audit week, the FDVU, in partnership with the Women's Council for Domestic and Family Violence Services, arranged for Dr Pence to make a presentation at a breakfast seminar. The Hon. Sheila McHale was invited to open the seminar. Dr Pence gave an overview of the Audit findings that included presenting the overarching problem areas identified by the Audit team to an audience of senior government officials, policy makers and key domestic violence stakeholders. This provided an opportunity to articulate the findings and recommendations to an audience that was receptive and encouraged by the information provided.

Audit Week Schedule

Each morning and at lunchbreaks the Audit team met, elucidated collectively issues of concern, and investigated the validity of their findings from the previous day. The time spent *en masse* provided invaluable intense learning opportunities and extra support before the team broke into subgroups or attended observations and interviews. The Audit team regrouped at the end of the day to debrief and engage in dialogue to enhance each member's learning. This process was crucial to the Audit team's ability to comprehend the events that unfolded daily.

Audit Schedule	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
8.30–9:30	Meeting with Magistrate Malley at Armadale Court	**Observations:** Domestic Violence Court **Interviews:** Police Prosecutor DCD Armadale	Police interview with Superintendent Shane Mayne, Inspector Trevor Davies and Dr Ellen Pence	**Observations:** ADVIP Interagency meeting Subgroups work	All-day group work and debrief with Audit team facilitated by Ellen
9:30–10:00		Gosnells Police DCD Armadale	**Interviews:** Refuge Coordinator		
10:00–10:30	Focus group with resident women at Starick House refuge	Subgroups work	Audit team met in their subgroups from 9.00 until lunch.	Group work with Audit team facilitated by Ellen	
10:30–11:00					Meeting with Minister Sheila McHale, Ellen and Mark Glasson.
11:00–11:30	Group work with Audit team facilitated by Ellen	Armadale Police Officers DCD Cannington	Group work with Audit team facilitated by Ellen		Mark Glasson FDVU Executive Director addressed ADVIP.
11:30–12:00		Armadale Police Officers DCD Cannington			
12:00–12:30		Group work with Audit team facilitated by Ellen	**Observations:** Police Communication Centre		
12:30–1:00	Group lunch with Ellen	Group lunch with Ellen	Group lunch with Ellen	Group lunch with Ellen	Group lunch with Ellen
1:00–1:30	**Interviews:** Cannington Police Officers OIC	**Interviews:** DCD Armadale Gosnells Police	**Interviews:** Cannington FV project staff Maddington staff	Work in subgroups	Work in subgroups

1:30–2:00	Starick Court Support Officer Armadale court officers	RAWA Men's Group facilitator	SPEARS DV advocate	Work in subgroups	Work in subgroups
2:00–2:30	Armadale Police Officers DCD Cannington	**Observations:** ADVIP Core Group	Department of Corrective Services Maddington staff	Work in subgroups	Work in subgroups
2:30–3:00	**Observations:** Starick House Refuge Central Police visit	**Interviews:** Crisis Care staff **Observations:** Helpline operators	RAWA Gosnells - Women's Group facilitator	Work in subgroups	Work in subgroups
3:00–3:30	Debriefing and formal discussions with the whole group facilitated by Ellen	Debriefing and formal discussions with the whole group facilitated by Ellen	Debriefing and formal discussions with the whole group facilitated by Ellen	Work in subgroups	Work in subgroups
3:30–4:00	Debriefing and formal discussions with the whole group facilitated by Ellen	Debriefing and formal discussions with the whole group facilitated by Ellen	Debriefing and formal discussions with the whole group facilitated by Ellen	Work in subgroups	Work in subgroups
4:00–5:00	Debriefing and formal discussions with the whole group facilitated by Ellen	Debriefing and formal discussions with the whole group facilitated by Ellen	Debriefing and formal discussions with the whole group facilitated by Ellen	Debriefing and formal discussions with the whole group facilitated by Ellen	Close – and distribution of gifts from Ellen to Audit team
5:00–6:00	Prime Support Team meeting and debrief with Ellen	Prime Support Team meeting and debrief with Ellen	Prime Support Team meeting and debrief with Ellen	Prime Support Team meeting and debrief with Ellen	Prime Support Team meeting and debrief with Ellen
Subgroup members	**Facilitator** Ellen	**Criminal Justice Subgroup** Huia, Ben, Holly, Patrick, Michael, Donna, Evan	**Advocacy/ADVIP Subgroup** Arina, Gaye, Sue, Helen	**Child Protection Subgroup** Sherrilee, Angie Daphne, Trevor, Ellen	**Prime Support Team** Donna, Holly, Arina, Sherrilee, Gaye

4 Collecting and Analysing the Data

4.1 Problem Area One: Gathering, Documenting and Sharing Information

Gathering, documenting and sharing information is not adequately conceived and coordinated to enable the achievement of the goals of victim protection and offender accountability.

Institutions document and share information to accomplish a number of case-management goals. The process of documenting is a vital part of the entire case-processing mechanism. One of the goals of the Audit was to determine how agencies worked collaboratively to intervene in cases involving domestic violence, ie how agencies participating in ADVIP gathered and shared information to further ADVIP's goals of centralising victim safety and holding offenders accountable for their abuse.

In the initial training, the Audit team discussed how practitioners intervening in cases always gather information through a particular lens. The child protection worker, responding police officer, prosecutor, advocate and community corrections officer all deal with the same people, the same situation, the same past events, and the impact those events have had on peoples' lives; however, each worker gathers information in ways particular to their case-management mandate. They gather information and record events, but do not attempt to record everything that happened. Instead, they are 'charged' with documenting issues of institutional relevance.

Practitioners are not organised to gather information in anticipation of the informational needs of all intervening practitioners and agencies that are working to end violence in each particular case. They are organised to anticipate the needs of practitioners only in relation to very narrow aspects of case processing, such as evidence gathering, risk assessment and eligibility requirements.

During the Audit week, the team did not see the gathering of information as a neutral or even an objective process but one that is shaped by the institutional processes at hand. During observations, interviews, reading of case files and debriefings, the documentation process itself was constantly questioned, such as:

- What information was gathered, and how was it gathered? What forms, directives and training guides practitioners in what to look for, ask for and see?
- Did the process of information gathering make the victim's experience of abuse and violence available to intervening practitioners?
- Did the documentation process enhance intervening practitioners' understanding of an abuser's capacity to continue the abuse, the likelihood of abuse continuing, and the probable method of future abuse?
- How was the information available to practitioners recorded or documented?
- Was the information made available to subsequent intervening practitioners in ways that enhanced or diminished the goals of safety and accountability?
- How was the gathered and recorded information translated into an institutional way of talking about the case?
- How was the information translated into something upon which intervening practitioners could act?

- How did the institutional version of the case enhance or diminish the likelihood that victim safety would be the motivating principle of institutional action?
- How did the documentation and sharing of information that went on among practitioners serve to centralise safety?
- How did ADVIP's work serve to enhance any of these practices?
- Could anyone see who was doing what to whom, and with what impact? Does, or could, the practitioner (or process) adjust his/her intervention based on the answer to this question?

The Audit team also did not enter into the observing, reading and interviewing process without its own data-gathering lens or framework. One Audit member said: "I see now that I've had tunnel vision when reading these case files. When I read police reports, I look for very specific items, mostly related to evidence; but this [the Audit process] has made me want to know more, but the 'more' just isn't there." Another member commented: "We all want to know just the things we can do something about, and that means most of the information about what is happening gets left behind." A third member said: "I always assume that what I read is what happened. I'm seeing so many ways that we all put our mark on that information."

As the Audit team read the files, they were asked to note how practitioners are organised to document events of institutional significance, how they document information that explains the course of action taken, and how they document for subsequent intervenors. In addition, the task was to find how practitioners were organised to document information in ways that centralised victim safety and enhanced opportunities to hold offenders accountable for their violence.

On the last day, as the discussion on documentation was concluded and the team considered the information that had been gathered from various files on just one case, a team leader said: "We can count over two hundred contacts with this family by over 30 workers and a dozen agencies, and what do we know?" A law enforcement member replied: "Not much; none of the people intervening ever got a full picture of what was going on from where they stood." Another team member said: "But we have a lot of it here. This case went on for three more years than necessary. How different it all could have been for this woman and her children if we had done way back then what we've just done here today!"

The Audit team found that the collective capacity and process of the intervening agencies was profoundly inadequate in respect to:

- collecting meaningful information
- sharing that information in a timely and cautious manner with other intervenors
- linking that information to the actual experiences of victims of abuse
- crafting interventions that would maximise the protective nature of interventions

Although not all aspects of this problem were able to be explored fully, the Audit team suggested a method of beginning the process (see Recommendations in Section 5 of this report).

Below are six specific factors which were identified as contributing to this problem and limiting the ability to achieve the goals of intervention:

Contributing Factor One – Legislative Limits to Communication

The current legislation governing the collection, dissemination, and use of information in criminal and civil restraining order courts, the child protection system, and associated community and non-government sectors limits agencies and practitioners from collecting and sharing information in ways important for effective interagency interventions in domestic violence–related cases. In addition, there is no comprehensive interagency strategy to work effectively within existing laws.

The following are examples of both real and perceived legislative limits that have blocked practitioners from sharing information in ways that could have enhanced the ability of the intervening practitioner to provide protection:

- The police make available to the DCS a Statement of Material Facts (SMF), which includes the most recent incident and the victim's name. In putting his case together, the prosecutor uses the SMF, arresting officer's report, and a police brief that includes the offender's criminal record, list of witnesses, and so on. The SMF is limited in that it only gives an account of the most recent incident and does not show the history of the offender. Once the offender has been charged with a criminal offence, police are no longer involved in the management of the case. Between the court system and police, the police database is automatically updated of new charges, and the DCS is electronically notified of any new offences. Although there are some formal processes in place, valuable information is still lost in exchange between government agencies. Since only the details of criminal offences are shared, important information on incidents that do not result in the offender being charged—such as involvement of children in the event that lead to the arrest; past acts of harassment, stalking, and nuisance calls—is precluded from being passed on.
- Where there is an Intensive Supervised Order or a more serious case, the Magistrate must ask for a Pre-Sentence Investigation report (PSI) (a legal requirement under the *Sentencing Act 1995* (Western Australia), Part 10, Section 68). In compiling the PSI, the Community Corrections Officer (CCO) of the DCS can contact the victim to gather information on the offender's behaviour. If the CCO does choose to contact the victim then safety concerns may be discussed. It was found that this is the only time that CCOs can have contact with victims of abuse as part of their procedural requirements but discussions with DCS indicate this does not always happen.
- When the DCS refers an offender to RAWA to ensure his eligibility to access a program, the process of documentation sharing is, again, restricted. Formal arrangements between RAWA and the DCS allow for the exchange of the following information: a referral form that records details such as demographic information; the Spousal Assault Risk Assessment (SARA) in instances where the CCO has been trained in the use of SARA; and, depending on the location and relationship, the incident report and/or history of offences.

  In their assessment of an offender, RAWA relies heavily on the information collected from the offender, the data captured on the incident report, and the history of offences, when it is available. A report is then forwarded to DCS. There are limits to the credibility of an offender's testimony, and relying on this information to monitor the risk he poses to his victim is problematic. Over-reliance on this information has the potential to undermine a response that aims to protect women and children. RAWA notifies the DCS only when it assesses that there is a potential risk to the offender's partner; other information captured during the two-hour assessment remains confidential.

The Audit team found a number of ways that intervening agencies were trying to operate effectively within current legislation. Some examples[22] follow:

- Section 70A of the *Restraining Orders Act 1997* (Western Australia) allows the exchange of prescribed information between certain government agencies in certain situations. This section essentially allows police, the DCD and the DCS to exchange prescribed information about a person who has been issued with a Violence Restraining Order (VRO) or a related child. Under this section, information sharing is strictly limited to the above-mentioned departments; the legislation does not authorise information sharing with other government or non-government agencies, nor in situations of family violence where no restraining order has been issued. It also allows (but does not require) any person or agency to provide information in good faith to DCD without their being any breach of confidentiality or professional ethics.
- Another provision for exchange of information is contained in Section 23 of the new *Child and Community Services Act 2004* (Western Australia). In terms of what information can be exchanged, and with whom, this provision is much broader than the restraining order provision. It permits information exchange, potentially with any individual person and non-government agency. That is, it effectively allows the DCD to release information relevant to the wellbeing of a child to any relevant person or agency.
- In addition to these statutory provisions, in situations of family violence, there is, arguably, an ability to disclose information in order for individuals, agencies, and government departments to comply with their common law duty of care. In other words, under the common law related to the tort of negligence, information sharing/disclosure might be permitted or required under a general duty of care in order to avoid being negligent. Finally, the consent of the person to whom the information relates is usually sufficient in most legal situations to permit information exchange.

It should be noted that the clarification of some misunderstandings and conflicting interpretations of current legislation was beyond the scope of this investigation. Some examples of the effects of unclear legislation on the ability or willingness of agencies to share information are discussed below:

- Investigations revealed conflicting understandings relating to the dissemination of police reports. Many intervening practitioners could benefit greatly from having access to police reports on an offender's use of violence in present and previous relationships. The Audit team discussed the advantages that could result from a number of practitioners having access to such reports, not only of the incident that preceded arrest but also related reports on the offender. It was concluded that there needs to be more information on the legal constraints of providing access to these reports, as well as on the ethical and safety implications of allowing intervening practitioners access to them.
- A further example of legislative limits to communication is while the offender awaits trial during the court processes, which can take several months to complete, his behaviour is only monitored if he is released on protective bail conditions. Where the offender was charged and imprisoned, access to domestic violence offender programs or different forms of counselling was accessible to him only upon his release.

22 Summary of law in relation to information sharing as provided by Michael Hovane, Managing Solicitor, Child Support Legal Unit, Domestic Violence Legal Unit, Legal Aid WA.

- The Audit team found that informal methods of sharing information exist between agencies that did not wish to be identified, as they believed that these practices 'may be illegal in nature'. There were many instances where agencies felt that they were not legally able to share information, but at the same time recognised that it was vital to a shared approach to case management. While most practitioners were aware of the limitations current regulations pose to effective intervention there did not seem to be a way for the shortcomings of these regulations to be documented and then changed at a policy level. Instead, practitioners worked around the rules in informal ways, which lead to inconsistencies and the inability to build critical information sharing into daily work routines.
- There appears to be some confusion about the release of the PSI report and with whom this document could be shared[23]. In Section 22 of the *Sentencing Act 1995* instructions for PSI report preparation state: 'A written pre-sentence report must not be given to anyone other than the court for which it was ordered and the Chief Executive Officer.' This legislative boundary prevents information being made available to other intervening agencies that are involved in the case. The PSI report, although completed by the DCS chief executive officer, essentially belongs to the court. It is understood that amendments to the current Sentencing Act will be presented to parliament shortly. The amendments will allow information to be shared for case-management purposes when the offender is considered to be 'high risk' or for the purposes of research.

Contributing Factor Two – Absence of Information

There is an absence of an overall map, understanding and plan for intervening legal and human services agencies that:

- identifies what information a practitioner needs to act protectively in a case
- tells practitioners what information is available to them regarding a case
- tells practitioners how to gather, document and direct information for subsequent intervening processes
- allows, whenever possible, interventions to be based on an understanding of who is doing what to whom and with what impact
- informs practitioners of safety concerns regarding the dissemination of information on domestic violence cases
- protects clients' rights to confidentiality
- reduces the duplication of data-gathering activities in the system.

The following examples illustrate the absences described above:

- It is often not known what information a practitioner needs to act protectively in a case. For example, Police have the most up-to-date information on an offender's behaviour such as callouts to the home where he has not been charged with an offence or harassing phone calls to the victim. This information is valuable to practitioners also working on the case in order to gain a full picture of the offender and the potential risk he poses to the victim. Where there are concerns regarding the safety of children, child protection workers have the potential to access a range of reports

23 http://www.slp.wa.gov.au/statutes/index.nsf

from the police, the DCS and RAWA that would give them information on the offender. However, practitioners are often unaware that this information exists and/or do not think it is needed in their work to protect children.

- Practitioners are often not aware of what information is institutionally available to them regarding a case. For example, when women make applications for a VRO, their affidavits are available to child protection workers and Starick advocates. However, there was no evidence that these were actually read by practitioners to assist them in getting a full picture of a woman's situation.
- Although the ADVIP Core Group selects a number of 'frontline' workers to attend fortnightly meetings, the information discussed there is heavily influenced by what the attendees know about cases that are raised and by who raises a case for discussion. For example, the Core Group does not have a refuge or education representative, and attendance by the women's and offender's group facilitator is intermittent, as is that of the legal representative. Those who do come do not come with agency information but their own individual knowledge of a case. Useful information that would enhance the ability of the Core Group to identify problematic cases is available to them; however, it is completely reliant on individuals to raise issues. The group was lacking a methodical way to be alerted to problematic cases and to discuss those cases.
- Practitioners are often unaware of how to gather, document and direct information for subsequent intervening processes. A range of government databases that record important information pertaining to domestic violence and child protection cases currently exist. However, it was found that these databases are often not accessible to all the intervening agencies. For example, the Department of the Attorney General has a database which holds records of the criminal histories of offenders and the recent criminal offences with which they have been charged. However, this information is only available to court staff and police. Making such information available to intervenors such as RAWA, the DCD or advocacy services could increase their capacity to act protectively in cases.

During the Audit, many examples of practitioners gathering information to meet very narrow case-processing requirements became apparent. Evidence was found that this was not a course of action decided upon by individual practitioners but instructions issued by their governing agencies. For example:

- Magistrates gather information to establish a pattern of abuse and miss the opportunity to look at the context of the abuse.
- Child protection workers gather information that will support an investigatory focus, but they miss the opportunity to gain a full account of the history of domestic violence in a given situation and, thereby, a clearer picture of the safety and service needs of both the mother and her children.
- Starick advocates gather the information required for case management and present it at fortnightly meetings. However, advocates miss opportunities to collate critical information located in other programs within the organisation, such as court support, outreach and counsellors.
- Police officers responding to initial calls do not routinely ask for and document the victims account of the pattern of abuse; what forms of abuse is she experiencing, how often and how severe.
- DCD workers focus on documenting the witnessing of abuse by the children but leave unanswered so many questions about what the family members are actually experiencing. For example,

because Leanne kept insisting that Brian was not dangerous when he was sober, the Audit team wanted to know how he treated her and the children when sober, what changed when he drank, what it meant that he was the primary caretaker of the children, what the children did when he was violent toward her or Bobby, how Brian influenced her ability to parent, how Leanne thought the violence impacted the children and so forth.

Contributing Factor Three – Protocols on Information Exchange

In addition to individual practitioners being poorly positioned to exchange information important to the task of protecting victims, there are significant gaps in agency-to-agency protocols on information exchange.

Protocols are necessary to provide the foundation for individual practitioners to communicate on cases. A number of places where an interagency protocol was needed, poorly designed, or under-utilised was noted. For example:

- ADVIP members have no written protocols for the exchange of information at the Interagency Safety Committee or Core Group levels.
- ADVIP has no process in place that would flag a similar 'Jones' case for group discussion and action. As was discovered during the Audit, this case came up at two ADVIP meetings over a two-year period; however, both times it was in relation to a specific isolated problem.
- ADVIP does not have a concrete way of analysing the entire response to a particular case. Instead, the Audit team saw segments of the response being discussed, and the outcome was negative. For example, in the Jones case, on numerous occasions the victim, Leanne, reported her partner to the police for breaching VRO and bail conditions. She said: "I am very disappointed in the system that keeps allowing Brian to get away with breaching his parole. I have to contact police owing to Brian breaching bail conditions and restraining order [conditions], and I am fed up with having to call the police and go through a process that is not supporting me."

In the Jones case, Leanne appears to give up counting on a response. She assumes calling the police will not help. She tells her worker she placates Brian, she tries to control his violence by giving him what he wants. She says her attempts to call the police have backfired on her. She also tells her worker that she has learned to just tell outsiders 'what they want to hear'. She tells her worker she has been doing this with her. This conversation does not translate into an effort to work out a plan with the police or courts to be more consistent with Brian, thus removing Leanne's need to placate and cover up. Instead, it is recorded as evidence of Leanne being uncooperative. As will be discussed later in this report, it becomes the beginning of a label that Leanne is a 'compulsive liar' and 'unable to say no to Brian'.

It was noted how different this conversation would have been if the DCD worker's job was partially to coordinate with the criminal justice system to bring pressure on Brian to stop his abuse. The exchange below between Leanne and her worker transcribed from a tape of the meeting shows how the lack of coordination between the two legal systems results in the worker washing her hands of any responsibility for 'the system's response' to Leanne's situation. Leanne does not make these distinctions; for her the state's intervention is and should be all linked together. Below are excerpts

from the interview with Leanne and her caseworker where Leanne almost demands action from a system that she feels is not able to protect her:

- CW - *Brian is not stupid. What happens if he goes to school?*
- Leanne - *Need to write it down. School has copies of VRO, they have to phone the police if any man starts…I'm not intimidated anymore by Brian, I'm not running-not moving out. My priority is keeping the kids balanced.*
- CW - *What happens about picking up and dropping off kids?*
- Leanne - *I pick up and drop off kids at their classrooms. I have discussed with Lorna that any contact she has with her father, grandparents or I will take her. I want supervised contact for two years.*
- CW - *Sounds like you need to formalise it in the Family Law Court.*
- CW - *The department is concerned. Brian is an intelligent man. He's very plausible. He has threatened to kill the children.*
- Leanne - *He might kill me, not the children. I had four children. Brian needed to be 'stoked' all the time. (Leanne again raised the issue of why Brian was not charged for abusing the children and making threats).*
- CW - *The department doesn't have the right to charge - only the police can do that.*
- Leanne - *What do I need to do? Can't I bring (names school principle/teacher)?*
- CW - Referred Leanne to police for advice on this matter.
- Leanne - *If we take away all avenues of attention…*
- CW - *We can't control Brian. You can't. We need to make sure the kids are safe. How can we do this?*

Brian was not held accountable on a number of occasions for his ongoing harassment and abuse of Leanne – his violations were documented as technical breaches. In one incident, Brian was released on strict bail conditions, which stipulated that he was not to contact Leanne; the next day, Leanne attended the police station to advise them that Brian had called her. Police took her statement but did not follow up due to lack of evidence. Without documentation of the history of his pattern of ongoing violations of court orders, Brian's violations are viewed as isolated events and appear harmless.

ADVIP does not have a process by which to piece together a more comprehensive understanding of a case, nor even an expectation that prior to discussing aspects of a case, the group would attempt to put together a picture of the broader context. For example, a list of cases to be discussed is not sent to members before the meeting allowing them to find out what their agency knows about the changes in the case. In the Jones case, ADVIP addressed issues that were marginal to the central problem of Brian's violence and abuse, as well as the imprudent intervention of the child protection system. Both of these problems could have been identified earlier, allowing the DCS to act proactively with Brian much sooner than it eventually did, and allowing the child protection workers to take an approach that shifted the responsibility of controlling Brian's behaviour from Leanne to the child protection and criminal justice systems.

In the same vein, there is no central pool of information on high-risk cases. As noted earlier, the discussion of a case at ADVIP relies primarily on participants' knowledge of the case in question. There are limited records of past discussions of a case available to the group, but these generally occur only in response to a member raising an issue about the case. Assignments to follow up on cases are not always recorded or checked on in subsequent meetings.

The CCO of the DCS had no way of knowing how often police were responding to calls regarding Brian, nor was this information required for their case profile. They were only notified of police activity that resulted in an arrest of a suspect already on probation.

Police officers interviewed were unaware that they had the ability to provide vital information to the CCO to enable them to monitor the ongoing risk posed by the offender. The CCO did not know that this information was available to them. The opportunity to share this information is not built into report-writing routines; neither is there a plan for sharing information on cases related to domestic violence between the DCS and police.

Child protection workers are not consistently notified of police contact with the subjects of their investigation, such as Brian. The Audit revealed that when the practitioners did find out about police contact, they used it only as documentation of children witnessing abuse, rather than as an opportunity to offer protective measures to Leanne. (See Section 4.2.2 'Conceptual Practices'.) There is no process in place to allow the DCS and the DCD to share information on an offender. Consequently, in the Jones case, although this information was available to them, no one agency had sufficient information to monitor the level of risk Brian posed to Leanne and the children.

Section 4 of the *Victims of Crime Act (1994)* allows for the exchange of client information between the Police and Department of the Attorney General, without the consent of the victim. Information provided includes:

- Offence Report Number
- Type of Offence
- Brief details of the offence
- Name of the offender or alleged offender, if known
- The status of the investigation and prosecution of the offence by the Police Force
- Victim's full name
- Victim's date of birth and gender
- Victim's ethnicity
- Victim's residential address and telephone number, and
- Parent/guardian name, address and telephone number (if applicable).

The use of this information is restricted to allowing the Victim Support and Child Witness Service (VSS), which includes the Family Violence Service, to make an offer of service to the victim. Using this provision in the legislation, all victims of serious crime from assault occasioning bodily harm through to homicide are automatically referred to the VSS by the police following the lodging of an offence.

The Department of the Attorney General's Victim Notification Register (VNR) is a service that enables the DCS Offender Management Division to provide timely and accurate information to victims of crime regarding the offender who committed the offence(s) against them. During the Audit, little evidence was found that CCOs did indeed contact the victim although this information was readily available to them, nor was evidence found within the procedural manual for CCOs where contact with the victim occurs during case management of the offender. Section 7.3.14 of the DCS procedural manual for CCOs 'Contact procedures for Community Corrections Officers with victims of domestic violence' states:

> As part of advice preparation to sentencing and releasing authorities:
>
> > When the report is for the court, the victim of domestic violence should be contacted to confirm that the information provided by the offender is correct. At the same time, the Community Corrections Officer provides the victim with information on available services in the community.
>
> Further to this provision, the procedures also state:
>
> > If the Community Corrections Officer has any concerns with the offender during this time he or she contacts Relationships Australia and the Victim Mediation Unit (VMU) or contact these services on the victim's behalf.
>
> When the offender is not, or is no longer, participating in the Domestic Violence Program:
>
> > When the victim contacts the Community Corrections Officer, unless the offender has signed an authority to release information, the Community Corrections Officer will only provide information on available services in the community and will refer the victim to VMU or contact VMU on the victim's behalf.
>
> NOTE: The Community Corrections Officer does not contact the victim as part of case management, while supervising the offender.

Important information gathered by institutions but not acted upon or made available to others who can, significantly decreases the ability for institutions to act more protectively for victims. This is a clear example, where the DCS procedural guidelines give CCOs limited opportunity to contact the victim; however within the guidelines, the CCO is instructed to prioritise the safety of the victim. Specific services and databases exist to support the victim within the same department but are not linked to the case management processes of the CCO. This poses the question – How can an agency intervene in a safe and accountable manner if the victim is not central to that process?

In the Jones case, the CCOs advised Brian to make an appointment with RAWA to discuss his eligibility for an offender program, and they gave him responsibility for making the necessary arrangements. CCOs are not routinely advised of the VROs issued to offenders unless the order is violated and the offender is convicted of the violation. In the Jones case, Brian and Leanne attended a meeting with the CCO, who did not realise that this meeting constituted a breach of the VRO.

There are no protocols in place to share information between government and non-government agencies. In the Jones case, if formal processes were in place to share information between the DCD and non-government agencies, the advocates would have had the opportunity to take a more proactive role in advocating for Leanne's needs.

Neither Starick Services, Gosnells Community Legal Services, nor RAWA have formal processes in place to facilitate the sharing of information that would enable the ongoing monitoring and tracking of the offender in order to provide a greater level of protection to the victim.

Contributing Factor Four – Documentation

The documentation process for domestic violence–related cases is not accountable on a number of levels. For example:

- prioritising victim safety
- objectivity[24]
- contextualising commentary and documentation
- addressing the needs of subsequent intervening practitioners.

A case entry from the discussion between Leanne and her worker highlights this statement. Here, Leanne told the worker she had been covering up aspects of her contact and relationship with Brian – note the words the worker chooses to use when documenting this conversation. An entry from the file of an interview between the child protection worker and Leanne is cited below:

> Leanne advised she has been lying throughout her involvement with the Department and that Brian has been having regular telephone and home contact with the children. Leanne advised that she can say no to Brian however this has no impact on him whatsoever. Leanne advised that she has a ten-year habit of lying about her relationship and issues arising from the relationship, and she stated that she finds it easier to tell people what they want to hear. Leanne stated that she 'can't stop it'. Further, as a result of not being able to say no, she cannot keep the children safe. I acknowledged that she needs counselling to deal with her own inability to deal effectively with all of the issues, including her compulsive lying and inability to say no to Brian. I was very clear about her understanding of the agreement and reiterated that statutory action will be necessary if Leanne does not work with the Department.

While Audit team members were struck by the sheer lack of compassion in such entries, the focus was on the problem as structural rather than related to the attitudes of a particular worker. This focus ensured team members returned to the perception of concepts and assumptions built into the worker's case processing routines. The worker's job at this point is to keep Brian away from the children. The worker does not have a method to intervene directly with Brian so the focus is getting Leanne to do so. Leanne's vulnerable position to further violence, to retaliation, to having her children harmed is obscured and the worker's responsibility under the law to protect the children from Brian is the sole framework for documentation and intervention.

It is important not to assume too much from a single entry like this in a case file, but this is not a single entry. It is the beginning of the creation of what the Audit team called a 'factoid' (something that is said often enough to be taken as fact).

The Audit team discussed documentation such as this as being problematic in a number of ways. For example, Leanne is frequently labelled as unprotective of her children when in fact she is arguing with workers as to the best way to protect her children. Leanne believes that Brian's threats about

24 Of course there are differing opinions about the possibility of any intervention being objective and free from bias or preconceived beliefs about the people, the circumstances of the case, or the desired outcome. However, it was agreed that the intervention process should, as much as possible, engage in documentary practices that tried to preserve and reflect the actualities of a case, as opposed to a distorted institutional version of what happened.

killing his children are fixed in his belief that he is going to be denied access to the children. Leanne thinks if he can see the children he will be less dangerous. Discussions between Leanne and her worker show the disagreement and call into question the characterisation of Leanne as a woman who is unwilling to take care of her children. Notice that the worker never engages in a real dialogue with Leanne trying to figure out together how Brian might respond to different interventions.

The Leanne seen in this case file is fully engaged in trying to confront Brian's violence. She is trying to manage both Brian and the intervening practitioners. She does not want to hide in a motel. She believes she needs to stand up to him. She thinks that it is a mistake to add fuel to the fire by denying him access to the children. Is it fair to assume that she is completely wrong in this approach? Research[25] shows that men are most apt to harm their children when they are cut off from contact with them. In fact, Brian's threats become increasingly dangerous as he is cut off from his children.

Practitioners are also constrained as to what they can say and when they can say it. Nonetheless, practitioners have the capacity to document a case in ways that present their own interpretation of situations as objective accounts. Practitioners employ frameworks, assumptions, and concepts in the process of documentation, the use of which may or may not fully explicate the problem of 'spin'.

There were commonly held assumptions and theories used by practitioners in processing cases. It was troublesome that these assumptions and theories were applied to cases even when there were strong indicators that another explanation was possible. It was also noted by the Audit team that the application of these assumptions was not transparent and therefore conjecture looked like objective conclusions. The Audit team did not think that practitioners could document outside a conceptual framework, but this practice was made invisible when information was presented as if it was factual and not rooted in the concepts of the practitioner's discipline or governing institution, in an agency's philosophical orientation, or in the personal opinions and beliefs of the worker.

Leanne was first characterised as unable to protect her children by the child protection worker but the label stuck as she was referred to therapists for counselling and a psychologist for assessments. Yet a number of Audit team members' reading the entire case file found her to be a strong advocate for her children. From the first entries, she is seen as arguing with a school official about giving her child Bobby medication for children with Attention Deficit (Hyperactivity) Disorder [AD(H)D or ADD]. Leanne was resisting giving the drug even though it made Bobby easier to manage because it made him lose his appetite. He was getting thin and he became too lethargic on the drug. Leanne wasn't convinced he had ADHD and wanted to find organic medications for his problems. Later she was proven right when Bobby was diagnosed as mildly autistic, a condition that would not suggest prescribed ADHD medication.

Leanne was also desperately trying to hold things together in order to get a mortgage that would get them into their own house and out of the substandard housing they were living in. She maintained a full time job under incredibly stressful conditions, she was an active parent in school activities until the school began to file reports to DCD. Leanne basically complied with all of the requests by DCD

25 Campbell, JC, Sharps, P, and Glass, N (2000). Risk Assessment for Intimate Partner Homicide. In: Clinical Assessment of Dangerousness: *Empirical Contributions,* edited by GF Pinard and L Pagani, New York: Cambridge University Press.
Campbell, JC, and Webster, D (submitted). Rhe Danger Assessment: Psychometric support from a case control study of intimate partner homicide.
Campbell, J C, and Webster, D, Koziol-McLain, J., et.al (2003). Assessing risk factors for intimate partner homicide. *National Institute of Justice Journal* (250): 14-19. (full text: http://ncjrs.org/psffiles1/jr000250e.pdf)
Campbell., JC, Webster, D, Koziol-McLain, J, et al (2003). Risk Factors for Femicide in Abusive Relationships: Results from a Multi-Site Case Control Study. *American Journal of Public Health,* 93 (7): 1089-1097

to obtain services for her children and she made many efforts to help her husband sober up including seeking interventions from the criminal justice system.

In reading over 500 pages of her case file, the Audit team concluded Leanne was argumentative, but none of the team members saw her as non-protective of her children, quite the opposite. She was generally seen as a strong woman coping with an abusive alcoholic husband, a child with significant behaviour problems, and a weak criminal justice system response to her attempts to confront her abuser. As one Audit team member said: "The worker was intent on showing that the children were being exposed to ongoing domestic violence; nothing else seemed to matter. If Leanne didn't keep the children from seeing this abuse she was failing to protect those children. All of the information coming into the worker is filtered through that lens and so as long as Brian was out there threatening, or coming over, or hitting Leanne she was failing her children".

Finally, the documentation of any worker must be accountable to subsequent intervenors. In other words, practitioners must rely on what workers before them did or did not do, what they found out, and what they did or did not record. The ways in which workers transform the actualities of each situation into an institutional version of those realities is a crucial component of effective intervention.

In the Jones case, the factoid—the statement that Leanne was unable and sometimes unwilling to protect her children—obscured the problem of an unreliable criminal justice system response. Had all the breaches and all of Leanne's attempts to use the police and the courts been documented a very different picture would be painted. Her decision to placate Brian cannot be assessed outside of a realistic assessment of her choices given a legal system poorly designed to keep him away from her and the children. The question for members of the Audit team became, 'Is DCD preparing to place the children in protective custody because Leanne can't keep Brian away or because the legal system can't?'.

Leanne as a mother 'who is unwilling to protect her children' took on weight when subsequent intervening practitioners within the DCD acted on the case based on that information. For example, the influence of the factoid can be seen in the actions of the manager or team leader who approved statutory involvement and the decision to remove the children, and in the actions of the DCD staff who subsequently became involved with the Jones case. This influence can also be seen in the many file notes made by staff in the various sections of the Department. One case entry in one file was used to make these points, but the lack of accountability for documentation practices, subsequent intervenors' reliance on existing documentation, and the shifting of responsibility back to victims was present in many of the case files and documents. Police reports, psychological evaluations, therapist reports and PSIs all had indicators of similar documentary problems.

Due to time constraints, the Audit team was unable to explicate fully these problems but did find traces of them in every process observed. For example, in sentencing practices the PSI is used by the court to inform its decisions. When a CCO provides a PSI report to a Magistrate, the format of the report only ensures that the most recent incident will be mentioned. The PSI report is inadequate to help the Magistrate see who is doing what to whom, and with what impact. The format of the PSI report and other information available to the officer treats each assault as an independent event, as

opposed to part of an ongoing pattern of abuse, and does not allow for non-criminal offences to be presented to the court[26].

The problem here is not that the details set out in the PSI report are documented, but that they become the focus of the report. Scant documentation of an offender's history of abuse or the pattern or frequency of their abuse was found, eg factors that might make a victim more vulnerable to future abuse. For example, two of the women interviewed in the refuge were dependent on their abusers in order to stay in the country, and one was not allowed to work. Both women felt unable to participate in a hostile legal action against their abuser because of their immigration status. A third woman was being abused by a man who had continuously threatened to have her family hurt. Information about these forms of control and others like them is important to know when taking action to protect victims.

CCOs complete their assessment of the offender with only the Statement of Material Facts (SMF) and some information pertaining to the offender's criminal history—if the offender has been charged with an offence. The SMF prepared by the police only documents the incident at hand, though there may be several other police reports on the suspect. Furthermore, this collection of data misses any behaviour that is abusive but not criminal.

A slightly different problem was found in the child protection system. Child protection risk factors appear to be linked to the statistical probability of future harm. Therefore, factors associated with a higher chance of child death or injury are the focus of documentation. Two problems with this approach to risk assessment were discussed. First, the risk factors in domestic violence cases are different from those in cases of parental abuse, which tend to be linked to excessive discipline, poor coping skills and a lack of parenting skills. Secondly, different factors may indicate an increased risk to a child in cases of domestic abuse. For example, the statistical risk factors of a father killing his child in action related to spousal abuse include: an offender's belief that his partner has left him and will not return, an offender's obsession with his contact provisions with his children and an offender's former partner starting another relationship. None of these factors are part of the risk assessment process currently being used. However, two of the risk factors are actually solutions being promoted by the intervening agencies.

While the Audit team did not feel competent to suggest what kind of changes should be made in the process of risk assessment, it could see that the current system did not fit the cases examined.

Contributing Factor Five – 'One Size Fits All' Approach

The documentation of cases frequently fails to account for the unique nature of domestic violence, a situation that contributes to a 'one size fits all' approach to very diverse cases. At the same time, the case-management infrastructure results in many missed opportunities to adjust the intervention to the level of danger, violence and risk of future abuse.

The legal system has a number of ways of making distinctions between cases that are essentially the same kind of crime. The primary methods of distinction are: giving police the discretion to arrest; coding crimes by level, making some acts more serious and egregious than others (that is, distinguishing between summary offences, which are lesser crimes, and indictable offences, which are the more

26 See Appendix Eleven for an example of a PSI report writing format used by CCOs to prepare reports for Magistrates who use these reports to determine an offender's sentence.

serious); giving prosecutors broad powers to represent the state's (the people's) interest in pursuing justice and public safety; and giving Magistrates and Supreme Court judges a similar range of powers to enable them to act in the interest of the public when sentencing.

While the Audit team identified a number of examples of practitioners adjusting their interventions to account for the level of violence and its context, an equal number of cases where information gathering was not oriented to making these distinctions and, hence, where a 'one size fits all' or 'cookie cutter' approach, was applied. The team examined whether the current system of documentation allowed intervenors to determine if the event under consideration involved: *battering*, or a patterned use of coercion, violence or intimidation by a person against an intimate partner, resulting in the offender establishing dominance over the victim; *resistive violence*, or violence used in reaction to abuse by the victim against the predominant aggressor in the relationship; *pathological violence*, or violence rooted in an offender's mental or physical disorder/s; or *situational domestic violence*, an act of violence by one intimate partner against another that neither intends nor contributes to the control and dominance of the offender over the victim.

It was noted that police were beginning to apply a predominant aggressor standard to their arrest decisions to avoid arresting both parties for abuse in cases where one party was clearly the dominant aggressor. In making this distinction, police assessed the following factors when attending a scene:

- identify the predominant aggressor and/or victim
- examine and identify any defensive/offensive injuries
- consider the build, height and strength of persons involved
- take immediate action to ensure victim safety and protection as well as provide medical assistance if required
- identify and consider drug/alcohol factors when assessing safety of victims and children[27].

Below are team members' notes on interchanges they observed, read about in case files, or discussed in interviews where the absence of a more comprehensive understanding of the true nature of the domestic abuse was problematic:

> Prosecutors are organised to focus on the single report of the crime being charged. One prosecutor familiar with Brian's case said: "It took us five or six offences before we realised that this guy might be a real problem. You see, each incident seemed minor… but the accumulation of incidents started to paint a different picture."
>
> Although they have access to them, Magistrates are not compelled to read a woman's affidavit. This is often the only time a woman can give her account of the domestic violence she is experiencing.
>
> In looking for a pattern of violence, Magistrates use recorded incidents of assaults. This information comes to the attention of the criminal justice system only when an assault is recorded on a police incident report, which is then provided to the police prosecutor. The current response focuses on physical abuse, which limits the protection of women, due to

27 Extract from Police Commissioners Orders and Procedures Manual – OP-31.1.4 Family and Domestic Violence Intervention and Investigation. These procedures became operational as of 1 December 2004 and were articled in the Gazette and the Commissioner's Orders and Procedures Manual.

the assumption that any other form of violence is not as important to determining the level of protection afforded to women.

The Audit team found a number of problems related to this issue, including:

1 Risk is often ignored. In the ADVIP community, when a domestic violence offender is released from prison, the DCS is not required to notify the victim, thereby creating a potential risk. If police arrest a domestic violence offender and he is released on bail conditions, the DCS is not required to inform the victim of his release.

2 Initial interviews with victims and offenders are poorly designed to understand the needs of a client. Instead, they are designed to elicit information from the client that positions the agency to accomplish a specific case-management task. This is true of victims' encounters with all practitioners, but it is particularly obvious when a non-government worker conducts the initial interview.

Starick Services, like other service agencies, uses an intake process oriented to linking the client to their services, rather than obtaining understandings of what women entering their program are experiencing and what they need. Neither their intake form nor their practices are organised so as to gain a full picture of a victim's circumstances, her capacity to respond to the abuse, her support network, any social and personal circumstances that contribute to risk or resilience, and her immediate needs, other than housing and a protection order.

Information not gathered as part of the intake process included details of what was going on between the victim and her children, what kinds of conversations she wanted to have with staff, and whether she simply wanted time to talk and have someone listen. These absences are mentioned, not because the Audit team deemed them to be important inclusions in an intake process, but because the women in the focus group talked about them as being absent both in the intake process and their early days in the refuge. One woman stated: "Yes, they are here for us and they want to help us, but, at the same time, they avoid talking about what we need to talk about."

Child protection workers focused on the investigative task; being short on time, they often missed important opportunities to establish a positive relationship with the client. For example, a worker stated: "I have just a few minutes to get what I need in that first interview. The mum is usually reacting to the fact that I am there at all. I'm not there to interview her as a victim of domestic violence; I'm there to see if she can properly care for her children."

Dispatch workers, police officers, and prosecutors engage only functionally in their initial conversations with victims, and 'orientation' means that the needs of the victim are subsumed under the institutional case-processing task.

3 Workers are organised to collect information for very narrow case-processing purposes; thus, they lose many opportunities to gain a more complete picture of a case. Interventions from various systems were often short term and specifically focused on the agencies' mandates.

In the Jones case, the DCD looked through a 'child protection lens' at all times. The father and, perhaps, the mother were disciplining one of the children excessively. This child had some kind of hearing problem. He appeared to be suffering from some degree of autism, but this did not emerge early in the case. The workers focused on the child's injuries and tried to

ascertain which parent was abusing him. The parents were sent to parenting classes; in all the interactions with the family, the opportunity to uncover the autism and Brian's abuse of Leanne was subverted by the workers' narrow focus on the investigative aspects of their obligations and the immediate provision of relevant services.

The issue of Brian's violence toward Leanne was not treated as a primary problem in the case, nor was the child's health issue, which made him unresponsive to his parents' instructions. Issues of violence and abuse are rarely resolved without understanding the context in which the violence is occurring. Simply documenting the excessive discipline and sending Brian and Leanne to parenting classes fails to address the cause of the problems. It was, however, not a practice particular to one worker. Documentation in this case clearly shows a worker oriented to very specific, institutionally pre-formulated actions. Even the workers interviewed felt that their 'menu' of services and the help that they can offer tend to dictate what they observe and, ultimately, what they document. One worker said: "If I have five forms of help I can offer, and I'm obligated to offer some kind of help, then you can be sure that my write-up of the case will call for one or two of those pre-chosen services. Give me different services and I will probably see and understand different things."

DCS documentation distinctly stated that on one occasion Brian breached his VRO seven times before the police arrested him. The case file entry where Leanne feels let down by the system follows:

"I am very disappointed in the system that keeps allowing Brian to get away with breaching his parole. I have to contact police owing to Brian breaching bail conditions and restraining order [conditions], and I am fed up with having to call the police and go through a process that is not supporting me."

A police report filed by a supervisor after officers had attended a call concerning Brian was found in the Jones file. The report communicates the officers' concerns about the conditions of the house and the potential health risks to the children. Below are some excerpts from that report:

- 'The stench in the house was such that officers had to take regular 'fresh air' breaks.'
- 'In the kitchen area it was quite filthy and dirty, there were cockroaches and ants located in the draws and cupboards'.
- 'Clothes had not been washed in some time there were piles strewn throughout various locations in the house'.
- 'Located leaning against the wall in the hallway were two mattresses, upon further inspection they were quite dirty and smelt of stale urine very strongly'.

In addition, there are reports from the school that mention how dirty Bobby's clothes were and another that indicates the children have not brushed their teeth or hair in days.

There is a notation in the DCD case file that the condition of the house does not warrant an investigation; 'there is not adequate information to base the decision to reclassify as a CMA (child maltreatment allegation) on the observations of the home by police'. Because the DCD is not going to further investigate this as a form of neglect it disappears from the totality of circumstances being considered in Leanne's case until the end of the case when there is a

notation; 'Leanne has still not shown the ability to keep a neat and tidy house but…'. A cleaning service is offered and is used once at the home. When the case is closed it is unclear as to the nature of the cleanliness problem. The concern raised by members of the Audit team centred on the comments Leanne made on a number of occasions about Brian being the primary caretaker. Leanne states on several occasions that Brian did not want her to take care of her children. She said that he even controlled her ability to feed the children.

"I was never able to care for them. They were bottle fed before I got home, Brian would not let me look after them". The situation raised a number of questions; If Leanne has not been in a position to care for her children in this way, how is this being addressed in her counselling and services? A common tactic of abusers is to undermine the relationship between mothers and their children. This form of neglect of children's needs is pronounced considering how central Leanne's children are to her. This is an example of how issues very real to the children and the mother are sidelined when they do not meet an institutional criterion of neglect. It does not appear that any of the intervening service providers including the refuge services ever addressed this issue with Leanne yet it is likely a significant aspect of Leanne's struggle to establish what she said she needed. Leanne writes a safety plan to her DCD caseworker in which she states:

My plans for the future are the following:

- *To raise my children to be safe and happy.*
- *I wish to stay at my current address as a stable environment is paramount for my children's wellbeing.*
- *I will not be intimidated by ex partner in any way which means that I will not be bullied or pressured into anything. Any decisions or actions regarding the children will be on my terms.*

The data-gathering instruments designed to standardise how individual practitioners gather information were inadequate for many domestic violence cases, as they limited the ability of workers to act on the case. Workers do not independently decide when to gather information, how to do so, or what information they should gather; they are coordinated to do this through administrative forms and through the directives of institutions. Almost every information-gathering form—from the initial 000 report to the police report-writing format, to the refuge intake form, the prosecution charging paperwork, and the Magistrate's requested PSI report—was in need of at least some modification. All information gathering has to be considered in light of the intervention goals of holding offenders accountable for their violence and keeping victims safe from further harm. The gathering of information needs to happen in cognisance of how other practitioners need to intervene and how that information might be used to further protect victims.

The Audit team made some comments on the administrative tools used to standardise the ways in which workers intervene in cases. For example, it was noted:

- The format that guides a CCO's completion of a PSI report does not require information on domestic violence. Instead, it asks for a summary of demographics, such as the offender's marital situation, education, employment, financial situation, health and substance abuse. The only provision for an offender's history of domestic violence to be documented is under

the headings of court history and charges pending, categories restricted to showing criminal activity only.

- The police incident report that is completed when officers attend a domestic violence incident records only that particular call-out, which officers describe in a one-paragraph narrative. Questions the officers ask are directed by the format of the report, which does not capture the pattern of abuse or the level of fear the victim is experiencing.
- Intake assessments completed by advocates record the crisis at hand, which can often be seen from a different perspective the next day, depending on the stress level of the victim when admitted to the refuge. The full picture of her situation is not realised until fortnightly case management occurs.
- Tools for child protection and safety management do not reveal the context of a domestic violence situation, and they are weighted toward the risk that caregivers may pose to children. There is limited opportunity for workers to speak with the non-abusive parent to talk to her about the abuse she is experiencing.
- The DCS referral form used for external services directs the referral agency to assess an offender under different categories; however, domestic violence is not stipulated. The information gives the referral agency only the offender's current legal status, and no ability to seek information regarding the offender's history.

Further discussion of some of these information-gathering and sharing instruments takes place in Section 4.2.2 - Conceptual Practices.

Contributing Factor Six – Engaging Victims

Finally, a pervasive custom of practitioners being organised to treat people as data points, rather than engage in a dialogue that would constitute an enhanced engagement with clients was identified. This tendency leads to a number of missed opportunities to enhance victim safety and to ensure offender accountability.

At every level of intervention, practitioners were organised to solicit information from the client and then fit that information into some existing case-management framework. There was very little engagement of victims in discussions, which would have increased the practitioners' understanding of a case and may have lead to a partnership between the practitioner and the victim in responding to the violence. Some examples of missed opportunities to gather information or establish a relationship include the following situations:

- In a focus group held with former and current residents of the refuge, women said that they had very little conversation with staff even though they were living at the refuge. Almost every woman interviewed was on a waiting list to see a counsellor and feeling intensely anxious. They needed some time with staff to talk about all aspects of what they were going through. According to Starick staff, this dynamic was not so much a function of information gathering as it was an unfortunate shift in the role of refuge workers that had occurred over a period of years. Workers saw themselves as brokering services for residents at the refuge, rather than as engaging with them in a continuous dialogue and form of education. Even those workers who did see their role as educators and who had ongoing dialogue with women continued to

schedule appointments, rather than making these discussions part of the full experience of living in the refuge.

- Child protection workers did not follow up the issue of their son's behaviour in discussions with either Brian or Leanne. A lack of time; focus on the investigative role of the worker; an orientation toward clients as objects of service, rather than as partners in ending abuse; an inadequate assessment process; and an over-reliance on risk-assessment tools that do not require direct engagement with clients lead to missed opportunities to fully explore the dynamics of the family that was central to the abuse of Bobby, the only one of the three children being continually abused.

The problem was also evident in the legal system where women are not being asked pertinent questions that may give Magistrates insight into their experiences of abuse. Instead, it was found that, because the Magistrate was focused on establishing a pattern of physical abuse, he/she failed to ask any probing questions when victims talked about acts other than violence or imminent threats. In the Jones case the Audit team observed, most of the violence the woman was experiencing simply did not make it through the application for a VRO process. The system's response missed an important opportunity to engage with the woman.

The Audit team observed two applications for VROs with surprising outcomes:

- A grandmother applied for a VRO against her son-in-law. She testified that her son-in-law had been verbally abusive for a long time toward her, her daughter and the children, but that it had 'gotten physical' for the first time in a recent event. The Magistrate stated that the Supreme Court might question the need for a VRO if there had been only one instance of violence, as it might be a 'one-off', and that a pattern of physical violence needed to be established.

  The grandmother then mentioned that the verbal abuse had been going on for a long time and that he had a violent temper. She said she had witnessed him physically abusing his children, specifically mentioning kicking and pulling hair. She indicated that she had reported this abuse to the DCD and they had recommended her son-in-law participate in an anger management program, which he had not completed. However, nothing further had happened.

  The Magistrate did not grant an ex-parte VRO but told the grandmother that he would be summoning the son-in-law to a VRO hearing. He also suggested that she report the matter again to the Department, which she said she was already planning to do immediately after the hearing.

- Another *ex parte* VRO application heard on the same morning, with the same Magistrate presiding, was from a mother applying for one against her daughter. She said that she and her daughter always got on well, but that the other night her daughter had come to get some of her things from her mother's house and became verbally abusive. When the mother told her to stop her verbal abuse, the daughter became violent and there was 'fighting'.

  The Magistrate asked the mother to describe the nature of the abuse, and the mother again described it as 'fighting' with no further specifics. She reiterated that there had never been any violence like this before from her daughter or verbal abuse, only 'normal arguments'. The *ex parte* VRO was granted.

4.2 Problem Area Two: 'Victim Blaming' Practices

Interventions tend to hold victims of abuse responsible for an offender's behaviour in ways that compromise the safety of the victim, fail to deter the offender from abusing other victims, and undermine the justice and fairness of the legal system.

For many years, victim advocates have asserted that western-style legal systems, and the 'psy-'[28] professions that are closely tied to those systems, tend to blame women who have experienced physical and sexual abuse. Eliminating this practice has been the goal of many reform efforts; however, criticisms have largely placed the responsibility for this 'victim blaming' orientation on the attitudes and biases of practitioners within the system.

During the Audit, all members of the team were struck by the pervasive nature of this phenomenon. While the Audit team was not able to explicate fully all of the ways in which the interventions placed responsibility for violence on victims of abuse, rather than their abusers, it did conclude that it is a pervasive problem embedded, not in the mindset of individuals, but in the organisation of their work.

The Audit team spent a significant amount of time discussing the Jones case, on which all of the intervening agencies had worked, and decided to document this problem in relation to that case. This part of the report is focused on the Jones case in order to demonstrate the ways in which workers were organised to produce 'victim blaming' practices. This part of the Audit process enabled the Audit team to gain an understanding of how problematic outcomes—outcomes that no one intends—come about.

The team dissected the institutional ways workers are organised to intervene in a single case. In doing so, multiple sources of what have been labelled 'victim blaming' practices were located. DCD staff saw the Jones case as a typical response to a situation involving child abuse related to domestic violence. It was a case on which every agency involved in ADVIP's Core Group had worked. It was a case where no one practitioner acted outside the bounds of routine responses to similar cases. This single case reveals the ways in which workers are organised to act on cases. Through the example of the Jones case, the Audit team was able to examine the everyday routines workers used to process cases and assess the implications of these routines for victim safety and offender accountability.

While this analysis is based on a reading of this DCD case file, the reader should not assume that the identified problems occur solely within the child protection system. It is likely that this phenomenon of making victims responsible for the abuse they are experiencing occurs in related institutional processes. This is not so much a function of workers individual biases or attitudes as it is structured into the systemic way of conceptualising and then acting on these cases.

The entire Audit team identified an overarching problem in the Jones case as being that the combined responses placed too much responsibility for the abuse on the victim. The child protection subgroup was charged with locating how that situation came about through its interviews, review of the case file, and focus groups. On the final Audit day, the subgroup reported their findings using the eight audit trails, and members of the other subgroups added information they had gathered in their interviews, observations and case review.

28 The term 'psy-' refers to the psychology and psychiatry fields of practice.

The Audit Team's Analysis: How workers are organised to process cases such as the Jones'

The Audit team found that from reading the Jones case file[29] and interviewing DCD workers and court personnel, Leanne was held disproportionately responsible for the harm done to her children by Brian. Below are some of the conclusions made by the Audit team:

- Brian's use of violence against Leanne and their six year old son was harmful to both Leanne and Bobby, but most of the workers' efforts were directed towards pressing Leanne, rather than Brian, to change her behaviour.
- The violence against Leanne was not uncovered in a timely fashion, nor was the worker organised to work effectively with the police and the criminal justice system to control Brian's access to, and abuse of, Leanne and the children.
- Brian almost disappeared as a player in the case.
- Leanne was characterised as not protective of her children. She felt 'powerless to stop Brian' and 'fails to protect her children'.
- The criminal justice system did not use the power of the state effectively to control Brian's violence.
- Leanne needed services that were more tailored to her situation and available to her at the times she needed them.
- The shortcomings of the system's response were never openly discussed, and the blame for Brian's continued violence and harm of his children was placed onto Leanne.
- The full scope of the harm done to the children was never assessed and responded to including the:

  physical abuse by Brian of Bobby and intimidation of James

  fundamental undermining of Leanne as a mother/parent by Brian

  harm of being taken from their mother and put into foster care

  trauma of being put in a motel to hide because their father was threatening to kill them (there were no support services offered to any of the family members during that four day period)

  delay in properly diagnosing Bobby's behaviour problems as connected to autism

  impact of living in extreme conditions of disarray and lack of hygiene.

The Audit team asked the question: How does the focus on Leanne failing to protect the children, rather than on Brian's continued abuse, come about in practice, and what are its implications for Bobby, James and Lorna's safety and wellbeing? The team knew that this phenomenon was not unique to this case—many domestic violence cases were handled this way—so the team assumed the problem was systemic and not particular to this case, nor to the workers assigned to this case.

29 This case was open prior to the DCD restructure, which occurred in 2002 moving to a focus of enhancing the ability of workers to engage in strength-based interventions. However, most of the structural problems located during the Audit still exist and continue to compromise workers' ability to engage fully in what strength-based proponents of social work envision as an ideal intervention.

The task, then, was to see how Leanne's worker was organised to focus on her behaviour, rather than Brian's. How was she ultimately seen as a parent engaged in the maltreatment of her children? How did the worker miss opportunities to help Bobby? How did the intervention approach result in the caseworker establishing an adversarial and non-protective role with Leanne?

Also examined were the core methods that institutions, such as the child protection or criminal justice systems, use to standardise how workers talk about and act on cases. In order to understand how a particular problematic approach to cases comes about, the source of the problem in institutional methods of organising workers needs to be located. These methods interrelate; they do not operate separately from one another, nor can they be talked about one at a time.

First, job function, conceptual practices and regulations are linked together to partly answer the question of how the focus of intervention came to be Leanne's failures (not her strengths), rather than Brian's relentless pattern of abuse and control. From the interviews undertaken by the Audit team, it was identified that the tasks of a child protection caseworker change, based on the status of the case. The initial task is to determine whether child abuse or negligence occurred, and document that conclusion. At the same time, the worker assesses how dangerous the current situation is and makes a decision on whether to recommend to the courts the immediate removal of the child or to keep the child with the parents and work with the family on a plan to resolve the problems underlying the abuse. If the worker leaves the child in a home where there is a likelihood of continued abuse, he or she must put into place measures and plans that will circumvent the abuse.

Here, job function and the agency's mission are mediated by child protection laws and regulations[30], producing the first systemic problem in adequately addressing domestic violence cases.

The worker is organised to determine whether one or both parents are maltreating or abusing a child. In this case, the worker initially sees the case as one involving parents who are unable to cope appropriately with a child who has special needs. Later, Brian is seen as abusing the children (especially Bobby) and causing further harm by exposing them to the trauma of witnessing violence against their mother. The worker is also organised to determine whether either parent can protect the child from the abuse; Brian, by engaging in efforts to change his abusive behaviour, or Leanne, by keeping Brian away from the children. This directive to the worker is a key factor in the production of many of the problematic practices the team uncovered. Leanne is not seen as a co-victim of Brian's violence but almost as his accomplice. Like the driver of a get-away car, she is conceptualised as one who creates the conditions that allow him to cause harm. Her statements about Brian's abuse of her are treated as evidence of her role in exposing the children to violence.

The labelling of abused women who cannot stop their abusers' violence as 'neglectful parents' is an institutional practice that interferes with a worker's ability to build a relationship with the client, to form a partnership with the abused woman, and to elicit information about what is happening to the children from the abused mother. It is a major component of the creation of conditions for practice that are ineffective in achieving the goal of safety for children; it undermines the commitment to strength-based approaches to work with clients; in the eyes of abused mothers, it is unfair; and, as demonstrated by the Jones case, it is sometimes unsafe.

30 See Appendix Three. *The Acts Amendment (Domestic Violence) Bill 2004 – that amends the Restraining Order's Act 1997 (WA), The Criminal Code (WA) and the Bail Act 1892 (WA).*

If the task of the worker is to protect children from further exposure to the trauma of seeing their mother abused, and from the danger of being hurt themselves, then: What tools are given to the worker to help stop the abuser from continuing the abuse? The answer leads to one of the recommendations of this report - the testing of a pilot program linking workers to the criminal justice system in an effective way. Currently, the worker has only the powers of persuasion and coercion. She or he can try to persuade the abuser to seek help and to stop the abuse for the good of his family. This is not a course that the workers interviewed felt was likely to produce results, and it was not a course of action workers felt skilled in taking. The second course of action on the workers' part is to have the mother persuade the abuser to get help, stop the abuse, or leave and stay away.

The worker uses the power of persuasion and then coercion. However, the only coercive power the worker has is to recommend that the children are removed from the home if the abuse does not stop. This reality shapes every interaction between a worker and a mother who is abused. The Audit team concluded that in many cases, such as the one analysed, if the worker was linked to the criminal justice system, police, Magistrates, CCOs and Family Court Judges, cases like the Jones case would be resolved faster and with less trauma to the children. There would be less undermining of the children's relationship with their mother and less opportunity for the offender to commit further acts of violence.

Such an arrangement would, however, require a court that was consistent, clear and unyielding in its enforcement of its orders. None of the caseworkers interviewed felt that it was possible for the courts or law enforcement to achieve such consistency. While there was a fairly consistent enforcement of VROs by police when the offender is found to be physically breaching his VRO, the court's enforcement of its orders through the imposition of consequences for offenders was erratic. Consistent enforcement on which a caseworker could rely would require an agreement between agencies and the judiciary.

In the current system, the worker is not organised to act as an advocate for mothers trying to raise their children in a context of violence, stalking and constant emotional abuse. However, this problem is not the result of an uncaring worker but one organised to treat victims of domestic violence who cannot stop their abusers, as neglectful parents. The answer to the team's initial inquiries in interviews and discussion with practitioners about this problem was: 'The system can't put a guard outside her house; she is going to have to 'cooperate' and keep him out. If she won't do that, we have no choice but to remove the children'. This was heard from Magistrates, police and prosecutors; however, reading the Jones case file led the team to a very different conclusion. The police and courts had more than 20 contacts with Brian, most of them initiated by Leanne calling or visiting the DCD, in some cases with a drunken Brian in her car. The police did in fact arrest Brian on a number of occasions, but he was continually allowed to sidestep any consequences for his violence. As the violence and breaches of VROs and probation conditions mounted, Leanne was characterised as unprotective and unwilling to take steps to protect her children.

The case file contains no comprehensive assessment that details all of the violence, threats and abusive acts against Leanne or her children. For the caseworker, each encounter with Leanne or Brian had a very narrow purpose; none of which required a comprehensive assessment of the extent and impact of the abuse on Leanne or the children. As a result, no one in the DCD had a full picture of her family's situation. However, as the team read the file, a picture emerged of a pattern of coercion and violence that seemed to worsen as Leanne sought outside help and as Brian began to feel that his children would be taken away.

Summarised excerpts[31] from the case file, which began in September of 1999 and ended in December of 2003, are given below:

Many notations in the file characterise Leanne as unprotective or powerless; for example, a caseworker noted:

> *In the past, Leanne failed to act protectively by allowing Mr Jones to return to the family home. This is possibly due to the chronic and intense nature of the violence to which Leanne has been subjected to over a significant number of years.*

Despite numerous notations in the file about Leanne's attempts to protect her children, call the police, hide, and confront Brian, a caseworker noted:

> *Leanne was only able to commence working pro-actively with the Department to ensure her children's safety and wellbeing once she understood the real risk of her children being apprehended and placed into alternative care.*

The psychologist conducting an evaluation of the children stated:

> *Due to the constant physical and psychological abuse from Brian, Leanne has in the past felt powerless to oppose his aggression; as a consequence, has continued to be non-protective for both herself and her children.*

In addition, caseworkers documented three years of Leanne's struggle to confront Brian's violence, her children reported that she actively sought to protect them, and criminal court records show that she enlisted the help of police and the courts over and over again.

> In an interview with a psychologist, Leanne's daughter Lorna stated: *He drinks lots of boobs [booze], and when he hurts Mummy, she rings up the prison … Mummy presses emergency button to get the police if he comes around. She is scared that Daddy will come back.*
>
> Bobby reported that his parents fought 'a lot', and when this happened his mother took the children out to 'McDonalds, the museum or the zoo'.
>
> Leanne did not want to leave the family home, as she was in the process of buying it, and she needed to stay near work to keep the house and the children. She was very anxious to keep her job.
>
> Brian was arrested on a Friday. Leanne requested legal help and wanted to know whether she could go home until Brian's next court hearing. She stayed alone in a hotel over the weekend. An advocate followed up and reported to Leanne that Brian was in prison and would be held until his hearing. Leanne returned home for Bobby's medication; Brian was there, not in prison, as she had been told. He kicked her mobile telephone out of her hand when she tried to call police. Leanne talked him into letting her call the DCD to discuss the children.
>
> Brian came to Leanne's workplace drunk and looking for money. She left work to take him home, and she refused to give him money, as she'd given him some that morning. He became more angry and irate in the car, yelling and swearing at her. When they got home, he kicked the car and banged the windows. He then assaulted Leanne; punched her in the head, knocked her down, and kicked her until a neighbour came to her assistance. Leanne then drove to a police station to report the incident.

31 Many of these excerpts are summarised from the actual case file, in some instances to protect the identity of practitioners and family members and, in others, to ensure that the file notations make sense to the reader.

> Brian came to Leanne's workplace, again intoxicated and demanding to see her. She persuaded him to get into the car and then drove him to Armadale police station, where he was arrested.

During this period, in addition to Brian's unchecked harassment and violence, Leanne dealt with a child who was diagnosed as having AD(H)D (and later re-diagnosed as having a form of autism) and constant worry that she would lose her job. At one point, she attempted to obtain a loan for her house, so needed stability, which made her reluctant to go into hiding or leave the area. These ongoing life situations became far more difficult to manage while she was being abused. These matters were discussed with her, but they were not a focus of intervention. The worker seemed constrained as to the kinds of problems she could work to resolve by a fairly narrow case-management function. The file contains no indication that the worker had a way to link all of Leanne's life circumstances together to propose solutions that fitted Leanne's experience of the problems she faced as a mother.

Several notations in the file indicate that Leanne actively opposed the continued use of drugs for AD(H)D to medicate Bobby because of their side effects. She expresses concern that, while the drugs make him easier to manage, he had a 'lack of appetite' and is losing weight each month. For example: 'Leanne advises she has ceased Bobby's medication for a while and changed to alternative natural medication as Bobby's appetite had become a great concern'.

Bobby's school disagreed with Leanne's decision to take him off his current AD(H)D medication and stated that Bobby's behaviour deteriorated because of the change of medication. The relationship between Leanne and the school became strained over the period that the DCD instructed the school to monitor the children on their behalf. It is evident that before intervention the school was a valuable resource for Leanne, who was actively involved in the children's schooling. The school wrote a letter to the DCD in which they questioned Leanne's concerns regarding Bobby's medication and his behaviour:

> *I also said that the medication Bobby was taking seemed to allow him to sit and concentrate on his work and that his crying was always the result of not getting what he wanted. Leanne said at home she had no problem with Bobby and he never threw any tantrums! I told her that I would have loved to see how she handled him when he couldn't get what he wanted!!!*

As demonstrated by the above extracts, there are numerous entries in the case file that show Leanne did in fact take measures to protect her children - she left the house when she sensed danger, took Brian to the police station, even when he threatened to assault her, and she called the police on several occasions. She also is shown to have tried to address the source of Bobby's medical problem, rather than simply medicating him, even though medication apparently made him easier to control.

From interviews, observations and review of texts and case-file material, the team attempted to make visible the conceptual practices underlying the case-management processes.

Audit team members found a number of problematic conceptual practices in the following areas:

- language used to describe what was going on
- categories used to place events or people into common groups
- observations and inferences made by practitioners

- justifications for actions
- discussions with clients or observations
- conclusions that were drawn from interviews and observations.

Audit team members noted many occasions when these conceptual practices did not seem to match the actual experiences of Leanne and her children, nor did they lead to enhanced safety measures or measures to hold Brian accountable for the violence he used and the harm he had caused. While these practices may seem to be the personal opinions or theories of an individual worker, the Audit team discovered that they were in fact embedded in the processes designed to administer cases. Examples of these problematic processes could be seen in risk-assessment forms, legislation and departmental regulations, administrative forms, the general professional discourse of the discipline, documentation guidelines and expectations, and the conceptual lens through which case-processing forms and tools encouraged a practitioner to view a case. None of the entries or notations strayed from the professional discourses that were being used as a framework for talking about and acting on these cases.

Conceptual Practices

In this section is documented some of the conceptual practices discussed by the Audit team. It is beyond the scope of this report to detail fully how these practices might be problematic or what practices might replace them. Problem Area Four and its corresponding recommendation addresses these issues further, proposing a course of action to reduce the negative impact on the intervention goals of safety and accountability of certain conceptual practices. Identified below are a number of problematic conceptual practices:

1 Practices that made Leanne responsible for Brian's violence or ending his violence are demonstrated in the following extract:

Interview with Bobby and talk with Leanne. Gave information to Leanne that she must keep the children safe. She is also to pass on info re parenting programs to Brian and to let him know that he should contact them for an interview appointment.

Even though it is recognised that many offenders have a propensity to increase the severity of their violence when their victims seek outside intervention, Leanne was frequently asked to relay information and even departmental requirements to Brian.

2 Practices that failed to hold Brian accountable for his violence are demonstrated by the following events:

Brian physically assaulted Leanne, and it was noted that a neighbour witnessed the assault and came to her assistance. Leanne drove to the police station to report the incident. She spoke to the advocate at the police station, where they discussed the option of a VRO and arranged to attend central court within the next two days. In this instance, Brian was not charged with assault, despite Leanne wanting to have him charged and the presence of a witness to the assault. This was the 19th time Brian had appeared before the court for an assault, a breach of a VRO, or for threatening Leanne.

COURT HEARING OUTCOME: Supervision order

1. 120 hours community work.
2. Contact with Alcoholics Anonymous daily.
3. Prison sentence of 15 months, suspended for two years.

This sentence follows months of Brian's stalking behaviour, repeated assaults, threats to kill his children and his refusal to comply with any court orders or DCD requests to seek help. Within hours of receiving this sentence, Brian went to Leanne's house, from which she fled.

Leanne informed the child protection caseworker that Brian is out of prison, across the road, and that by the time the police arrived he was gone. Police do not attempt to locate Brian. Leanne then leaves for her parents' house so as not to be home alone.

3 Practices that failed to account for the serious nature of the violence and abuse Leanne and the children were experiencing, and practices that make that experience secondary to another intervention goal, can be seen in the following excerpts:

The psychologist recommended that the children have no contact with their father. Four months later, with a hearing on access pending, the DCD caseworker sent a letter to DCD Legal Department saying: 'it's best to have legal representation at any hearing on access'. She goes on to say what the DCD's position should be regarding Brian's access to his children:

We discussed the issue of the psychologist's report, which indicated that the children should not have access to their father… Over 4 months has elapsed and the children are now more settled. We would not oppose limited and appropriately supervised access in a supervised access centre[32]. We would oppose all contact for Bobby as we believe he has been severely affected by his father's violence and we have substantiated physical abuse by Brian against Bobby.

The memo goes on to say:

Brian has made three threats to DCD staff that, if pushed, he will murder his children. I believe he is quite capable of carrying out these threats. Brian will probably be released [from prison] some time next week.

In a second incident, Leanne advised the caseworker that 'she was too afraid to be honest as Brian makes threats to kill her and the children, and she believes his threats to be real'. Leanne advised that 'she was too frightened to stay but more frightened to leave, she advised that her face and body were covered in blood and that she was terrified that Brian would kill her, also Brian prevents her from ringing out on the mobile or using the telephone box across the road'.

The following excerpt is taken from an interview with the prosecutor who remarked about this case: "It took a while to get that this was a bad guy … she was so aggressive, and his breaches seemed to be technical in nature … so it wasn't until his fifth or sixth breach that we went after him."

32 This is despite the complete absence of any indication that Brian has engaged in any kind of a personal change process and the worker's stated belief that she thinks Brian could murder his children.

4 Practices that are too generic to be useful, or which are unable to adapt to the circumstances of the specific case before the worker, are illustrated by the following situations:

The conclusion of the first case involving Brian's abuse of Bobby is that the parents have difficulty managing Bobby's behaviour and would benefit from parenting education (specifically about 'time out' or 'privilege and reward' approaches) and family support services. The emphasis throughout the investigation on these parenting/behavioural management skills eventually look out of place. Brian threatened to murder his children if he could not have his desired level of access; the investigation's emphasis is misguided from the onset:

Brian openly acknowledged he smacks Bobby as a form of discipline, and he constantly asks Bobby to do things or not to do things, and Bobby ignores these requests. Both Leanne and Brian are referred to a support group for children with ADD and are given information on a number of parenting programs for them to make their own arrangements for appointments.

Brokerage-style Intervention

The Audit team noted that, because counselling services are what workers have to offer clients, then counselling is what they seem to suggest is needed. Most of the service plans and proposals for help refer clients to counselling; while much of that counselling is related to the problems people are facing, it is not necessarily directly related to those problems. For example, the women's focus group was asked how many women had been referred to counselling by the DCD, an advocate, or another intervenor in her case. Every woman had been referred. They were then asked to identify the key problems they faced in relation to their children. Each woman faced a different set of circumstances, yet they were all referred to a generic parenting group that focused on age-appropriate expectations, development and discipline. One woman complained:

> *I can't talk to my son; we are like strangers to each other. He is sitting in the other room, but he might as well be miles from me. He is angry with me. He hates it here. He hates me for leaving. I need help connecting to him. What I have in my hand is a referral to a parenting group two weeks from now.*

In the Jones case file, it was noted on the DCD assessment transfer report, which recommended the case be moved from the statutory to the family support category, that Leanne advised caseworkers of a previous parenting program that she was instructed to undertake and how it had been ineffective. In the same report, Leanne is again referred to a parenting program to assist her with positive parenting and boundary setting. A further recommendation in the report also refers Leanne to another program to provide 'some practical parenting' techniques.

In this instance, the DCD's reliance on a brokerage-style intervention prevented workers from taking on an advocacy role. Agreements were drawn up between the DCD and Leanne that set conditions, such as Leanne making appointments and attending the services to which she had been referred. The intervention focus was on whether Leanne attended the counselling and parenting programs, rather than on how she was coping with parenting as a victim of domestic violence. More broadly, while workers focused on identifying the client's needs and referring them to services, these services often did not match the client's true needs.

The documentation on Leanne in the Jones case file do not necessarily suggest that the primary help she needed was counselling, though she could very well have wanted and needed that service.

The file suggests that she may have needed other kinds of help, such as help with her house, which was chaotic. The DCD did arrange for a cleaner to come in on one occasion, but the expectation was that this would solve her problem. Leanne needed help with her son's medication and diagnosis; something was not quite right, but she could not figure out what. Leanne needed help getting the courts to control Brian; she could have used a good legal advocate and an aggressive prosecutor. She needed help to fulfil her obligations without missing work, help to settle her mortgage, help to talk to her children, help to deal with the adversarial relationship that developed between her and the school counsellors, and help to get Brian to sober up and attend his counselling or leave the family.

The resources to help Leanne with these problems were not available to her caseworker. Workers are limited to referring clients to certain agencies and certain counselling programs; these programs often have long waiting lists, and workers have no direct way of assuring the quality of the services they provide. Workers saw themselves in many ways as relegated to a brokerage role in the provision of concrete assistance. Caseworkers are compelled by caseloads and administrative duties to farm out the 'real social work' (as one supervisor noted); however, the programs to which they refer their clients are often filled to capacity and beyond, as shown in Leanne's file:

- The children are taken into voluntary foster care as there are no refuge beds available. In November 2000, Leanne gives information on Brian hurting Bobby and herself (she has an eye injury and bruising on an arm): she called the police, waited half an hour outside, and then cancelled the request, as Brian left the house. (This is not a case of police ignoring the call but being backed up on calls requiring police attendance.)
- A letter was sent from the DCD to the Educational Support Centre at the children's school to say that the Department is 'unable to take an active role in this family's life at present' but that they want the centre to continue to monitor the children and to inform them of any indications of abuse or if Bobby is taken out of the centre by Leanne.
- Three of the women interviewed in the focus group for victims of domestic violence had been on waiting lists for weeks in order to have basic conversations with staff or a counsellor.
- An offender program facilitator remarked that there was a waiting list of approximately 150 offenders at any given time.

The Audit team located many concrete examples (like those above) of how the lack of adequate resources prevented intervening agencies from being fully protective of children and adult victims. However, the team was also keenly aware of how such a shortage of resources is affecting the system's ability to act protectively in cases of domestic violence.

The caseworkers charged with protecting children from abuse and neglect by one or both parents are under constant scrutiny, and they are compelled to accomplish certain risk assessments and certain tasks within narrow timeframes. They face constant pressure to avoid leaving children unprotected. The pressure a worker puts on mothers like Leanne is rooted in the very pressures the workers experience. It was clear from the Audit team's interview with a DCD supervisor, as well as from reading the Jones case file, that the caseworkers are accountable for their documentation, for accomplishing certain tasks within certain timeframes, for continually assessing possible dangers to a child. However, they are not accountable for the safety of an adult victim of domestic violence. During the course of the Jones investigations by the DCD, Brian engaged in violent or abusive behaviours several times and his behaviour demonstrated a lack of safety for Bobby and for Leanne,

but Leanne's safety was all but ignored. Yet there is no requirement that intervening agencies and practitioners be accountable to each other's agencies. The risk to Leanne and her children may have been reduced had the intervening agencies coordinated their response.

These shortages of resources also exist in the criminal justice system. One prosecutor was observed preparing for an initial court hearing on arrested suspects. The cases he was to handle in court contained more than 1000 pieces of paper and involved numerous separate cases - including four domestic violence cases. The prosecutor had just minutes to review each file to determine the position the state would take on the case; it became apparent to Audit team members that no one could, day after day, maximise the ability of the state to protect victims under such working conditions.

The system is working on a social problem of huge magnitude one case at a time - and time was what most workers complained they had too little of. Police supervisors could not read every arrest report or investigation to ensure it met the high standards needed for conviction; prosecutors had minutes to prepare for some hearings; Magistrates and judges were inundated with paperwork on cases and had to rely on those presenting in court to summarise adequately their content. Police were backed up on many shifts, leaving victims waiting and agonising for long periods before help could arrive; jail cells were full; law enforcement was backed up in serving VROs and warrants; counselling programs were full; refuges were full.

The Audit team has listed a number of observations, pieces of information (some documented and some not), and examples of directives or regulations that seem to be obstacles to the centralisation of victim safety. Pointers for those who will implement the recommendations in this report noted by the Audit team are as follows:

- A brokerage-style approach to intervention circumvented valuable opportunities for workers to have informative dialogue with clients; further, on many occasions the clients' needs were identified by the caseworker, not the client.
- The criminal justice system does not always consider the testimony of victims when sentencing offenders. It became apparent from observations of and interviews with court staff that many opportunities to hear about offenders' histories of abuse were missed.
- The sharing of vital information did not occur, preventing intervenors from gaining a full picture of their clients' situations and making it difficult for risk to be monitored and for all intervenors to act protectively.

Linkages and Accountability

Over the course of ADVIP's 14-year history, a primary goal has been to coordinate what was for years a fragmented, disjointed, inconsistent and contradictory collection of responses to domestic violence from government and non-government agencies charged with the task of ensuring the safety of the public. During this Audit, the team found several examples of the benefit of ADVIP's work:

- victim safety–focused practices in government policies, in administrative processes designed to connect practitioners across agencies and in case-management processes
- language and theories being applied to cases that showed evidence of cross-training, interdisciplinary agreements and priorities focused on the goals of intervention
- resources new to the community, such as perpetrator programs, were being used in interventions.

Statements on Linkages and Accountability

The team provided the following points for ADVIP to consider when implementing the Audit findings. Each point is connected to the discussions of accountable interventions and integrated approaches to safety.

1 Each practitioner's job should be designed to protect victims from continued and future harm.

2 How each practitioner acts on a case can position subsequent workers on that case to centralise victim safety as an intervention outcome.

3 Each practitioner is dependent on the work of those who previously acted on a case for their ability to centralise victim safety as an intervention outcome.

4 An accountable intervention system is one in which agencies coordinate workers to perform their individual tasks in ways that recognise the inter-connections among intervenors and which is based in the realities of the experiences of victims of abuse.

The Jones case file summary offers a snapshot of what the Audit team found in relation to these statements. More than 30 agencies were involved with members of the Jones family, and their case file reveals the current systemic relationships between these agencies. There were innumerable opportunities to create stronger links between and among intervening practitioners. The team concluded that when agencies worked well together and focused on controlling Brian's violence, rather than on controlling Leanne's response to his violence, both the children and Leanne were safer.

4.3 Problem Area Three: Safety and Accountability

There are inadequate systems of accountability in place to ensure that agencies participating in ADVIP meet their collective goals, as they relate to offender accountability and victim safety.

Since its inception, ADVIP has articulated a commitment to forging an interagency collaboration that would collectively seek to hold offenders in domestic violence cases accountable for the harm they cause and for the responsibility to stop their violence. At the same time, these agencies have agreed to organise their interventions in ways that centralise attention on victim safety.

The Audit team therefore wanted to uncover how those commitments were built into case-processing routines. This also led to the question of when and how institutional processes weaken, or are counter-productive to, the goals of accountability and victim safety. In this section, the focus is on the Audit team's observations and discussions of offender accountability and institutional accountability.

First, institutional accountability is defined as: 'being able to furnish an explanation and a justification for an institutional action on the basis that the action furthers the goals of protecting victims from continued harm and holding offenders accountable for the harm they have done'. In a safety audit, one applies this definition by looking for an explanation or a justification for each action taken on a domestic violence case in terms of victim safety and offender accountability.

The team entered the Audit process knowing it would find that practitioners in the legal and human service systems have a number of obligations they must meet within the standards of their professions and agencies. None of the practitioners observed or interviewed could be characterised

as ‘unaccountable’. However, the focus of the investigations was how their accountability and obligations related to victim safety and offender accountability.

The Praxis Audit is designed to guide team members to direct their attention to three levels of accountability. This Audit resulted in the addition of a fourth level. A description of each of these levels follows.

Level One: Institution-to-Victim Accountability

This level relates to the concept of institutional accountability, ie Does the design of a specific practice, policy or directive, or case-management routine have victim safety as a goal? This is not to imply it must be a primary or exclusive goal but that victim safety is a part of what the practitioner is trying to accomplish. The same question must be asked in relation to offender accountability. The Audit team members were charged with uncovering to what extent those designing a given intervention practice (policy makers and senior administrators) considered the implications of their actions on the safety of victims of domestic violence. This then led to the complementary question: Is this intervening practice designed in a way that it could actually increase the potential of harm to the victim? Because the Audit team was primarily interested in how workers are organised and coordinated to act in ways that are accountable to victim safety, when it did see situations where an individual practitioner failed to act protectively, the focus of inquiry was directed to the systemic causes of that individual’s failure.

Safe interventions were seen by most intervening practitioners as accomplished by adhering to prescribed methods of intervention. The interviews identified that most practitioners and advocates equated safety with following prescribed courses of action, such as removing children who repeatedly experienced violence, enforcing a VRO or prosecuting an offender. To test whether these methods increased victim safety in the Jones case, the Audit team devised questions reflecting workers’ prescribed courses of action:

- Did Leanne adhere to the conditions prescribed in contracts and agreements?
- Did Leanne follow through with referrals?
- Did Leanne apply for a VRO?
- Did Leanne follow through with residency with the Family Court?
- Did Brian move from the home?
- Did Brian complete the programs and conditions of his order?

Although it was noted that Leanne made every attempt to adhere to the conditions imposed on her (especially given the threat of the removal of her children if she didn’t fulfil the obligations set for her by the DCD) the Audit team did not see any evidence of Brian conforming to any conditions placed on him. It was also evident that the conditions placed on Leanne did not protect her from further abuse.

In interviews with practitioners and advocates, there was little, if any, questioning of the ability of these practices to protect victims, nor of what makes a victim safe in a certain set of circumstances. For example, when asked about the goal of victim safety, practitioners tended to respond in terms of a specific action. Rarely did such questions engender a discussion about what makes victims safe or about the safety of the victim in the case being discussed. A prosecutor said: “We can’t keep victims safe by ourselves. They have to cooperate with us or we’ll lose or just not go forward on many of

these cases." A child protection worker noted, "Leanne seems willing now to protect her children by keeping Brian away." A CCO remarked, "If he stays clean and follows his requirements, we just assume she is safe." An offender group facilitator said, "the goal is to get him into a group as quickly as possible." The lack of distinction between what practitioners might consider a best practice and 'acting safely' poses problems. Interventions are not adapted to the safety considerations of a case, or even those of a type of case. A 'one size fits all' approach and the practice of victim safety are tied, not to the experience of the victim, but to the accomplishment of an institutional task.

Most practitioners work in agencies that are organised to treat ongoing physical, sexual and controlling abuse experienced by a mother as a distinct problem from the harm done to children who live with that abuser and whose mother is that victim. Nowhere was this more clear than in the case of a woman who received the letter excerpted below from the DCD after the police had attended her home for a domestic assault against her by her husband:

> *I am a social worker with this department. We recently received a standard notification from the police about their attendance at your family home… because of a violent incident that occurred there last… It was reported that your daughter… was at home at the time, and that is why the police have contacted us.*
>
> *It is known that apart from children being at some risk of direct harm when they witness actual violence, they also suffer anxiety from being witness to aggression. This will impact on their healthy development.*
>
> *I would be grateful if you would take the time to read the flyers I have enclosed about the impact that witnessing domestic violence has on children. I do not wish to cause you additional worry at what is already a very difficult time for you but rather hope that this information will be helpful to you. You may wish to consider contacting one of the services which the enclosures refer to.*
>
> *At this time I am not asking to meet with you personally, however you are welcome to contact me if you wish to.*[33]

This particular woman was one of the mothers interviewed as part of the Audit. She was experiencing extreme violence at the time she received this letter. Her abuser used the threat of deportation against her because she only had a temporary visa. The fact that she was dependent on her abuser for residency in Australia (the offender was sponsoring her stay) and that deportation would mean separation from her child, left this woman in an intolerable situation.

The letter was the subject of much conjecture and some debate by Audit team members. It was seen by some as cold and indifferent to a woman who, one would at least suspect, was being abused. It fulfilled the DCD's obligation to follow up on domestic violence calls involving children and offer services, but it was not viewed as an authentic institutional attempt at accountability to either the victim or her child.

The question the Audit team asked was: What should the DCD do when they gain information from another intervenor, such as the police, that a woman is being abused and she has children? While unable to explore fully all possible options, the team concluded that if the worker operates from the paradigm that mothers are harming their children by letting them be exposed to abuse, then the approach the worker takes will align more closely with a policing role than a helping role. The

33 Excerpt: Starick Services case file.

team tried to imagine what a letter to the perpetrator of such violence might say, since it was he who caused harm to the children. It was found to be difficult to draft such a letter that would not result in him potentially reacting in an escalated way. The reality of being unsure of how to intervene directly with perpetrators without increasing the level of danger they pose to children, their victims and intervenors is a cornerstone of the practice of placing the responsibility for keeping the children from harm on the non-abusing parent. In cases involving domestic violence, that parent is almost always the mother.

The Audit team also saw a number of examples of this 'lip service' to accountability in the criminal justice system's communications with victims. If there is insufficient evidence to proceed with a case, the prosecutor will confer with the police district office, but it is not necessary to confer with the victim before a case is dropped. While policies require CCOs to seek victim input in sentencing, the extremely low rate at which such input is obtained is considered the result of the victim's failure to respond, rather than the result an ineffective method of obtaining their input. As one solicitor stated:

> *It is highly unlikely that these victims have no thoughts about sentencing, or release conditions, or even bail. The reason victims don't provide input is never raised as a problem with the approach to cases; it is seen as a problem of the character of the victim.*

Neither RAWA (the primary organisation providing education for abusers) nor CCOs (the practitioners charged with monitoring offenders on probation) have adequate methods built into their practice to develop and maintain contact with a victim, the person who has the most information about an offender's behaviour.

Both child protection caseworkers and refuge advocates acted in a broker role to help clients to access services, but many of those services did not match the client's needs. For example, Leanne needed help to obtain a correct diagnosis and treatment plan for her son, but it was not until 2001 that a referral was made to a psychologist; this family first came to the attention of the DCD in 1999. Leanne had to wait a further two months for assistance, due to the psychologist's waiting list. During this time, her son suffered weight loss and a number of emotional problems connected to his disorder, which Leanne insisted were a result of the medication he had been prescribed as a result of his misdiagnosis. Her reluctance and, sometimes, her refusal to keep him on that medication were noted as signs of being non-cooperative.

To further illustrate, during Audit week many refuge residents were on waiting lists for counselling, and they had only restricted opportunities to discuss immediate problems with staff or with each other in informal support and educational groups.

A number of processes split the experiences of victims into two distinct problems: that of the adult victim of ongoing abuse, and that of the children who are harmed by the abuse of their parent. For example, Magistrates and Judges do not deal with the issue of an abuser's contact with children in criminal court hearings. Issuing a VRO in a criminal case without restricting an offender's ability to demand access to his children at school, in a medical facility, or at a social function is a problem. Simply saying that access issues do not belong in criminal court hearings abdicates the obligation of the judiciary to provide victims of domestic violence with much-needed forms of protection.

Agencies have a number of restrictions regarding the sharing of information about victims; some of these restrictions appear to prevent the successful functioning of an interagency process, rather than to protect victims' confidentiality. There is no group that sees it as their obligation to correct the obstacles that current confidentiality practices and laws present to effective intervention.

Level Two: Offender-to-Victim Accountability

In relation to individual offender accountability, the focus of the Audit is on how workers are organised to act in ways that hold individual offenders accountable to the victim(s) they harm and intimate partners they may have in the future. The Audit team questioned whether specific practices held offenders accountable for their abuse; further investigation dealt with institutional collusion with abusers, using the question: Is this practice likely to allow the offender to engage in a pattern of abuse with few or no consequences, and does it embolden the offender to carry out a pattern of abusive behaviours?

Many institutional practices worked on behalf of the offender, either because they ignored the danger in which they placed a victim or because they were reliant on a victim being able to speak freely or openly confront her abuser. An example of this kind of practice from the Jones case file is an email from a child protection worker to a Starick advocate, saying that: 'there is little point in taking out a VRO against Brian on behalf of the children, as they are already protected under Leanne's VRO, so she can refuse him contact'. This approach puts Leanne in the position of dealing directly with Brian if he approaches her to see the children, puts Leanne at risk of violence from Brian and shifts the responsibility for dealing with Brian's compliance to conditions from the criminal justice system and statutory child protection system to her.

On one occasion, Leanne was told by child protection caseworkers to pass on information to Brian while a current VRO was in place. It appears that there were no attempts by the DCD to engage with Brian direct to work with him to stop his abuse.

A number of offender program facilitators based their intakes for suitability to attend groups almost exclusively on information from the abuser. Further, despite the long waiting lists for admission to offender programs, offenders were not referred to existing voluntary programs within the service or to alternative programs run by other service providers. (A range of reasons could underlie the latter point; the Audit team was not sure of its implications but felt it to be significant to the provision of offender programs, given the shortfall of services.)

The assessment processes used in offender programs are primarily based on information from the offender. The system in which workers operate is one in which the policy makers in the courts and RAWA have not established a way to ensure that the person who is offering the court-ordered services to an abuser knows what the court knows about his pattern of abuse. There is no process in place to share this valuable information; it is not sought from other relevant sources, such as the police or DCS.

In one case the team reviewed, a jailed offender placed multiple telephone calls from the jail telephone to the victim who was staying at the refuge. It was the refuge policy not to accept any calls from the prison; however, the worker was advised by the supervisor of the jail that the offender would be aggravated further if the calls were to discontinue. The DCD also advised the worker to accept fewer telephone calls, rather than stopping them completely, which could aggravate the situation. The Audit team had a long discussion about this case, which resulted in people taking very definite stands about whether or not a supervisor should have advised the refuge worker to accept 'some calls'. In the end, it was clear that no one knew whether it was a protective move or a form of collusion, because not enough was known about the nature of the case or the alternatives available to the refuge worker and

her supervisor. It is important to note that this is the same strategy Leanne used for years to control Brian's use of violence, one that was documented as Leanne being 'unable to say no to Brian'.

There was agreement that before the refuge or the jail can write policy on this issue a tremendous amount of interagency discussions should occur, where at least one criterion for decisions on such matters is whether the action enhances the safety of the victim in question or others that their offender may abuse.

Level Three: Practitioner-to-Practitioner Accountability

This level was one that ADVIP had been working on for years but had not articulated the interagency work in terms of practitioners' accountability to one another. The important question here is what one might call the 'before and after' question: Do case-processing routines promote a system of interagency accountability, and do these routines hold practitioners accountable to both those who preceded their involvement in the case and those who will subsequently intervene in the case? On this level, each practitioner was only one part of an entire process; that is, what s/he did at a certain point of intervention positioned others to work in effective or ineffective ways.

The team found a number of examples of practitioners not being accountable to one another, in that they were not properly linked to one another within and by the intervention process.

CCOs are not provided with information by police when they attend a call involving one of their clients, unless there has been an arrest. The Audit team spoke with one CCO who found out at a breach hearing that his client had many contacts with the police since being placed on probation.

Police officers write investigation reports with the prosecutor in mind, not the range of intervenors who will subsequently act on the case, including CCOs, child protection workers and court advocates. Each intervenor is left to glean the information they need from a report written with criminal prosecution in mind.

ADVIP Core Group provided a forum to discuss cases, however, the information shared at the meetings is not organised in a way that reflects a planned approach. In observing the Core Group, it was noted that information is shared at the discretion of workers and what they view as a priority. No formal means of accountability can be established in the forum in its current form.

RAWA was linked to the Jones case through their work with Brian; however, had they been linked with Starick Services, then both intervening agency practitioners would have been accountable to each other in protecting the victim and holding the offender accountable for his abuse.

The Jones children's school was enlisted by the DCD to monitor the children each time the case was closed. The school notified the DCD on a regular basis of their concerns regarding the children. In a number of contacts, the school raised the concern that Brian was residing in the home while there was a current VRO in place. The school did not contact the police or the DCS, who were dealing directly with Brian.

Level Four: Agency-to-Agency Accountability

The question the Audit team used to investigate interagency accountability was: Are mechanisms in place that ensure an interagency system of accountability for the goals of victim safety and offender accountability? The team wanted to know how interagency work led to the identification of

weaknesses in the system and the correction of those weaknesses. In effect, the team was looking for a system of self-regulation and self-imposed quality assurance mechanisms.

Listed in this section are examples of observations, insights into case records, or conclusions drawn from interviews that demonstrate how lines of accountability for victim safety or for the goal of holding the offender accountable were ineffective, missing or mis-directed. The reader is reminded that the processes of accountability were examined through all of the lenses named above.

Because of the nature of the Audit question, the team continually identified ways in which practitioners were (or were not) drawn into processes of system enhancement. First, the Audit team looked at the number of times it came across practices put into place over the past 5–10 years that have made the system far more accountable to victim safety and which have held individual abusers far more accountable for their abuse. The team then examined the many opportunities for enhancing the systems of accountability in the interventions reviewed.

Western Australia has introduced new domestic violence legislation[34] that affords greater protection for victims of domestic violence including children. Heavy penalties now apply to offenders of domestic violence; the legislation also provides a platform for reform of the way in which the system holds victims accountable for offenders' abusive behaviour, with agencies and legislative bodies instead taking responsibility. Pro-arrest policies and a clear mandate to treat domestic violence as a criminal offence are evidence of a shift away from traditional responses that did little to hold offenders accountable.

The new *Children and Community Services Act 2004* allows for information to be shared among intervening agencies at all levels when dealing with child abuse. In cases of domestic violence, this will permit a more coordinated response to victim safety. These reforms create an opportunity for the development of new and innovative approaches to be piloted and endorsed.

This Audit effort was a prime example of agency-to-agency accountability. Interagency investigations similar to this Audit are not built into the existing collaboration. While each agency that acted on the cases examined had a way to track the cases within their agency, there was no interagency tracking system that would allow groups such as ADVIP to look for patterns of problems in cases and resolve those problems.

The following example demonstrates a systemic problem that could only be identified by a system of interagency accountability.

During the Audit, team members interviewed a woman who was being charged with an assault against her partner, who had abused her for a number of years. She faced a harsh sentence, the loss of her child, and she was required to go to an offenders' group. Given the history of violence within the relationship, the case seemed to call out for good advocacy and a good solicitor. The Audit team members were interested in knowing how many women who are victims of domestic violence face these kinds of charges and what typically happens when a woman who is being abused fights back. One team was asked to explore the problem in their interviews. A member reported back, "Well we asked eight or nine people and got 10 or 11 replies." Agency-to-agency accountability requires that someone is responsible for raising these issues, but this would require a tracking system that allows an interagency group to answer key questions, such as: How many women who are being abused

34 *The Acts Amendment (Domestic Violence) Bill 2004* – that amends *The Restraining Order's Act 1997 (WA), The Criminal Code (WA),* and *The Bail Act 1892 (WA).*

are arrested for assaulting their abuser? What happens to the case when they are arrested? What happens to their children because of the arrest and intervention? How does the intervention affect the woman's abuser; does he behave in a safer or more dangerous manner toward her? And so forth.

ADVIP has the potential to coordinate interventions between the legal system (statutory agencies) and the human service providers (often the non-government sector), but that work has previously been fragmented and *ad hoc* in nature.

ADVIP has acted as a coordinator between government and non-government agencies' interventions in a number of ways. The way that RAWA is positioned to take court-ordered offenders and Starick Services' placing of advocates in the local courts and police stations (Armadale, Belmont, Cannington and Gosnells) demonstrates a high level of collaboration in Armadale; however, connections between the legal system and human service practitioners could be strengthened and developed to a more complex level of coordination. This would require a thorough analysis of each connection and an articulation of what is needed to allow each non-governmental agency to do its work and enhance the protection of victims.

The Audit team identified some areas where interagency coordination and accountability could be improved. For example, RAWA is tasked with operating a rehabilitation program for offenders, yet many offenders are sent to RAWA with little or no accompanying information about their case. Much of the problem lies in statutory limitations regarding confidentiality. If RAWA is not able to make contact with the victim—which happens in a significant number of cases—then the agency is left with the abuser's account of the situation. Police reports, VRO affidavits and information in PSI reports could be important to the leader facilitating the group an offender attends, but this information is often not available. Altering current legal restrictions on information sharing and setting up formal referral protocols (with assurances of practitioner compliance) would be necessary in order to strengthen the capacity of the current system to hold offenders accountable.

Current interagency accountability also requires improvement in order to ensure offender accountability. For example, if an offender does not complete his court-ordered program, RAWA reports back to the CCO; the CCO then reports the non-compliance to the court. Where an offender does not complete his court-ordered program, he poses an ongoing risk to the victim or future intimate partners. If, in those cases, a CCO or prosecutor fails to act on the reported non-compliance, the case can just 'disappear'. The consistency and clarity of the court in making and enforcing its orders has a significant impact on the ability of agencies like RAWA, Starick Services and the DCD to perform their work effectively. However, there were no agreements in place on how agencies should hold one another accountable for agreed-upon protocols.

In Problem Area Two and Recommendation Two, the need for the DCD to be linked more closely with the criminal courts in order to have greater capacity to directly deal with abusers like Brian is discussed. The question here is: How does a problem like this get resolved? Coordination and collaboration are the practical application of agency-to-agency accountability.

The structures for agency-to-agency accountability are in place, but a plan to systematically identify the needs of each agency and each intervening practitioner is still missing. Such a plan might include using a forum like ADVIP to negotiate with each agency and the legal system for information, reporting agreements and enforcement protocols.

Conclusion

The Audit team recognised that interagency work demands more than across-agency communication. It requires a commitment to one another's intervention goals. For example, dispatchers are aware of, and attend to, the needs of police responding to a call; police are aware of the needs of prosecutors; prosecutors attend to the needs of Magistrates in processing the case, and so on. In undertaking these processes, the dispatcher could also attend to the case-processing needs of the prosecutor in more effective ways; police could attend to the needs of the CCO conducting the pre-sentence investigation, and so forth.

Finally, interagency accountability also requires across-institutional dialogue in order to think through the collective intervention process and to challenge the practices and assumptions that undermine the goals of safety and accountability.

4.4 Problem Area Four: Assumptions, Theories, Categories and Language

When practitioners process cases, they are both acting on cases and talking about cases. Acting on the case and talking about the case are inextricably linked. When a dispatcher notifies an officer of a domestic assault in progress, she or he is performing concrete tasks: talking to the caller, asking questions, coding the call for type and urgency, entering information into the computer and checking records[35]. At the same time, the dispatcher is 'talking' to a police officer about the case. How the dispatcher talks about the case is part of the practice of dispatching.

Throughout this report, the Audit team's efforts to discover how workers were organised and coordinated to act on a case have been discussed. The importance of recognising that workers are coordinated and organised to talk about a case in very specific ways is now examined.

Workers do not independently develop their ways of talking about the case. For example, when CCOs prepare PSI reports for the court, they use formats prepared by the DCS that guide the CCO on what information to include in the report. Embedded in that format is the institutionally authorised way of talking about the case before the court. That format is loaded with assumptions; for example, the current PSI report format for criminal offences in the criminal court requires CCOs to report to the court in 11 areas: the offender's court history, charges pending, previous response to supervision, marital situation, education and employment, substance abuse, and so forth. These categories tell the CCOs what matters of institutional significance they should report to the court. Consequently, PSI reports written by five different CCOs on the same defendant should look very similar. The 11 categories were determined by institutional processes that preceded the CCOs involvement in the case. They constitute the sentencing discourse on these cases. (See Appendix Eleven for a sample PSI report form.)

Every worker the Audit team observed was guided by similar institutionally authorised ways of talking about a case. Risk-assessment tools, police report-writing formats, and safety-plan formats were all instruments used by agencies to standardise a way of thinking and talking about cases as they are processed.

35 In large communities, the dispatching of officers is done in two stages, with a call taker and a dispatcher; for the purposes of this example we have combined the two functions.

Audit team members observed workers, interviewed them, and read their documentation of cases, suspects, victims and children. Each of these sources was examined in terms of victim safety and offender accountability.

When Audit team subgroups debriefed or reported back to the full group they commented far more frequently about how workers 'talked' about cases than about the actions they took. This talk was referred to as the 'institutional discourse'. The notes of debriefing sessions, the Audit team discussions themselves and the team members notes in the margins of the case files all show how focused the Audit team was on the discourses present in the courthouse, on police calls, and in the interchanges between victims of abuse and practitioners in the system charged with protecting the public from domestic violence. Just as the team was able to trace a practitioner's administrative actions on a case from an emergency call through the system, so could the team trace conceptual practices.

The Audit team attempted to capture the important aspects of the team's discussions and insights on the ways in which workers were organised to talk about cases. Recommendations Three and Four address the central role ADVIP plays in analysing and changing those conceptual practices which are not protective of women who are abused by their partners.

This line of inquiry is termed 'problematic discourses'; discussion falls into four areas of concern:

1 Problems identified when the different intervening agencies—the DCD, advocacy groups, the courts, and so on—used conflicting paradigms or theoretical frameworks.

2 Theories, concepts and assumptions contained within these competing paradigms and point to some problems that conceptual conflicts can pose for those who seek to ensure victim safety and offender accountability.

3 Ways an agency grouped cases, events or people together and treated them as a single category.

4 Use of language in a number of interventions that demonstrate how language can influence a case, both negatively and positively.

During the Audit, it was identified that the use of words is important and should be an object of examination in the Audit, as well as in its follow-up.

Paradigms

The physical and sexual abuse of women by their husbands has been a legal and cultural right of husbands in western societies for centuries. Chastising one's wife was sanctioned in British common law until 1828; after a long period of regulating the practice, it was finally outlawed in 1891. In Australia, a man could legally use physical violence to chastise his wife until 1902, when the *Old Law Justice Act* was amended. In Western Australia, the first reform effort in the area of wife assault occurred in 1997, with the introduction of the *Restraining Orders Act*. Until 1991 in Australia, a man could not be charged with rape in marriage. A man's right to chastise was linked to the right to control his property. As women's legal and social status changed, so did their ability to seek protection from the state for abuse by a husband.

The use of violence by women toward their husbands was either seen as resistive violence (women had 'their ways' of coping with a brutal husband), trivialised as an emotional outburst or seen as the result of a mental disturbance. Generally, women were not seen as using violence to dominate

a husband. Domineering women were seen to be emotionally abusive of a husband, rather than physically or sexually abusive, as is captured in the adage 'women do with their mouths what men do with their fists'.

Efforts to control domestic violence were focused on stopping or controlling the practice of 'wife beating'. Most efforts to stop the abuse of women in marriage were linked to other social efforts to improve the status of women in society, economically, politically and socially. Women's vulnerability to male violence was linked to their subordinate position in society. Men's authority and rights to chastise and control women, on the other hand, were rationalised in terms of notions of property rights and buttressed by the characterisation of women as irrational, mentally unstable, emotionally volatile, manipulative and deceitful[36].

Contemporary explanations for the violence that the Audit team read about in police reports and DCD files, and heard about in court rooms and focus groups are far more divergent. The Audit team began the Audit week seeking to discover how each worker was organised to act on and conceptualise a case. Again, the team did not seek to uncover the individual beliefs of practitioners but how the institutional processes they were engaging in were organised around certain assumptions, explanations and ways of conceptualising domestic violence.

The members of the Audit team were not schooled in similar disciplines, and so had different explanations for this violence. Just as competing—and frequently incompatible—ways of conceptualising the situations in case files and case-processing practices were encountered, so too were competing theories within the Audit team. However, the Audit process allowed some distance from individual perceptions which led to a surprising degree of agreement about problems in the conceptual practices embedded in the processing of cases.

The first discovery was made at a macro level. The three groups audited—child protection, the criminal justice system, and advocacy—had very different frameworks for talking about domestic violence. These different frameworks created division on substantive issues, such as the proper function of the state in domestic violence cases, the origin of domestic violence in individual cases, whose responsibility it is to stop domestic violence and what will stop it.

Three distinct paradigms operated in the processing of the Jones case:

1 The legal system conceptualises the violence as a single act that, if certain factors are present, constitutes a crime. That crime must be proven in a court of law based on the evidence of that case, not evidence of what the defendant has done previously. The particular crime before the court is the act for which the defendant was charged. That crime fits into the category of a summary offence (less serious offences) or an indictable offence (serious offences).

2 The DCD's conceptualisation of the violence centres on the impact of violence on children who witness or are exposed to it. The DCD analyses domestic violence in terms of whether a child has been harmed as a result of the intimate-partner violence, physically or emotionally; whether there is a non-offending parent; whether a non-offending parent is capable of protecting their child from the harm of witnessing, being exposed to, or being drawn into the violence; and whether they are willing to protect the child.

36 Dr Ellen Pence PhD

3 Advocacy's conceptualisation of the violence is that some of the violence is part of a pattern of abusive tactics used by the offender to dominate and control the victim. If that is the nature of the violence to be acted upon, then agencies must collaborate to control the abuser, rather than the victim.

These distinct paradigms reflect what each group sees as its mission, or purpose. The criminal justice system functions to deter criminals from repeating offences and 'would-be criminals' from offending. The child protection system functions to protect children from harm or neglect by a parent. The advocacy groups function on two levels: on the individual service level, advocates stand beside individual victims to ensure that fairness and safety is achieved in each case; on the systemic level, advocates identify and attempt to change the systemic problems that prevent victims of domestic violence from receiving effective help and protection. These differences may seem innocuous, but they frequently underscore serious tensions and conflict.

The previous discussion outlines the ways in which a group's function shapes its paradigm. The following discussion outlines the philosophical assumptions underlying the paradigm from which each group operates. Pope discusses paradigms in terms of perspectives:

> The current domestic violence discourse can be viewed through two dominant perspectives: one which understands violence in intimate relationships as 'family violence' and one as 'violence against women'. The differences between these two perspectives rest in their philosophical underpinnings, approach to practice, and recommendations for change.[37]

Pope goes on to explain that, if an institutional perspective centres on family relations, then the practice that follows will focus on issues such as stress, conflict management, communication, coping skills and parenting capacity; all of which were the focus of the DCD's intervention with Brian and Leanne. If, on the other hand, one acts from the perspective of the violence being rooted in gendered relations characterised by power differentials, then the central issues would be Brian's use of power tactics and the available means of social control over Brian, including police arrest, prosecution and re-education or punishment. Interventions with Leanne would include assistance to help her live independently of Brian and participation in educational groups with other abused women.

These two factors—the agency mission and function, and the philosophical framework that an agency makes available to its workers—shape the conceptual practices used by an institution. In the case of domestic violence, these practices will either protect or collude with the abuser. In a community that operates from what Pope describes as a paradigm that sees intimate-partner violence in its historic context of violence against women as 'wives', the Jones case would have been handled quite differently, and workers would have been organised to act with very different tools of intervention, including different assessment tools, different links to the criminal court, different resources to offer Leanne, and different expectations of Brian.

The subgroup reading Leanne and Brian's case file sensed how different the caseworker's relationship with Leanne would be if she were operating from different philosophical and functional paradigms. To illustrate: the subgroup discussed a conversation between the caseworker and Leanne in which Leanne reveals that she has been lying about Brian for 10 years and that she appeases him because

37 An Exploration of the Domestic Abuse Intervention Project as a Site of Resistance and Border Crossing; Pope, Lucille Janette – 1999
Unpublished dissertation in partial fulfillment of the requirements of a Doctor of Philosophy – Arizona State University

it is easier and less scary. The following is an excerpt from the file where the caseworker raises the issue of lying:

> Leanne advised that she has been lying throughout her involvement with the Department and that Brian has been having regular telephone and home contact with the children. Leanne advised that she can say no to Brian, however this has no impact on him whatsoever. Leanne advised that she has a ten-year habit of lying about her relationship and issues arising from the relationship, and she stated that she finds it easier to tell people what they want to hear. Leanne stated that she 'can't stop it'. Further, as a result of not being able to say no, she cannot keep the children safe.

After reading this passage, the first reaction of some Audit team members was to think that the caseworker was cold and uncaring – "How could she not see this was an important conversation to have with Leanne to help her get unstuck?" However, this worker's lens is 'parental responsibility'; she requires Leanne to step forward and protect her children from Brian. From this perspective, Leanne's words are interpreted differently than, for example, from a perspective that viewed the confrontation of Brian as being the state's responsibility, or from a perspective that gave equal regard to the protection of Leanne and Bobby.

When seen through the lens of historical violence against women, lies such as Leanne's are often viewed as survival tactics or coping skills in an environment where the victim has little power but that of her choice of when to speak the truth and when not to do so. The intervenor is seen not as a neutral outsider but as one that either emboldens Brian and his violence or curtails him.

In this paradigm, and from the perspective of the victim, the caseworker is suspect and not to be trusted until the victim has no choice or the worker has demonstrated their capacity to understand and help. The caseworker, who sees the Jones case through a very different lens, sees Leanne's lying as an example of uncooperativeness; she documented the conversation by noting:

> The contract that was drawn up by the caseworker was presented to Leanne and discussed at length. Leanne advised that she is willing to sign the Agreement; however, she will have difficulty implementing the issues to do with Brian. It was emphasised that Leanne needs to take responsibility for her own commitment to her children and not try to solve Brian's issues. Leanne admitted that she feels the need to solve Brian's problems as well. Caseworker emphasised the need for the DCD and Leanne to work together and, further, this required an up-front and honest approach to all our dealings with each other.

On several other occasions, the caseworker refers to Leanne's compulsive lying and talks to Leanne in those terms:

> Leanne acknowledged that she needs counselling to deal with her own inability to deal effectively with all of the issues, including her compulsive lying and inability to say no to Brian.

The caseworker goes so far as to refer Leanne to a psychologist, at least in part to deal with her compulsive lying. In her records of her conversation with the psychologist, the case worker states:

> I outlined my concerns in relation to Leanne and her disclosure about compulsively lying and her inability to place her children before her abusive husband. Following detailed discussion, it was agreed that Leanne will require some treatment.

The task of coordinating a collaborative response to domestic violence requires agreement on how to operate within the confines of the criminal justice and child protection systems while still addressing the problem of violence as it is experienced by the victims and carried out by the offenders.

Theories, Concepts and Assumptions

As previously discussed, Audit team members received training on how to talk about institutional practices, rather than the individual behaviours or thinking of practitioners. The team was exposed to a discourse about institutions; this exposure shaped investigative practices. One part of the training was a lecture and presentation on the features of institutions that other community groups similar to ADVIP had discovered were always present, always problematic, and which were not often seen as creating poor case outcomes. Dr Pence presented the material on these features[38], beginning with this introduction:

> From our institutional change work over the past 30 years and our more recent safety Audit work, an understanding of the ways in which the nature of institutions contributes to this gap has emerged. Twelve features of institutions that are always somehow related to the poor outcomes of cases were identified. These features are present in all aspects of institutional work. They are central to the nature of institutions. Reform work cannot necessarily eliminate these features, but it must account for them in order to establish practices and interventions that take up the complexity of people's lives, and the corresponding complexity of safety, as completely as possible.

Appendix Twelve presents a brief description of the 12 problematic features of institutional social management features. These came up frequently during the Audit, and are incorporated into this report in a number of places. Here, one of those features is drawn upon to discuss a problem encountered in every part of case processing that was analysed: the creation of dialogue without communication. The following description of this feature informed the investigation:

> In order to process cases, practitioners need information. They collect and analyse information within the discourse of their field, the specific institutional task they are accomplishing, the directives and protocols in which the case is embedded, and the sequence of actions in which their task is located. Within this framework, people frequently become data points; communication is one-way, from institutional workers to the individuals they are helping. It is framed and filtered through forms, rules, liability concerns, and professional concepts and theories.

The Audit team was asked to examine how discussions between workers and adult victims, offenders, or children are carried out. Between practitioners and their clients is a professional discourse, which acts as a filter of information. When the police officers assigned to an investigation of an assault

38 Based on the process designed by Praxis International: <http://www.praxisinternational.org/>.

begin their interviews with victims or suspects, they begin with gathering the 'facts'. When an officer asks for the facts, s/he does not want to begin at the beginning:

> "We met 12 years ago, and I should have known then, because my mother warned me…"
>
> "Ma'am, can you just start with what happened here tonight?"

The officer is trained to ask questions through a policing framework. He or she is required to establish whether a crime was committed, whether there is evidence, whether there are other explanations for the events, and whether there are reasonable grounds for arrest[39]. In policing, that professional framework is often quite visible, because the 'discourse' officers are applying to the exchange between the victim or suspect and themselves is clear; when human service workers apply their craft, the idea of a framing discourse can be less clear. For example, the social worker, advocate and offender program facilitator all perceive an incident of domestic violence through a different, predetermined conceptual lens. Between women like Leanne, men like Brian, and the people who are positioned to intervene on behalf of safety, there exists a conceptual filter that Audit team members were asked to make visible.

The Audit team aimed, first, to reveal the assumptions and concepts that guide practitioners' perception of cases, and, secondly, to ask whether those concepts help the practitioner to understand cases and act to protect victims of domestic abuse.

The following is a discussion of an excerpt from the Jones file of the caseworker's conversation with Leanne about her hiding her contact with Brian:

'Leanne advised that she has been lying throughout her involvement with the Department'. From one perspective, this can be seen as Leanne initiating a very honest and straightforward dialogue for the first time. However, the caseworker reverts to a policing role and misses the opportunity to have this important discussion with Leanne:

> It was emphasised that Leanne needs to take responsibility for her own commitment to her children… Caseworker emphasised the need for the DCD and Leanne to work together, and, further, this required an up-front and honest approach to all our dealings with each other…

One might question whether Leanne would see this response as an opportunity to work together.

Most Audit team members found this entry to be disturbing, even those who share the caseworker's framework. The team, of course, was operating with the benefit of hindsight and were able to consider more than 500 pages of documents from police files, DCS summaries, psychological reports and DCD case notes. Further, team members believed that Brian would eventually threaten DCD caseworkers and that they too would act to placate him; that he would intimidate teachers and school administrators; and that his threats and violence would escalate with confrontation, intervention, or attempts by Leanne to live separately from him or prevent him from contacting the children.

The Audit team questioned how one could read this case entry for how the worker is being coordinated to talk about the case? The team returned to the audit trails, asking: What is her job function? What rules and regulations shape this interaction? What administrative processes are operating here? What resources does the worker have to act on the case?

39 Since the involvement police had with the Jones case, and to address the issue of looking at each incident of domestic violence as just that, a single incident, police training now encourages officers to preface victim statements and the statement of material facts with general information that may cover the history of the family and domestic violence, children and the relationship.

The caseworker's job function is to get the non-abusing parent to take steps to protect the child. In the Jones case, that goal became synonymous with 'getting Brian out of the house and keeping him out'. To Leanne, protecting the children meant keeping Brian from doing something drastic, such as carrying out his threats to kill the children. In many places in the case file, Leanne is recorded as saying, "It's easier to just go along with him." She eventually takes the same approach with her caseworker, signing a contract she has no way of honouring.

Leanne's 'truth-telling session' with her caseworker became the basis of a series of file entries in which Leanne was said to have admitted to compulsive lying. These records demonstrate a conceptual framework that does not fully grasp the power dynamics involved in intimate-partner violence. The limited tools available to the caseworker underlie her characterisation of Leanne as a compulsive liar. If the caseworker's task was to work directly with Brian, to bring to bear the full power of the state to offer him choices of stopping his abuse or facing significant consequences, then Leanne's statement would be evidence of Brian's abuse of power, not Leanne's dishonest character.

In addition, the worker employs psychological theories about learned helplessness and victimisation, which has two effects. First, the theories and their underlying assumptions prevent the caseworker from asking Leanne more questions, such as: 'What do you mean when saying it has no impact on Brian? Whom is it easier to tell what they want to hear? Does anyone seem like a source of help to you right now; if so, who, and why? What do you think Brian will do if you…? How can we help you deal with Brian? What works for you when you try to control his violence?' Questions like these would lead to a constructive dialogue with Leanne, but they require a very different conceptual orientation on the part of the caseworker.

The Jones' house was very messy, and the children were often dirty. Leanne says on a number of occasions to the worker that Brian takes care of the children, as she works full time and he will not allow her to do those kinds of caretaking tasks. The caseworker notes this, but she never talks with Leanne in any detail about what she means or how this dynamic plays out in the Jones' day-to-day lives. Four months before the conversation in which Leanne's 'lying' is revealed, the same caseworker made the following notation:

> The house was in a state of chaos, and Leanne said that it was too hard for it to be any different when Brian was around, as she needed to do whatever was required to placate him.

Again, there is no evidence of dialogue with Leanne about these situations. The exchanges are noted in the file for documentation purposes, but the opportunities to work collaboratively with Leanne slip past the caseworker, who is focused on getting Leanne to 'take responsibility' for the safety of her children in very prescribed ways.

This phenomenon was common to many recorded interactions with Leanne and other victims files to which the Audit team had partial access. Audit team members from DCD and the refuge were surprised by the lack of dialogue demonstrated in the files, which was confirmed in the focus group with women. The absence of collaboration has significant implications for safety, and it undermines both the DCD's commitment to strength-based engagement with clients and Starick Services' commitment to the empowerment of victims.

In reading the files, the Audit team noted many examples of workers making conceptual leaps from an exchange with a client to an interpretation of that exchange through a theory such as 'the cycle of violence', 'victim dependencies', or 'learned helplessness'. All of these filters must be made visible

and discussed to expose the ways in which certain conceptual filters are undermining the task of acting protectively in light of the danger posed by a particular offender or a victim's circumstances.

The following notation from the Jones case file demonstrates how the concept of the cycle of violence was used to interpret Leanne's comments about Brian abstaining from alcohol:

> Leanne advised that Brian has been sober since his recent involvement with the family, and that, because she is not coping well with work and the children, it is an easier option to let Brian into her life, rather than to exclude him.

It appears from the case file that Brian is only violent when he is drinking. When he is sober, he is very helpful with the children.

What can be made of such a statement? Perhaps Leanne is saying here what many professionals would say: His violence is caused by his drinking; if he can get sober (which he has now managed to do) and stay sober, he should be safe to live with. Whether it is true some abusers' violence is caused by the consumption of alcohol and, when sober, they are not a risk, it must be conceded that Magistrates, CCOs, solicitors, and even prosecutors have made this same claim in a courtroom. In this instance, a dialogue with Leanne might start with the following questions: Is it safe to assume that because he is sober today, you are safe? If he drinks, will it be harder to deal with him if he is living at home than if he was living separately from you and the children? When he sobers up, do only the violence and threats stop, or do other abusive behaviours stop, like calling you names, or keeping you from caring for the children? If the questions are asked sincerely, the worker may engage in a real conversation with Leanne.

Unfortunately, the worker does what many professionals are trained to do: she hears Leanne's words, moves into a professional discourse, and uses that discourse as a filter through which to understand Leanne's situation. In this case, the worker filters Leanne's words through Lenore Walker's 'cycle of violence' theory[40]. The caseworker makes the following entry in her case notes:

> The cycle of violence was discussed with Leanne, in particular, the honeymoon stage, which Leanne is experiencing at present. Leanne acknowledged this; however, she stated that at times she feels powerless to deal with it.

Instead of talking with Leanne to understand her situation and assist her to figure out whether living with Brian right now is a safe idea or a desperate one, or something in between, the worker almost by rote goes through a theory that may or may not apply in this case. Leanne is forced to talk to her worker through the filter of this theory. Walker's cycle of violence becomes the framework for the worker to talk about the case and determine an appropriate action. Unfortunately, the theory transforms Leanne's experience of not forcing Brian to leave and instead trying to placate him while also managing a household with three children, working full time, and coping with a child who has a significant health problem into a psychological state called the 'honeymoon' stage.

Similar theories can be seen operating in Leanne's interchanges with other practitioners. The following police notation, from another case file, shows an officer using a more straightforward

40 This cycle is a theory developed by Lenore Walker, which is widely used and equally widely criticised in the domestic violence field. Walker asserts that battering is a learned response to stress and anger, and she argues that batterers go through a three-phased cycle of battering. In phase one, tension builds; the abuser may taunt or threaten the victim. In phase two, he explodes and hits her or perpetrates some other form of violence against her. In phase three, he wants to kiss and make up, and he treats her as if they are on a honeymoon, buying gifts and flowers, talking with her and being attentive. Eventually, the honeymoon phase wears down and the tension-building phase returns.

and less psychological interpretation, but with similar effect. In this notation, the 'family violence' paradigm is seen in operation. In this case, the offender's violence is attributed to a breakdown in the marital relationship. Many examples showed practitioners framing domestic violence as an outcome of relationship troubles.

This notation is from a police report on a case of a woman who was being abused and who called the police for help:

> Suspect has been issued a police order—it would appear from the Compl[aintant's] statement that she has to bear some of the blame for this particular incident, however that can be worked out later—I doubt she's in the running for Mum of the Year.[41]

The Jones case is summed up on the criminal side in a PSI Report to the court. The excerpts below include all of the pertinent information to the court on Brian's background. This is what is being presented to the court as the reason to incarcerate him. Missing from this report are the details of his threats to gas his children, his numerous breaches of VRO's by coming over to Leanne's house or harassing her by telephone, his threats to kill her, his physical attacks including pulling her hair out, beating her on the face, choking her until she passes out, threatening to take away her children, not allowing her to care for her children, not allowing her to use the phone and telling her he had put a bomb under her car. These are the acts that are left out of the report to the court though the report goes into great detail about missed appointments, failures to complete programs and confrontational attitudes when dealing with practitioners. The court seems to be sentencing Brian to prison because he just won't cooperate rather than because he is dangerous to his family.

Below is a summary from a PSI report[42] prepared for court.

> B's performance on supervision in the past three weeks has also not been satisfactory. Although he attended supervision appointments, he procrastinated in undertaking the program requirements. B is also on a two year suspended sentence that was imposed on him on ---- for the offences of assault occasioning bodily harm, breach of VRO and stealing and the present offences occurred during the suspended sentence. It thus appears that a prison sentence is inevitable given the present circumstances. It is recommended that B be subject to a psychiatric assessment whilst in prison which also addresses the risk that he poses to his children. It is also recommended that B be made eligible for Parole so that he can be assessed and referred for substance abuse counselling as well as the domestic violence program so as to reduce his risk of re-offending in future.

Problematic Practices

The following section lists the practices that were discussed as having safety implications. This list is a place to start the dialogue; it is not a fixed list of problems—in fact, through dialogue, it may be determined that a practice listed here is not problematic. This list does not constitute a list of Audit findings but Audit discussions that need to be continued.

41 Western Australia Police Incident Report – Frontline Incident Management System (PRD) 2005. NB: All identifying information was taken out of this report before its release to the Audit team and the authors wish to express there is no intentional connection between the persons referred to on the Incident Report and the Jones case.

42 DCS Community Based Services Pre-Sentence Report

(1) Institutional Forms

The following section discusses the ways in which concepts and assumptions are embedded in institutional forms.

If a CCO were to write a PSI report on Brian using the PSI format, the type of information the court would see would include: 'Brian is an alcoholic; he did not go to university; he works; he's been married to Leanne for --- years. They have three children, and he performs much of the childcare. Until recently, he has been active at the children's school'.

What if the 11 categories on the format were ingrained in different assumptions? What if the categories included questions such as: 'Has he engaged in any stalking behaviour, or are there indications that the victim might not be free to leave the relationship? Has she tried in the past, and what happened if she did? Has he ever threatened the children; if so, in what ways? What does the victim say was the time she was most afraid of, or hurt by, him? What kinds of safety precautions does the victim think are necessary for her and her children? How has his abuse affected each of the children? Do you think he can change? What makes you think so?' Alternative questions, such as these, reveal that every administrative document has some assumptions attached to it. A greater range of questions could improve the ability of Magistrates to protect the victims of domestic violence.

In this vein, the Audit team looked at the assessment tools used by the DCD. The Child Safety Assessment Framework does not incorporate effective methods of discussing the presence or absence of domestic violence in the lives of clients like Bobby and Leanne, and they frequently do not discover the domestic violence early in the case. Improvement of the ability of the form to detect domestic violence would improve the safety of victims of abuse.

Police report-writing formats, Police Incident Reports and Statement of Material Facts, could include having officers ask a few straightforward questions of victims during the initial investigation, such as: Do you think he will seriously injure you or your children? What is the time you were most afraid or injured? These questions reach beyond the specific event and help officers gain a clearer picture of the offender's actions, which could also enable police to give subsequent intervenors, such as the DCD, important information about the context of cases.

The Starick House Refuge intake process form is too focused on what the service offers and not on gaining a complete picture of the range of the needs of a woman entering the refuge; further, the intake is only conducted once. Many women in the focus group said they needed time to think and develop trust for refuge staff before revealing the extent of their abuse.

(2) Responsibility for Protection

The basic principle underlying child protection intervention is that if a parent is unable or unwilling to protect a child, the state must take responsibility for protection. Currently, in domestic violence cases, the DCD places the primary responsibility for controlling the abuser on the victim, who is the object of abuse. Most casework is oriented toward getting the victim to change her psychological response to the abuse and abuser in order to achieve this end. According this responsibility to victims compromises the safety of the victim and any children she may have. Further, as long as voluntary counselling programs are the primary tool of the caseworker attempting to end an offender's abuse, effective interventions will not routinely occur, because the majority of abusers do not complete non-mandatory counselling.

There were tremendous differences in whom practitioners saw as having the responsibility to control violence. Everyone agreed that the offender should be held accountable, but how should this be done? There was agreement that victims should not be held responsible; nonetheless, some level of victim participation was needed in every intervention. There was agreement that the victim is not responsible for the violence, nor are they in a strong position to control it, but the practices observed did not match these agreements. This disconnect between theory and practice can compromise victim safety.

(3) Interventions

The advocacy community's framework for domestic violence promotes the view that the most dangerous domestic violence is the violence that is rooted in a pattern of controlling and abusive tactics used by the offender against the victim. While other forms of domestic violence do occur—such as victims fighting back, violence associated with drugs and alcohol, and situational violence where there is no power imbalance—the intervention strategies are all the same.

(4) The Role of Advocacy

There are a number of disconnects between the advocacy community's articulated goals and objectives and the way the group is organised to operate. The advocacy community has a general belief that it wants the criminal justice system to criminalise domestic violence by arresting the abuser, prosecuting, and placing court controls on the offender, while also offering the offender the opportunity to change through appropriate intervention. It wants a greater commitment from the police, prosecution and judiciary to proactively—even aggressively—enforce court orders. However, it has a limited strategy for achieving this. Currently, there is no way to account for the differences in paradigm between advocacy groups and the judiciary.

In addition, the advocacy community does not necessarily challenge problematic frameworks effectively. For example, in the Jones case, an advocate working with Leanne and reporting to the DCD had an opportunity to ascertain the context and framework of Leanne's abuse, which most Audit team members noted as absent but essential to gaining an accurate picture of her case. Instead, in the letter below from an advocate who counselled Leanne, there can be seen an acceptance of the worker's framework:

> Further explorations of… reality [have] also illuminated significant shifts in [Leanne's] perceptions of her and the children's abusive experience. [Leanne] no longer minimises the previous abuse perpetrated by her ex-partner, as can be observed by… giving permission for her situation to be monitored by ADVIP Core Group participants as part of an ongoing safety strategy for [Leanne] and the children. Practical considerations [have] seen… police provide a duress alarm and … allocate funds for a security upgrade at… home. Within all our conversations [Leanne] has consistently maintained a determined and responsible strength of purpose in wanting to provide the children with a safe and loving environment[43].

It appears the advocate is linking into the same psychological explanations of Leanne's situation as the DCD caseworker and the psychologist cited earlier by talking about Leanne's minimisation of the violence. While the letter can be seen as supportive of Leanne, it also fails to replace the worker's framework with one that more adequately describes and accounts for Brian's violence and controlling tactics and Leanne's experiences as a mother living with an abuser like Brian. The failure

43 Excerpt: Starick Services case file.

to provide contextual details of the abuse limits the ability of advocates, as well as other practitioners, to respond as effectively as possible to each case of domestic violence.

The Audit team noted that the legal and child protection systems, whenever possible, should be able to understand the significance of any domestic violence that is occurring in the cases they are processing. This means that neither system should treat domestic abuse or violence as one static or fixed phenomenon.

In one case, the violence might be perpetrated by a victim of ongoing abuse striking back; in another case, abuse might take the form of a threat to kill the children if a partner leaves; in another, it might be a physical assault intended to punish a partner for a transgression.

The frequency, pattern, severity and impact of the abuse are all important aspects to consider when determining appropriate state and community interventions. However, cases where such an understanding was present were rarely found. Instead, workers quickly made assessments using the concepts available to them—such as 'summary offence', 'indictable offence', 'assault', 'technical violation', 'letting him back in', 'failure to protect'—as simplistic descriptions of very complex relationships. Discussions about these concepts lead to the next conceptual practice which was seen as undermining efforts to protect victims: the problematic use of categories.

(5) The Problematic Use of Categories

Institutions process large numbers of cases. In order to do so, they must organise their workers to take up cases in an efficient manner. This means that systems as large as the legal or child protection systems are not able to treat every situation as distinct from others. Legal institutions seek to treat 'similarly situated cases similarly'. To do this, the legal system groups similar situations together and attempts to treat them equally. For example, the law has one set of processing practices for criminal cases, and a different set of practices for civil cases. There are also processing distinctions between summary offences (which are less serious) and indictable offences (those considered to be of a serious nature).

Audit team members were asked to note any categories that practitioners were organised to use in processing a case. They were instructed to ask workers about the use of such categories, using such questions as: Are the categories adequate? Are there problems with grouping situations into certain categories? Do some categories obscure the truth of what is going on? The aim was not to find categories to eliminate but to see whether and in what ways a category may need to be reconceptualised for cases involving domestic assault.

An example of the positive results of reviewing and reconceptualising categories in a way that increases the safety of victims and the accountability of offenders is provided by the police. In cases where both parties have committed an offence—for example, if a victim responds to a domestic assault by attacking her abuser—police officers are required to make a determination as to which party is the predominant aggressor[44]. Officers are now discouraged from making double arrests, which are seen as both difficult to prosecute and, perhaps more importantly, as strengthening an abuser's power over a victim. This change in policy and the accompanying changes in administrative case processing and officer training will all but eliminate the previously problematic category of mutual abuse and mutual combatants.

44 Extract from Police Commissioners Orders and Procedures Manual – OP-31.1.4 Family and Domestic Violence Intervention and Investigation.

During the Audit, a number of examples that needed further exploration were found (see Section 5: Audit Recommendations for further details):

- The first problematic category is the grouping together of all acts of violence between intimate partners as one phenomenon, such as the use of the term 'domestic violence' in both legal contexts and agencies such as the DCD. The lack of clear definitions of domestic violence and how it can be used negatively against women impairs the ability of practitioners to protect victims and hold offenders accountable.
- In court, Magistrates did not necessarily want to consider the history of the victim's situation when sentencing an offender, although the victim's affidavit was available. This was often the only opportunity a woman had to 'tell her story'.
- The categorisation of a victim's actions may lead to an inaccurate understanding of the ways in which they increase safety for themselves and their children. In many instances, Leanne's actions were seen as a failure to protect her children. For example, Leanne's ongoing contact with Brian and her comments that she felt it was easier and less dangerous to give into him were interpreted as her being unprotective of the children. On a number of occasions, contracts and agreements were drawn up between Leanne and the DCD that threatened Leanne with losing her children if she had contact with Brian.
- The categories of adult and child victims of domestic violence also engendered some problems in the provision of safety. The protection of the children was seen as separate from the protection of both the children and their parent who is being abused. For example, the Jones children were placed in foster care on a number of occasions, as Leanne was seen as incapable of protecting them from Brian. The strong focus on protecting the children did not recognise the importance of the relationship between Leanne and her children and the need to nurture those relationships.

(6) The Problematic Use of Language

The Audit team's final discussion of conceptual practices centred on the many times Audit team members found that the use of certain language impeded the goals of holding offenders accountable or enhancing victim safety. Each intervening agency is attached to a professional field, such as dispatching, policing, prosecution, the judiciary, child protection, social work, psychology, or advocacy and support. Many of the professional ways of talking about and conceptualising cases—the professional or institutional discourses—are closely linked.

For example, police and dispatchers talk together all the time, and they talk in very similar ways. It is rare that one finds a language or jargon disconnect between police and dispatchers. On the other hand, there is a gap between police and prosecutors. While both are embedded in the criminal justice system, they have markedly different tasks, functions and ways of talking about a case.

The child protection system operates in a world between the courts and the human service providers. They police families, perform surveillance, conduct investigations, gather evidence, have a coercive power second only to police, and they are charged with helping families to address the root causes of neglect or abuse, which is typically seen as psychological in nature[45]. Each profession is linked

45 While we recognise that workers have the power to remove a child from the home under statutory regulations, they can also be influential, as theirs is the primary voice heard in court about what needs to be done in relation to ensuring the safety of children.

via the lens through which they gather, interpret, and act on information. The research in a field, articles in professional journals, conference speeches and workshops, new intervention models and traditional practices in a field shape that lens. All of this—the ways people are organised to talk about a phenomenon—contributes to professional discourse on 'domestic violence'.

Workers are schooled in their professional discourse and, regardless of their personal backgrounds or personal ways of knowing about domestic violence, that professional discourse becomes the primary discourse they employ when processing cases. These processes lead to the use of metonymic language, in which a word or phrase comes to invoke complex meaning. Such language can come to stand in for an entire body of literature; for example: 'she is in denial', 'she minimises the abuse', 'he is her abuser', 'he's a chronic alcoholic', 'she refuses to take responsibility for her children' and 'we've been here before'. These are not neutral phrases; when used in domestic violence cases, they are loaded.

During the Audit week, these phrases were found to be problematic. The multi-disciplinary team did not agree on which terms were problematic or for what safety reasons they were problematic, but did note words or phrases that needed further exploration.

The first word to be identified as a loaded word was 'mum' or 'mums'. Human service providers and some advocates and refuge workers used the term when referring to women clients who have children. It was used in the training as an example of a word that shapes the perceptions of the listener. Referring to women as 'mums' reduces them to a particular role they play in a complex life. It is precarious to use the term in the child protection field because it erases the complexities of mothers' lives as women, wives, workers, cleaners, cooks and so on. Reducing women to a particular relationship they have with their children actually shapes the listener's perception.

To demonstrate the potential for language to determine the framework in which individuals and their actions are seen, consider the following: Is he a freedom fighter or an insurgent, a tax resister or a criminal; is she lying or protecting herself from an unwanted intrusion into her life?

Team members were asked to take note of words that might give an intervening practitioner a biased interpretation of a case that could lead them to not act in adequately protective ways. Some submissions included: 'he has *anger* problems', 'she *chooses* to go back', 'she *let* him back', and 'it was *mutual abuse*'.

The following is an excerpt from a DCD case file note where the caseworker speaks with Leanne:

> The children are doing very well and the carer has commented that the children are the most 'abused and neglected' she's ever dealt with. What do you think about that?

This particular statement made by the caseworker to Leanne could suggest to the reader that Leanne is an uncaring and unprotective mother when in reality she was trying desperately to protect her children.

Conclusion

Every member of the Audit team expressed amazement at the opportunity the Audit gave to step back and listen to the language used in domestic violence cases. The Audit team asked the following questions: 'What are the underlying assumptions of these statements, of this report format, of this form? How does each practice observed and discussed relate to what the women in the focus group

were living with and through?' The team listened to Leanne and Brian through their case file, and found that their stories could not be heard because they have been re-told through the institutional practices discussed in this report. It was concluded that the practice of interviewing offenders and victims of domestic violence needs to be carried out methodically and according to a comprehensive plan (see Recommendations Three and Four in Section 5 of this report).

4.5 Problem Area Five: Across-Agency Cooperation

ADVIP's current operating structure and processes are focused on across-agency cooperation on individual cases. This focus misses vital opportunities to identify and resolve systemic issues that compromise victim safety and offender accountability.

There is ample evidence to show that communities that have made the most progress in creating a coordinated, safety-oriented, interagency approach to domestic violence cases are those with a recognised coordinating group. ADVIP has acted in this role for 14 years. The strengths and weaknesses of the interagency approach to cases in the South East Metropolitan Corridor are a reflection of both the strengths and weaknesses of ADVIP as a coordinating entity. The Audit team did not audit ADVIP as an organisation. The team did observe a Core Group meeting and an Interagency Safety Committee meeting, and conducted a few interviews.

The Audit team identified a number of problems with the current ADVIP structure:

(1) It does not adequately capitalise on the high level of cooperation among police, advocates, courts and human service agencies. In the Core Group meeting there was a free flow of discussion and problem solving not found in many more rigidly structured interagency groups; the Core Group's informal nature seemed to work to its advantage. Several cases were raised and specific actions were decided upon in order to resolve a problem. However, the group's very informal nature also had its drawbacks. The meeting centred on the issues practitioners brought to the table. If no one in the room knew about a problem, it would not be raised in this forum. Further, no information was provided about the cases being raised, other than what practitioners in the room knew about it. Once again, legal restrictions on the sharing of information played a negative role here. In addition, when an issue was raised, it was treated as an issue only for the case in question. There could be a process by which each issue is discussed to ascertain whether it is an issue in many cases and therefore structural in nature. There was a process for bringing a structural issue to the table, but no format for determining the full scope or cause of the problem. Several members had ideas on what would solve the problem, but there was no thorough analysis of its cause and, therefore, its solution.

    ADVIP agencies signed off on a commitment statement that relied heavily on interagency goodwill. This had the effect of strengthening members' resolve to maintain good working relationships. Because no formal agreements were made, it prevented structured information sharing and hindered ADVIP's capacity to address systemic issues formally.

(2) The Interagency Safety Committee is loosely attached to the Core Group, which is a problem in two ways. First, the Core Group tends to know the ways in which an issue is a problem, the ways the problem affects victims of abuse, the extent of the problem and so forth. The Interagency Safety Committee is composed of senior staff members of agencies and frontline workers. It is well placed to discuss systemic problems, but, like the Core Group, it has no

format in which to do so. Audit team members discussed how impressive it is that this group has met for so many years and taken on so many projects. Yet, it seemed that it could be used much more strategically. Secondly, the group has limited access to coherent information that would highlight the current strengths and weaknesses within the system. Undertaking the Audit was a significant and innovative step in that direction.

(3) The ADVIP Interagency Safety Committee and Core Group began widening its membership base—the majority of its represented agencies were from the criminal justice system—to encompass other agencies, such as housing and social security authorities, and drug and alcohol agencies. This change in membership, in turn, affected the information that was discussed at the Interagency Safety Committee level, which moved from being case-focused to sharing information on domestic violence in the south east metropolitan corridor. Interagency Safety Committee meetings became a forum for domestic violence information updates, agency reports, and lobbying on individual cases, rather than focusing on systemic issues. These functions do not have to stay separated.

(4) ADVIP has no mechanism in place to embrace and orientate new members to ADVIP's mode of operation even though they are provided with copies of the principles of intervention, commitment statement, agency prevention and follow up charts and the history of ADVIP. This could be resolved by ensuring that new members support the principles of ADVIP and have an understanding of domestic violence and integrated agency responses based on the criminal justice system.

(5) The absence of any kind of case-tracking system seems to undermine the capacity of both the Core Group and the Interagency Safety Committee to uncover and resolve systemic issues. The stable membership enhances ADVIP's coordinated interagency response to victim safety and offender accountability. ADVIP needs to link the three tiers (Core Group, Interagency and Board) together in order to coordinate agency responses effectively.

Conclusion

ADVIP has the capacity and structure to operate effectively as a community intervention project; however, its current functions fall short of its potential. The Audit team was able to determine that this was mainly due to the limited reporting and recording processes, a lack of coordination across ADVIP's tiers, a lack of formalised agreements and a lack of funding for a full-time coordinator. ADVIP's original purpose has been displaced by a wider agenda, which has had implications for the way in which ADVIP has been able to manage cases within the area. The Audit team has made suggestions to assist ADVIP to address each of the problems uncovered in this report.

5 Audit Recommendations

The Audit team discussed a number of strategies to resolve the problems it uncovered during the Audit week. However, discussion is limited to recommendations directly related to the five problems areas identified in Section 4: Collecting and Analysing the Data. The Audit team discussed a number of strategies that simultaneously address a specific problem in the system related to victim safety and offender accountability and propose an approach that will strengthen the ADVIP process of interagency reform and collaboration.

The first recommendation addresses the problem of gathering, sharing and using information that makes visible who is doing what to whom, and with what impact. As discussed in Section 4, an intervention that is not based on that understanding will be inadequate at best, and dangerous in many cases. The recommendation calls for the construction of a system-wide map showing each intervening practitioner from the agencies that are actively involved in ADVIP. For each practitioner, the map should identify the information they need in order to act protectively and ensure offender accountability, as well as the information they need to gather and document for others. This task seems simple and straightforward, but it will require an unprecedented level of conversation among and between intervening agencies. It will require a commitment to embedding new information-gathering, documenting and sharing processes within the framework of what makes victims safe.

The second recommendation relies on the first, but it is in fact more far-reaching in its implications for change. This recommendation proposes a pilot project that will fundamentally change the current intervention paradigm in child protection cases where there is a co-occurrence of child abuse or neglect and domestic violence. Based on the findings articulated in Section 4 of this report, the Audit team concluded that a pilot project involving a small number of cases was needed in order to determine a method for transferring the responsibility of controlling an offender's violence from the parent who is being abused to the intervening agencies and the offender. This approach will require a special task force or working group to chart an intervention strategy that: first, redirects the focus of intervention toward the primary offending parent; and, secondly, uses the criminal and civil restraining order systems as coercive tools to gain offender compliance, rather than threatening the removal of the children in order to coerce the victim into taking action against the abuser.

This shift could position social workers to enter into significantly different relationships with victims of abuse and help them realise the strength-based approach they now articulate under current practice. It would rely on agreements to intervening principles by child protection, police, prosecutors, the judiciary and the DCS.

The third and fourth recommendations were identified but not fully articulated by the Audit team due to the limited time available; the full recommendations were developed from the information gathered for the writing of this report.

The recommendations call for a small interagency working group to examine and develop methods to address two key issues: first, building adequate systems of accountability into interagency work on domestic violence-related cases; and, secondly, making transparent the theories, concepts and assumptions that underlie current and proposed practices. Both of the problems these recommendations seek to address are largely conceptual, although they are 'played out' in cases in very concrete and specific ways. The team located many examples, both small and large, where

practitioners intervened in ways that were philosophically at odds with the approach taken by a previous or subsequent intervenor. As one woman in the focus group noted:

> It's not right when a social worker is telling you that if you let your children stay home alone with him, you are not protecting them, and we may have to remove the children. Then a month later a Family Court Judge says, "If you don't let him have the children every other weekend, you will lose contact".

The team recognised that it would be impossible to reach consensus on all of the philosophical aspects of these cases. The team also noted that it was important to determine where there was agreement, and to provide a process for reaching further agreement. The achievement of consensus would also require ensuring that the agreed-upon philosophical understandings were reflected in the policies, procedures, specific duties, training programs, allocation of resources, and working relations among intervenors. At the same time, the team recognised the need to articulate an understanding of obligations in terms of accountability, to which each participating agency would commit.

These two interrelated working groups would act as a common reference for continued interagency collaboration; they could also articulate the conceptual goals that participating agencies seek to achieve. This report, includes suggested content for the development of methods to address the abovementioned areas, based on the discussions of the Audit team, problems the team observed or uncovered in interviews and case-file reviews, and notes taken by Audit team members. These content suggestions are not meant to serve as a comprehensive guide for future working groups but to act as a starting point for discussion.

Finally, the Audit team saw a need for ADVIP to make some significant structural changes. The fifth recommendation calls for three changes within ADVIP:

1 Change the Core Group purpose from solving problems on individual cases to using problems in individual cases to identify and resolve structural problems in interagency case-management processes. The goal here is to create a structure and working process that emphasises identifying problems that occur in a number of cases and are not unique to a specific case, analysing the cause of the problem, proposing solutions, and then providing leadership and help in implementing the proposed changes. While the Audit team is not suggesting that ADVIP abandon the work it does on individual cases, it is suggesting that the current emphasis on problems known to individuals who attend ADVIP meetings is far too narrow a focus for substantive change to occur.

2 The development of a tracking system for all cases involving domestic violence that come into the civil and criminal system. This tracking system would be an effective tool for uncovering systemic problems. It could be used to monitor, for example, changes in arrest, prosecution, or sentencing patterns, or the compliance rate of offenders to court orders, and subsequent court action to achieve compliance.

   Currently there is no process through which to record the data needed to monitor offenders within the system; although this information may be recorded by individual agencies, it is not recorded in a way that allows for the tracking of cases. To reliably monitor and track offenders requires, for example, knowledge of how many offenders are ordered to attend counselling or access rehabilitation services, how many of those offenders complete programs, what happens to those who do not, how many times police are called to attend a domestic dispute, how

many of these instances result in a suspect being charged, and so on. The proposed tracking system would be useful to every agency participating in the ADVIP interagency collaborative. Some form of this exists in individual agencies, most notably the police service, but these databases are limited to use within a specific agency. A tracking system would also be a key tool for addressing the problems of accountability among agencies and between individual practitioners.

3 For ADVIP to better utilise the tremendous resource it has in its membership. The Audit team discussed scenarios that would fundamentally change the ways in which ADVIP uses its capital and influence to resolve any problems identified by the Core Group. The Audit team recognised how powerful the ADVIP Interagency Safety Committee could be if there was more overt use of its considerable capacity to effect change, particularly if the committee was linked to other regional policy forums. The fifth recommendation envisions ADVIP expanding its involvement to regional and state levels whenever intervention at such levels of policy making are needed in order to make the changes necessary for reaching the local goals of safety and accountability.

The Audit team's five recommendations are presented below with suggested activities that could advance the stated goal of the recommendation. All of the recommendations assume that ADVIP will organise working committees of its members from both the Core Group and the Interagency Safety Committee. The Audit team assumed that ADVIP would invite experts and key stakeholders who are not members to participate in these working groups. Several members of the Audit team expressed an interest in continuing their involvement in the implementation phase of the Audit.

5.1 Recommendation One

Form an interagency working group to design an interagency system for gathering, documenting and sharing information on cases that will allow government and non-government workers to intervene effectively in domestic violence cases.

Suggested actions to achieve this goal are:

1 Design an interagency map that identifies each practitioner intervening in civil, and criminal and child protection cases.

2 Develop a set of guiding principles to inform the process of documentation and information sharing that is cognisant of the experiences of victims of domestic violence, particularly those who experience ongoing abuse.

3 Using these guiding principles, determine what information each practitioner needs in order to act protectively and ensure offender accountability.

4 Determine how that information can be made readily available to the practitioner as she or he acts on a case. This determination could be made using the following questions:

   a To whom does the practitioner need to be linked in order to access the information she or he needs?

   b What information-gathering instruments/tools, including assessment forms, report-writing forms, and databases, are necessary for this practitioner to act?

5 Provide each agency participating in ADVIP with assistance in order to: craft these tools to meet the case-processing and service-response needs of the agency and the safety needs of victims; test the tools with selected practitioners and cases prior to wider distribution; and provide instructions for practitioners on the use of these tools.

6 Determine and enhance how each practitioner positions subsequent practitioners to act protectively and ensure accountability. Questions that could be used in this determination include:

   a Who will use the information produced by this practitioner?

   b What does that practitioner need?

   c How can this practitioner gather and document the information needed by subsequent intervenors?

7 Determine how this working group will operate so as to guard an offender's due process (the offender's right to privacy and agencies' duty of care) and centralise victim safety, recognising the vulnerability of victims in some documentation and data-gathering practices, and ensuring their protection at all stages of information gathering and sharing. This determination would involve the following steps:

   a Consider the restrictions created by current confidentiality laws and policies, and their implications for adequate information sharing. Develop a plan to overcome those restrictions while temporarily operating within them.

   b Analyse legislation that limits workers' ability to share information that would enable them to act protectively in a case. Make recommendations for change to overcome those limitations.

   c Analyse existing barriers to information sharing, particularly between government and non-government agencies, and develop a method of formalising agreements to share required information.

8 Ensure that the information-sharing system includes attention to the following factors:

   a Client consent should be obtained, wherever possible, in the development of information-sharing agreements.

   b Authority should be obtained for agencies to release corresponding case files for the consideration of the ADVIP Core Group.

   c The information shared among practitioners should include, whenever possible and appropriate, the following details:

      - history of the abuse
      - pattern and severity of the abuse
      - impact of the abuse on victims (including consideration of the many levels of risk victims face, such as the offender's use of force, risks posed by the intervention itself, and risks generated by the victim's social circumstances)
      - impact of power differentials on the intervention (including consideration of the fact that the only power many victims have is the power to choose whether to speak truthfully or not)
      - social vulnerability of the victim.

9. Determine the leadership roles of stakeholders in the domestic violence community, including government and non-government agencies, to ensure that they act in partnership during the implementation phase.

All of the points included in the suggestions related to this problem came from specific observations made or insights gained during the Audit week. It is not meant to be a complete set of instructions on this recommendation but, instead, a list of issues the team thought important to address in developing a complete information system on domestic violence cases.

5.2 Recommendation Two

Develop new methods of child protection intervention in domestic violence cases that will shift the responsibility of holding an abuser accountable for the harm done to children from the non-abusive parent (typically a mother who herself is a victim of abuse) to the child protection and legal systems (criminal and civil) and, ultimately, to the offending parent.

Suggested actions to assist in the achievement of this goal:

1 Design an intervention process that addresses all three participants in the violence and recognises that each participant has very different capacities to stop the violence:

   a the children, who live with the violence and participate by hiding, becoming involved, calling the police, keeping it a secret, and so forth

   b the abuser, who engages in a pattern of physical and often sexual threats and actions, accompanied by other abusive tactics of control

   c the adult victim, who is the object of much of the abuser's violence.

2 Organise a direct intervention with the offender by the Department for Community Development, Western Australia Police, Department of Corrective Services and offender program providers to stop the violence and abuse. This intervention should consider the following factors:

   a Explore the use of arrest, prosecution, and state-initiated restraining orders as methods to control offenders' use of force and, when necessary, to remove them from the family home.

   b Discontinue or severely limit the practice of using the threat of the removal of children as a method to gain victims' compliance with a plan to control offenders' behaviour.

   c Analyse existing services to determine the changes that need to be made in order to offer services that reduce the likelihood of the offending parent:

      • using children to abuse their partners

      • engaging in abusive parenting behaviours with their child

      • socialising their children to believe that violence and its accompanying verbal, sexual, and economic abuse is acceptable or normal

      • continuing to abuse their partner.

3 Organise a support and advocacy intervention for victims of abuse that is focused on:

   a assisting them to help their children to remain safe and to cope with the harm caused by the abuse

b assisting victims to take whatever steps necessary to remain safe

c working to help adult victims and their children to deal with the harm done to their relationships by the abuse and, in some cases, by the intervention

d helping victims, when necessary, to live independently of the offender.

4 Design an intervention that directly assists the children harmed by the abuse (see Problem Area Two on the absence of such interventions). This should include the development of a training curriculum and program that informs all intervening practitioners of the needs of children whose parent is perpetrating domestic violence[46]. The curriculum should educate practitioners on:

a the tactics of abusive parents in relation to children

b the impact of the abuse on the child's:

- self concept
- relationship with their non-offending parent
- relationships with their siblings
- physical health
- emotional wellbeing
- social adjustment

c the basis of children's resilience to abuse and the ways in which interventions can bolster children's resilience

d protecting children from abusers who use institutions such as the law, the church, and the family to continue their abuse, and those who draw their children into the abuse of the parent who is being abused

e develop assessment tools for intervening practitioners—such as child protection, refuge and mental health workers—that are specifically linked to the experiences of children who live with an offender

f evaluate current services provided to the children of offenders in order to determine the appropriateness of program content and provider skill-level so as to better address the specific needs of children of offenders and the needs of their non-offending partner.

These suggestions are all rooted in discussions that occurred during the Audit week. The team did not have time to fully envision this rather radical shift in intervention practices. However, the team believed that the current intervention in domestic violence–related child protection cases puts too much responsibility on victims (mostly mothers) to control the offenders' violence. It also forces intervening practitioners to engage in social work practices that go against their agency principles of strength-based[47] work with families (see Problem Area Two for examples).

The team took the position that, if workers had true access to the criminal court system and a working authorised relationship with colleagues in the criminal court, the worker could directly intervene

46 For the purpose of this report, domestic violence is defined as a systematic pattern of control, intimidation, and domination.

47 It needs to be noted that during the time the 'Jones' family were clients of DCD it had undertaken a restructure with a shift of focus to a strength-based approach. This restructure was acknowledged during the Audit. The Audit team held a number of interviews and observations with staff at DCD during the Audit week, and the findings concluded that fundamental problems still exist in the Department's current practice.

with the offender. Finally, the Audit team assumed that as the practice of child protection changed, workers would also find that the services they would want to use with their clients would have to be developed. These assumptions underlie the recommendations for evaluating and altering the current services provided for children and their abusive parents.

5.3 Recommendation Three

Produce an interagency framework and guiding principles for all government and non-government agencies to use in defining and describing interventions rooted in systems of accountability that centralise attention on the intervention goals of victim safety and offender accountability.

Suggested actions to assist in the achievement of this goal:

1 Form an interagency working group to write a document (hereafter referred to as the Accountability Monograph), which each participating agency in ADVIP can endorse, that:

   a defines the multiple levels of accountability that are needed to allow practitioners to work effectively on cases involving domestic violence

   b articulates assumptions about responsibility for the use of violence and abuse, and the control of that violence

   c provides guidelines for how to apply these concepts to an agency's everyday work practices.

2 ADVIP's Interagency Safety Committee to organise the working group and request key intervening agencies to provide a representative.

3 ADVIP's Interagency Safety Committee should appoint co-chairs from the non-government sector and the government sector (at the level of district manager) to oversee the work of the group and provide leadership in obtaining endorsements of its final products from intervening agencies.

4 Define the multiple levels of accountability that should be integrated into existing interventions into cases involving domestic abuse. The Audit team was organised to look for accountability on three levels during its observations, interviews and case-file readings; a fourth level was added to fit ADVIP into the framework Praxis provided. These levels of accountability are not intended to replace existing measures of practitioner accountability but to supplement that work. The Audit team suggests that the accountability working group use these four levels to begin the writing of the Accountability Monograph:

   a The accountability of the individual practitioner and the specific organisational process to victim safety which could be explored through the investigation question: Does the design of a particular case-processing step have victim safety and offender accountability at its centre?

   b The accountability of abusers to victims (both adult and child), which could be explored through the investigation question: Is the offender being held responsible for the harm they have caused, or are victims shouldering responsibility for an offender's violence and abuse?

c The accountability of intervening practitioners to one another, which could be explored through the investigation question: Do practitioners do their work in ways that position other practitioners to centralise safety and accountability?

d The accountability of collaborative intervening agencies for the assessment and correction of systemic problems, which could be explored through the investigation question: Is there an interagency system of self-regulation for the improvement of victim safety and offender accountability?

5 Design a method of developing an institutional safety plan[48] to provide systemic protection for victims of abuse. The institutional safety plan should detail the levels of responsibility held by the intervening agency. The institutional safety plan would be a tool for holding intervening agencies accountable to one another and to victims and offenders of domestic violence. The team envisioned a safety plan that defined the actions that both the victim and the intervening agency should take regarding an offender's use of violence.

6 Build into police reports the practice of asking all victims three risk-assessment questions. Subsequent intervenors could use the answers to assess the level of intervention required and to understand the context of the individual case. Below are example risk-assessment questions that are sometimes used by law-enforcement agencies:

a Do you think this offender will seriously injure or harm you or your children? What makes you think so?

b Can you describe the time or situation in which you felt the most afraid or were most seriously hurt?

c Can you describe the pattern of abuse? How often does it occur, and how serious is it? Is it changing? How is it changing, and why do you think this?

6 Build into current procedures a better system of notification of community correction officers of offenders' police or civil court contact.

7 Build into current practice a sense of the victim as the community corrections officer's client, in addition to the offender.

8 Develop better assessment tools for child protection workers and community corrections officers.

9 Require professionals who report to the court on child safety, contact recommendations, and access recommendations to account for the level and pattern of violence against both the children and the parent who is being abused.

10 Develop report-writing tools to guide the above practice.

11 Develop a quality-assurance program for services that victims and offenders are required to attend. Interviews with practitioners and clients indicated frequent disconnects between what a client needed and what service the agency provided. Agencies were not required to tailor services to clients' needs, which was problematic in a number of cases.

48 We recommend that the institutional safety plan replace the use of contracts/agreements between clients and agencies, where they currently exist. There was evidence that the use of contracts/agreements in the 'Jones' case put the responsibility of protecting the children onto Leanne, and conditions of the contracts/agreements threatened serious consequences for Leanne if she did not comply.

12 Balance child protection documentation with documentation on the strengths of parents (see discussion on Problem Area Two).

13 Conduct full family assessments early in the process of a child protection investigation in order to determine the full range of family needs and to put abuse or neglect claims in context (see discussion on Problem Area Two).

14 Make transparent the assumptions, theories, and concepts behind institutional claims and actions so they can be questioned when they do not fit the circumstances of a case (see discussion on Problem Area Four).

15 Require ADVIP members to use an agreed-upon process and mode of analysis to determine the source of problems and propose systemic solutions (see Recommendation Five).

16 Develop a tool to assist practitioners to examine ADVIP agencies' internal training programs, policies, procedures and texts, report formats, assessments, evaluation formats, and other material, continually asking the question: How does each practice, procedure, form or brochure enhance or compromise victim safety?

17 Reach agreements with agencies to ensure that changes to policies or practices related to the processing of domestic violence cases will be discussed in Interagency Safety Committee forums in order to provide input to policy makers before such changes are made (see discussion on Problem Area Three).

18 Build into definitions and all accountability practices attention to the dynamics and nature of domestic violence.

5.4 Recommendation Four

Produce a set of guiding principles on how to account for the unique aspects of domestic violence in policy development, case-management procedures and resource allocation in the Magistrate and Family Courts, child protection system and related human service providers.

Suggested actions to assist in the achievement of this goal:

1 Form an interagency working group to write a document (hereafter referred to as the Framework for Philosophical Agreement Monograph), which each participating agency in ADVIP can endorse, that:

   a articulates a series of agreed-upon premises that intervening agencies will use when intervening in cases involving domestic violence

   b provides common definitions for terms used across agencies

   c articulates understandings about domestic violence that agencies can agree upon and use as assumptions in the design of policies and intervention practices

   d provides guidelines for the ways in which agencies can apply these assumptions and concepts to everyday work routines

   e articulates a process for continually revisiting and updating this document as experience, new knowledge and changing social conditions require.

2 ADVIP's Interagency Safety Committee should organise the working group and ask key intervening agencies to provide representatives.

3 ADVIP's Interagency Safety Committee should appoint co-chairs from the government and non-government sectors (at the level of district manager) to oversee the work of the group and to provide leadership in obtaining endorsements of the its products from intervening agencies.

4 Incorporate into this Framework for Philosophical Agreement Monograph a series of agreements on the premises of interventions and interagency work. Each of the statements below came from discussions about current intervention practices. They are recorded here not as a statement of fact but as examples of the kinds of statements that an interagency group should determine if there is to be agreement:

   a Interventions must be adapted to the level and context of the abuse.

   b Interventions should, whenever possible, put the onus of controlling an offender's behaviour on the offender and on services, not on the victim.

   c Child protection intervention should be careful not to undermine the factors that contribute to a child's resilience.

   d Interventions on behalf of children in cases where the mother is being abused should strengthen the mother–child relationship and actively seek to undo the harm done to the relationship.

   e The belief that abused women who are unable to stop an offender from abusing children are themselves practicing a form of neglect should be reconsidered and altered.

   f 'More jail' does not equate to 'more justice', but the failure to impose consequences on abusers contributes to increased violence.

   g Intervening in an offender's use of violence is not the same as intervening in his/her relationship. The primary goal of intervention should be to stop the violence.

   h Relationship counselling for couples should not be associated with stopping abuse.

   i Victims are often made more vulnerable to abuse by the intervention itself.

   j Prosecution policies that depend on a victim wanting to testify will not work in most domestic violence cases.

   k Police should have some level of discretion to avoid arresting a suspect in cases of very low violence.

   l Mediation should never be considered a tool to stopping the abuse as freedom from violence is a right.

2 Incorporate into the Framework for Philosophical Agreement Monograph a section that defines terms that are used in the intervention process but which are not always understood in similar ways across disciplines and agencies. Further, this section should recognise that certain terms are used within certain legal processes (and are fixed in legislation or rule for that legal process) but are used differently in other settings. For example, 'domestic abuse' has a very specific meaning in a restraining order hearing but a broader meaning in a refuge women's group. The following terms are suggested for inclusion in the definitions:

a victim safety

b offender accountability

c systems accountability

d victim input

e predominant aggressor

f mutual abuse

g victim responsibility

h domestic violence/abuse

i uncooperative/cooperative victim

j post-separation violence

k advocacy

l effective interventions

m social life-risks that increase vulnerability and which might be used by an offender to control a victim

n intervention-generated risks that decrease the safety of victims.

2 Facilitate a process for the establishment of common understandings of the dynamics of domestic violence. This process should incorporate the following steps:

a Research and discuss the competing theories about the causes of domestic violence that lead to different intervention approaches.

b Avoid trying to apply one theory to all acts of violence within an intimate relationship, as this approach leads to misguided interventions.

c Account for the ways in which each intervention is affected when domestic violence involves the use of physical and/or sexual violence, intimidation, and the accompanying tactic of abusive control, which the dominant party uses to establish control and power over the victim.

d Account for the fact that victims of ongoing abuse, violence and intimidation frequently use violence in retaliation. In such cases, interventions cannot treat both parties in the same way without also increasing the dominant party's power over the victim of ongoing abuse.

2 Apply these common understandings to daily work practices. Some ways in which they could be applied are suggested below:

a Develop guidelines for policy makers on the use of language in intervention policies[49].

b Discuss proposed interventions and new practices with focus groups of victims and advocates to assess the ways in which a given practice might influence the safety of a wide range of adult and child victims of abuse.

49 Appendix Fourteen: Developing Policies and Protocols for Responding to Domestic Violence Cases

c The working group should make suggestions to each intervening agency on the specific applications of a proposed principle to core aspects of their case-management responsibilities.

d When making suggestions for a change in practice, the working group should use the categories of the eight audit trails to ensure that proposals fully embed new practices into the work of a given agency.

3 ADVIP should organise a process by which to change the agreed-upon assumptions, definitions and understandings as circumstances require. As part of this process:

a ADVIP should continue to serve as a facilitator of quality assurance, as it did in providing leadership in the Audit process.

b ADVIP should organise annual discussion sessions with key policy makers and practitioners to review the assumptions in the Framework for Philosophical Agreement Monograph and the Accountability Monograph in order to continually update these important documents.

2 Provide each member agency in ADVIP with assistance to craft policy and procedural guidelines consistent with the collective goals, common understandings and assumptions of ADVIP's membership.

3 Assist agencies to build into case-management practices underlying assumptions, concepts, language and theories that reflect the nature and dynamics of domestic violence.

4 Provide ADVIP members with ongoing training in the analysis of case-management practices, embedding attention to the dynamic of domestic violence in policy and practice, and implementing change within an interagency effort.

5 The Framework for Philosophical Agreement Monograph should be linked to the Accountability Monograph. The working groups should have overlapping memberships, and they should be organised to review the other group's work and processes.

5.5 Recommendation Five

Restructure ADVIP to enhance its effectiveness in identifying structural problems, analysing the reasons for the problems, proposing solutions and ensuring that changes are implemented.

Suggested actions to assist the Core Group to achieve this goal:

1 Formalise and clarify the Core Group participation and meeting process.

2 Thoroughly discuss all of the implications for victim safety and wellbeing when determining what level of case sharing is necessary to ensure victim safety.

3 Continue Core Group fortnightly meetings in which practitioners bring specific problem cases to the group for resolution.

4 For each problem addressed by the Core Group, determine whether the problem is specific to one case or indicative of a more systemic problem.

5 With the resources and information available to the group, analyse each systemic problem using the same process employed by the Audit team; that is: How do we know this is a problem; what

is our evidence? For whom is this issue a problem? How does it affect victim safety and offender accountability? How is the problem produced? The eight audit trails should be used to determine the cause of the problem.

6 After the initial analysis, systemic problems should be forwarded to the Interagency Safety Committee, and at least one Core Group member should be involved in all Interagency Safety Committee discussions on the issue.

7 Develop a tracking system to monitor all civil and criminal cases, and include a discussion on the trends revealed by the tracking system at each meeting[50].

Suggested actions to assist the Steering Committee to achieve this goal:

1 Work with the Core Group to develop an interagency tracking system that will allow the Core Group to follow all domestic violence–related cases, rather than only those known to the participating practitioners at a given meeting.

2 Employ a method of evaluating interagency work that continually uncovers systemic problems in the management of cases and works toward their resolution (refer to item 6 above in the list of actions for the Core Group).

3 Organise a method of communication that allows the Core Group to inform the Interagency Safety Committee of needed change.

4 Organise a system for the Interagency Safety Committee to link with other policy-making entities to effect change on legislative, regional and state levels.[51] These entities should include the Human Services Regional Management Forum, the Family and Domestic Violence Senior Officers' Group and/or the Family and Domestic Violence Unit.

Note: It is the responsibility of the abovementioned forums to refer systemic problems to Human Services Directors' General Group and the Cabinet Standing Committee on Social Policy.

5.6 Conclusion

This report represents a possible way forward for domestic violence service stakeholders in Western Australia. It suggests a method of working collaboratively to respond to victims and offenders of domestic violence to improve service delivery and better protect women and children from further abuse. In previous years, government and non-government agencies have tried different ways to respond to domestic violence; although there have been many improvements, there is still a long way to go. This Audit has not only provided an opportunity to challenge some practices, it has provided a basis for changing them and adopting challenging ways of working that go beyond current ways of thinking.

50 DAIN (the Domestic Abuse Information Network) is designed for use by domestic abuse prevention organisations. Its primary purpose is to maximise victim safety. The law enforcement and court records section tracks such incidents as arrests, citations, non-arrests or complaints. Conviction data includes details on sentencing, probation and any changes in charges. Protection order data includes orders granted and dismissed, emergency orders *(ex parte),* and details on court-ordered relief, including offender program orders. Offender program information includes details on referral, orientation, class enrolment and completion, as well as daily attendance records, suspensions and form letters for both participants and probation officers.

51 For example, Cabinet Standing Committee on Social Policy, Human Services Directors General Group, Human Services Regional Managers Forum, Family and Domestic Violence Unit, Family and Domestic Violence Senior Officers' Group.

This Audit has been a partnership effort in which all those involved shared the same vision: to better address the problem of domestic violence. The Audit report calls for action: first, at an individual level, when managing the cases of those whose lives are affected by domestic violence; and, secondly, at a systemic level, to challenge the current mandates—including legislation and other directives—that drive the state's response. The findings of the report recognised that only by working together can there be the level of protection needed to prevent the devastating consequences of this serious crime.

The report stresses the need for all agencies involved in addressing issues of domestic violence to ask continually: Does our work offer the level of protection needed to ensure that victims of domestic violence are not put at further risk by our interventions? How do we know this if we only look at our own piece of the puzzle; how can we possibly see what is really going on unless we seek the full picture? How can we see the full picture without working together, planning together, sharing common goals, and working to eliminate the obstacles that impede our attempts to protect women and children and hold offenders accountable? How can we be accountable to those we are trying to protect if we cannot be accountable to ourselves as service providers?

The Audit provided a depth of information, providing some key insights into the areas that require some form of change to enable a better response to the needs of both victims and offenders of abuse. It was found that some interventions, although well intentioned in their development, could heighten the risk of victims experiencing further abuse. The Audit allowed members of the Audit team to analyse the 'how' of agency workings, to seek the origins of poor intervention outcomes and, in turn, identify required changes to the system.

ADVIP is in a key position to trial some new ways of working that will equip agencies with a strengthened and more comprehensive approach; this approach, in turn, can influence a coordinated statewide response to domestic violence. ADVIP's Interagency Safety Committee has the key players on board, and its members have the vision, the commitment and the knowledge to lead the way in developing an effective interagency response to domestic violence.

The recommendations presented in this report are intended to provide ADVIP with five immediate and concrete ways to respond to the findings of the Audit. It was assumed by the Audit team that the driving forces behind the organising work would be the ADVIP Core Group and ADVIP Interagency Safety Committee. At the same time, both of these groups need to change their operating procedures to provide an effective forum through which to guide agencies to implement these recommendations.

Appendices

Appendix One:

History and Structure of the Armadale Domestic Violence Intervention Project

In the early 1990s, interest in coordinated interagency criminal justice interventions to address domestic violence and abuse was encouraged by Dawson Ruhl, who was employed by Relationships Australia WA, and who 'discovered' the Duluth model. This model sanctioned a coordinated, integrated, interagency, justice-focused intervention response to domestic violence.

This model of intervention was promoted to the Western Australian Government during 1991 and 1992. During this period, a series of community workshops on domestic violence and the Duluth model generated a great deal of interest and enthusiasm, as was evidenced by the rapid development of community-based domestic violence action groups.

The introduction of this model of intervention was an important event that was to significantly change and shape Western Australia's response to domestic violence. Dr Ellen Pence, co-founder of the Duluth Abuse Intervention Project and author of the 26-week offender group, was brought to Perth to present a two-day conference for people active in the domestic violence sector in Western Australia. The conference highlighted the need for a more concerted and coordinated response to domestic violence that involved both the government and the community.

A one-day 'search' consultation was held, bringing together local government and non-government agencies in the cities of Armadale and Gosnells, and the Shires of Serpentine and Jarrahdale to explore what services and support were available for both victims and offenders of domestic violence. This consultation also aimed to gauge interest in the development and implementation of a community intervention project in the region. The deciding factor that brought all agencies—particularly the police—together to begin working with one another in a more coordinated way was the desire to share important information and to formulate a more cohesive, broader plan for protecting victims and holding perpetrators accountable.

Not long after this consultation, Arina Aoina, coordinator of Starick House Refuge and Senior Sergeant Fred Heald, officer in charge of Armadale Police Station, were approached by Dawson Ruhl to determine their interest in beginning the pilot project. Both accepted the challenge, with others, of developing and implementing the pilot project in the Armadale region. In the 'early days' they approached local politicians and councillors, senior police in the South East Metropolitan corridor, managers of the Department for Community Development, Department of Corrective Services (formally Department Community Corrections), the Magistrate and staff of Armadale Court, and Armadale Health Services to secure their support and commitment. Senior Sergeant Heald went on to develop a comprehensive policy, ratified by his superiors and negotiated with the Magistrate of the Armadale Court, for the hearing of restraining order applications initiated by the police. This policy document has become the benchmark among Western Australian police, and it has been referred to by the Western Australian 'Report on Gender Bias' (Chief Justice's Taskforce, 1994).

In the early stages of committee development, an Aboriginal committee was established in recognition of the parallel development model that was established in the Hamilton Abuse Intervention Pilot Project

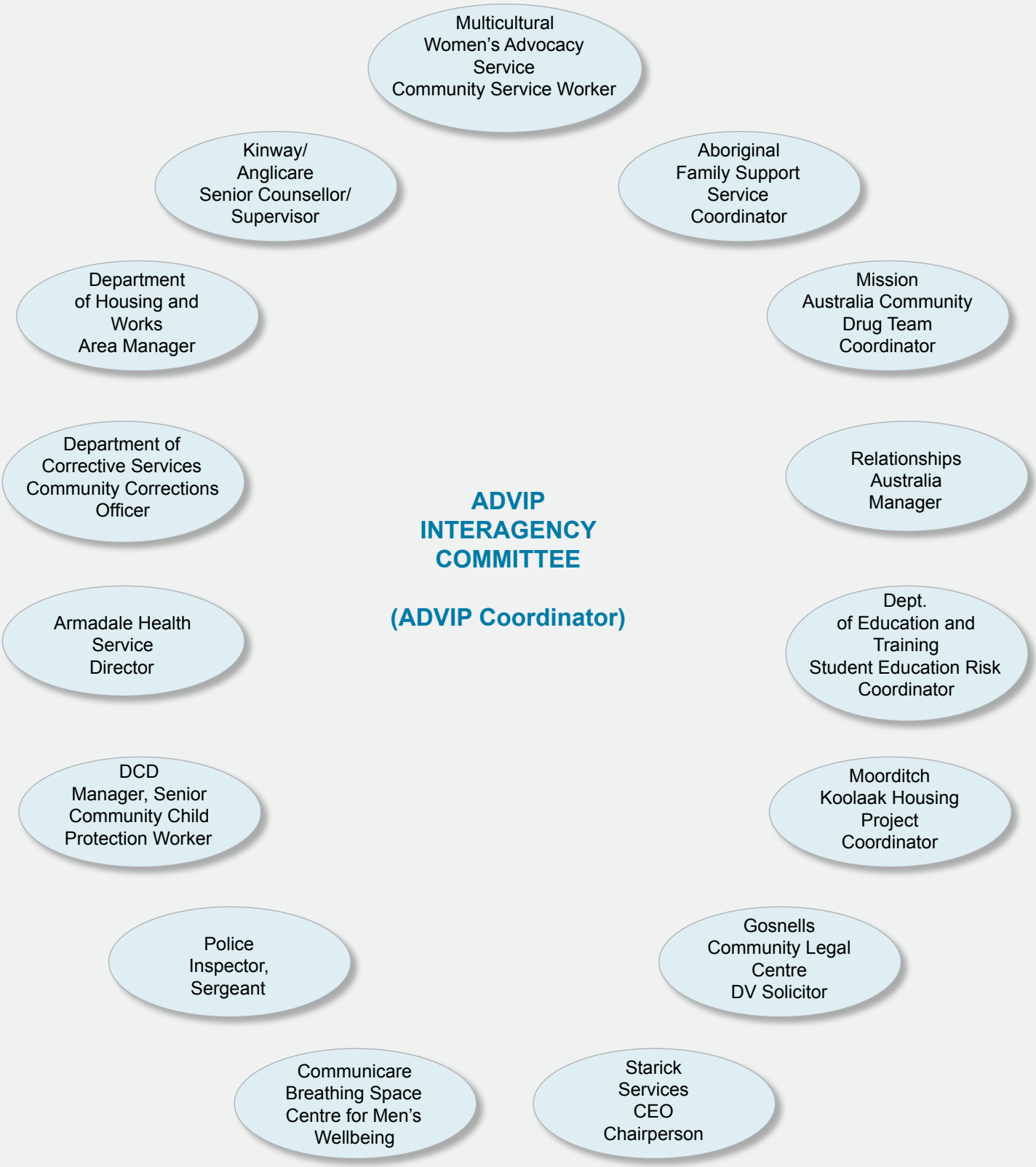
in New Zealand. It was envisaged that both committees would work side by side in developing victim-centred approaches to domestic violence. It must be noted that there were considerable concerns held by the Aboriginal community regarding the impact an increased criminal justice response would have on Aboriginal families.

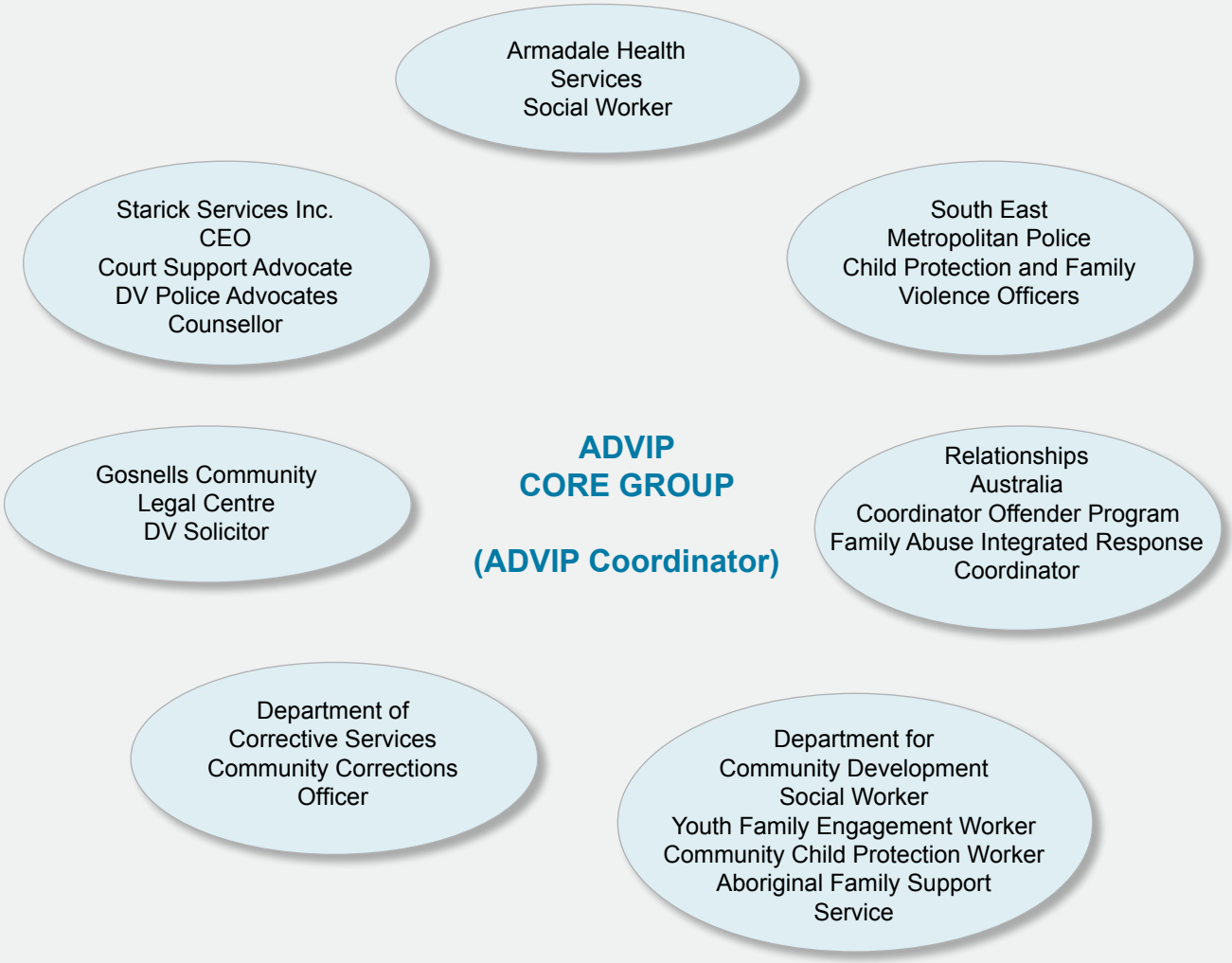
In 1996 the Government of Western Australia adopted the ADVIP model as its blueprint for a whole-of-government approach to family and domestic violence. Funding was administered through the Family and Domestic Violence Unit for the coordination of 16 regional committees, based on the existing 16 Police Department Regions throughout Western Australia.

ADVIP members developed a Commitment Statement in September 2002 for all relevant agencies and services to sign. The Commitment Statement acknowledged membership of ADVIP based on adherence to the Principles of Intervention and a shared understanding of both the dynamics of power and control involved in domestic violence and the impact of domestic violence on all family members.

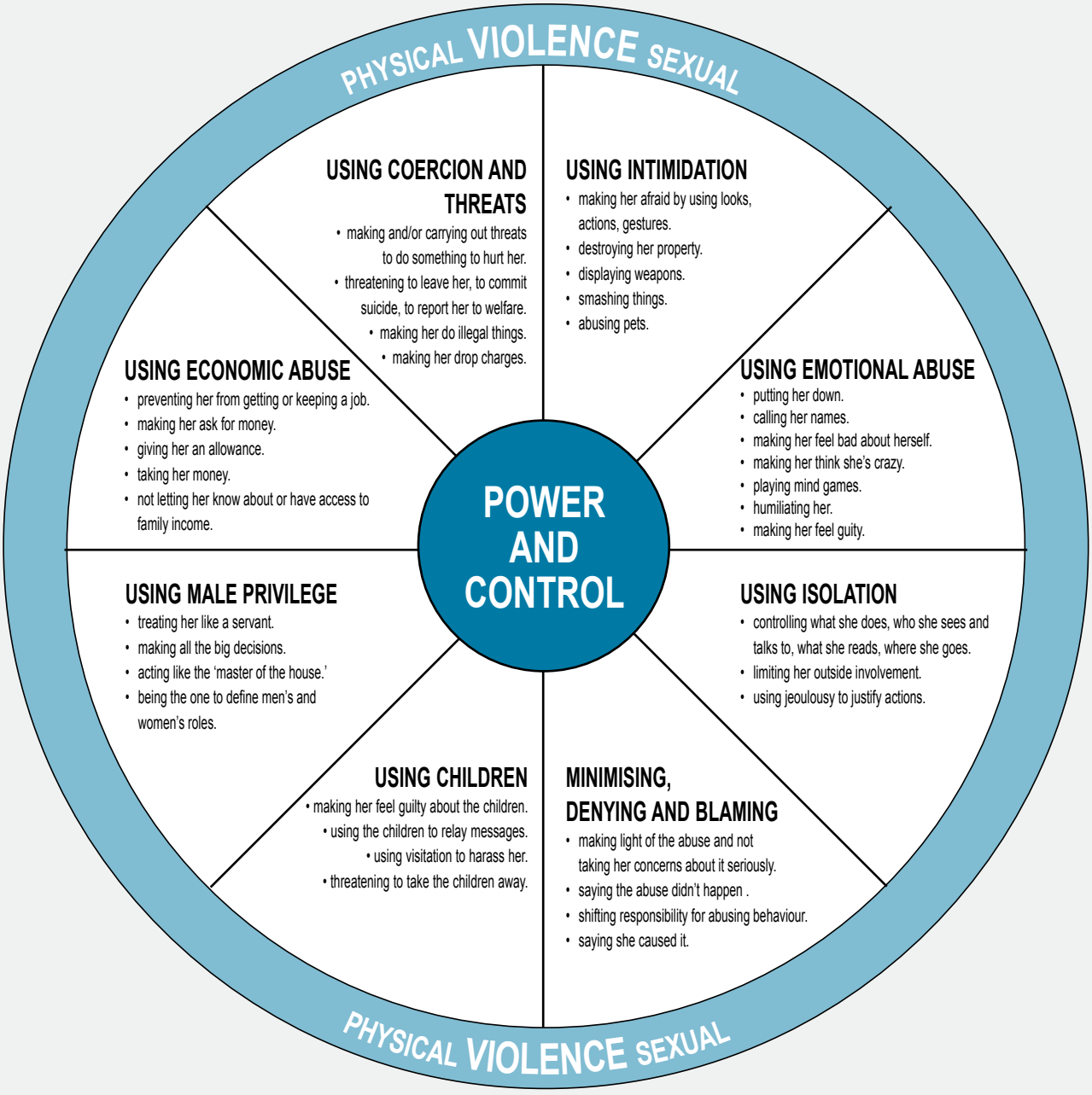
Principles of ADVIP:

- The focus of intervention is to stop the violence and to protect victims and their children.
- Intervention works towards enabling victims to access support, information and legal advocacy.
- While victims should be encouraged to support criminal justice intervention, victims have the choice not to participate.
- In relation to perpetrators of domestic violence, the goal of intervention should be to hold abusers accountable for their actions and support the application of legal sanctions, as appropriate.
- Intervention encourages equality in relationships and challenges the belief that a person can have control over his or her partner.
- Intervention is based on the community and its organisations taking responsibility for intervening to stop domestic violence.
- Assault in the home is criminal, and the community should respond to domestic assault in the same way as to assault outside the home.
- Intervention is based on the monitoring of the perpetrator's compliance with sanctions imposed through the criminal justice system.
- Intervention offers perpetrators the opportunity to change their abusive behaviours through offender education programs, which are open to review by victims and their representatives.
- Intervention is designed to enhance cooperation and information exchange between agencies. Agencies support the monitoring of ADVIP's guidelines, within the constraints of agencies' own policies and legislation.
- Intervention should be flexible enough to reflect cultural diversity.


Multicultural Women's Advocacy Service Community Service Worker
Kinway/ Anglicare Senior Counsellor/ Supervisor
Aboriginal Family Support Service Coordinator
Department of Housing and Works Area Manager
Mission Australia Community Drug Team Coordinator
Department of Corrective Services Community Corrections Officer
Relationships Australia Manager
ADVIP INTERAGENCY COMMITTEE
(ADVIP Coordinator)
Armadale Health Service Director
Dept. of Education and Training Student Education Risk Coordinator
DCD Manager, Senior Community Child Protection Worker
Moorditch Koolaak Housing Project Coordinator
Police Inspector, Sergeant
Gosnells Community Legal Centre DV Solicitor
Communicare Breathing Space Centre for Men's Wellbeing
Starick Services CEO Chairperson

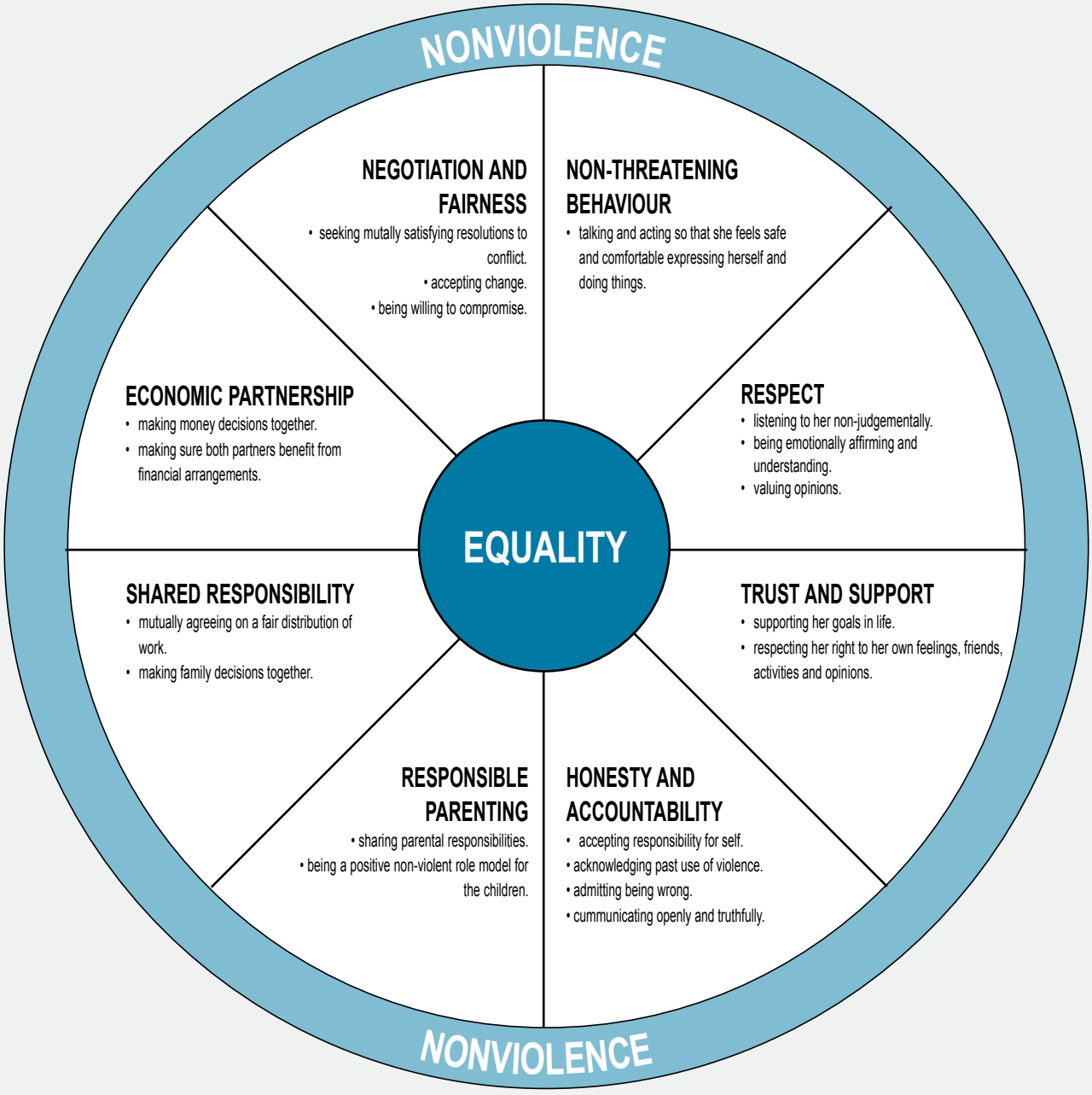

Armadale Health Services
Social Worker
Starick Services Inc.
CEO
Court Support Advocate
DV Police Advocates
Counsellor
South East Metropolitan Police
Child Protection and Family Violence Officers
Gosnells Community Legal Centre
DV Solicitor
ADVIP CORE GROUP
(ADVIP Coordinator)
Relationships Australia
Coordinator Offender Program
Family Abuse Integrated Response Coordinator
Department of Corrective Services
Community Corrections Officer
Department for Community Development
Social Worker
Youth Family Engagement Worker
Community Child Protection Worker
Aboriginal Family Support Service

Appendix Two:
The Power and Control Wheel



Domestic Abuse Intervention Project

Equality Wheel



Domestic Abuse Intervention Project

ADVIP Structure

ADVIP has three components: the Interagency Safety Committee, Board and Core Group.

The Interagency Safety Committee

The Interagency Safety Committee has representatives from regional government and non-government agencies. The Interagency Safety Committee members work collaboratively to:

- evaluate the practice and consider the policy development of their particular agencies in relation to ADVIP
- examine ways of increasing community awareness about domestic violence
- consider preventative measures
- provide strategic direction for the project
- identify gaps in service and take action to address those gaps.

The Board

The Board administers funding provided by FDVU to ensure compliance with funding requirements, and it considers alternative methods of fundraising. The Board also provides support for the coordinator.

The Core Group

The Core Group consists of 'coal-face' practitioners who work collaboratively to ensure accountability through the monitoring of agencies' responses to individual cases. Members share information in accordance with the relevant policies and legislative requirements of their agencies.

The Coordinator

The coordinator attends meetings and provides reports to all three groups, liaises with the FDVU and other regional coordinators, coordinates committee member agencies, and provides education to the community.

Projects

Men's Perpetrator Group

In 1997 ADVIP was successful in obtaining direct funding to deliver the Men's Perpetrator Group for the Department of Justice. In later years, Relationships Australia was successful in obtaining funding, and it continues to be a highly regarded member of ADVIP.

The Culturally and Linguistically Diverse (CALD) Project

The CALD Project was an initiative of several regional domestic violence committees, including Armadale, Central Metropolitan, Rockingham/Mandurah and Fremantle. ADVIP created a Domestic Violence Training Package for CALD workers before recruiting, training, and supporting women to run workshop sessions for women in their own languages.

Lighthouse Project

The purpose of the Lighthouse Project, which involved five states, was to enable and encourage the use of best practice in crime prevention among state and territory governments and their agencies, local government and community crime prevention participants, such as crime prevention workers

and community groups. ADVIP participated in all stages, demonstrating ADVIP's commitment to best practice in working with domestic violence.

ADVIP/Domestic Violence Legal Unit/Armadale Court Project

A domestic violence duty solicitor from Legal Aid was employed on a part-time basis to support victims through the court process. The pilot project was funded for six months and extended for a further six months.

Family Law Outreach Program

ADVIP members, Gosnells Community Legal Centre and Relationships Australia, Armadale, launched a Family Law Service to accommodate the needs of the local community and to improve the accessibility of services throughout the community.

Research and Education Unit on Gendered Violence (REUGV) Research Project — School of Social Work and Social Policy, University of South Australia

ADVIP was identified as one of five sites around Australia 'exemplifying promising integrated practice in domestic violence services' and the group was invited by Dr Donna Chung and Dr Patrick O'Leary of the Research and Education Unit on Gendered Violence (REUGV) to participate in a national research project. The project was aimed at reviewing the implementation and operation of integrated approaches to intervention with perpetrators of domestic violence, with the intention of making a significant contribution to the knowledge of the most effective ways of working with people (mainly men) who perpetrate violence. An underpinning principle of this research was that programs working with men who perpetrate violence must be accountable to the experience of women and children who are affected by men's violence.

Be Cool Not Cruel

ADVIP was awarded a government grant to implement an awareness campaign in local schools to promote the message 'Be Cool … Not Cruel'. Permission to use the slogan was granted by the Office of Women's Policy, Northern Territory, after a successful NT campaign. The project was aimed at promoting to primary school students the message that violence is neither acceptable nor tolerated, wherever it occurs. Campaign merchandise was used to reinforce the message.

Multicultural Women's Advocacy Service (MWAS) Forum

In October 2002 the Multicultural Women's Advocacy Service (MWAS), in collaboration with ADVIP and the Central Metropolitan Prevention of Domestic Violence Committee, presented the 'It's NOT Part of OUR Culture' Forum. The one-day forum was aimed at exploring perspectives on domestic violence within culturally and linguistically diverse communities.

Mornington Camp

The Mornington Camp for women and their children was a joint initiative between the South East Metropolitan Police (police domestic violence liaison officers), Starick Services, Nardine Wimmins Refuge and the Department for Community Development, Cannington.

Family Abuse Integrated Response Services (FAIRS)

Relationships Australia WA, in collaboration with ADVIP, was successful in securing three-year funding for the implementation of the FAIRS program to develop and implement domestic violence groups for children, women and male offenders.

Appendix Three:
Relevant Studies and Reports

The Acts Amendment (Domestic Violence) Bill 2004

Restraining Orders Act 1997

The *Restraining Orders Act 1997* was substantially amended on 1 December 2004 to provide greater support to situations of family and domestic violence. The changes increase the penalties for offenders of family and domestic violence and recognise the effects of abuse on children. The major reforms under the new family and domestic violence provisions include:

- For a number of violent offences such as assault, the maximum penalties were increased if they were committed in aggravating circumstances, eg, if the parties were in a domestic relationship or the offence was committed in front of children or if the offence also constituted a breach of a VRO.
- Police attending violent domestic disputes now have the power to issue on-the-spot police orders lasting 24 hours without the consent of the victim, and orders lasting 72 hours with the consent of the victim.
- Abusive persons can be removed from the family home by a police order or violence restraining order, to protect a child from exposure to domestic violence, such as seeing a parent assaulted. It is not necessary to prove that the abusive person was violent or abusive to the child, simply that the child might be exposed to the abuse or violence.
- Penalties of up to two years jail (presently 18 months) apply for breaching a violence restraining order.
- The legislation contains provisions for the granting of life-long violence restraining orders.
- The legislation contains provisions for granting of lifelong violence restraining orders to victims of certain serious violent offences in the criminal courts so they do not separately have to apply for a restraining order and be [re]-traumatised.

From December to January 2004, almost 1,000 on-the-spot police orders had been issued; 481 in December and 495 in January.

Complementing the new legislation is the recent shift in the Western Australia Police's response to family and domestic violence. The police have moved responsibility for family and domestic violence to the major crime portfolio, and 14 new positions have been created at the level of sergeant to provide quality assurance for all police interventions in family and domestic violence matters.

Exchange of Information in Situations of Family Violence

The following is a condensation of a summary of legislation regarding the exchange of information relating to domestic violence compiled by Michael Hovane, Solicitor, Domestic Violence Legal Unit, Legal Aid, Western Australia.

There is no single piece of legislation or provision that covers the entire range of situations in which information can be exchanged where there is domestic violence. Instead, there are a number of

provisions from different pieces of legislation—as well as, arguably, provisions at common law (non-statute law)—that may permit information exchange in certain situations.

Restraining Order Legislation

Section 70A of the *Restraining Orders Act 1997* permits the exchange of prescribed information between certain government agencies in certain situations. This section essentially allows police, the DCD and the DCS to exchange prescribed information about a person issued with a VRO or information about a related child. The information sharing conducted under this section is strictly limited to these departments and does not authorise information sharing with other agencies or with non-government agencies, nor in situations of family violence where no restraining order has been granted. For example, the provision would not authorise sharing information with women's refuges or non-government agencies that are assessing the suitability of perpetrators to attend family violence programs, such as Relationships Australia.

In summary, where there is a VRO, the police and the two relevant government departments can exchange personal information about the person with the restraining order, any related children, and the person bound, as well as details about the grounds for the order and anything on offences or investigations relating to the restraining order.

Child Welfare Legislation

Another provision for the exchange of information is contained in Section 23 of the new *Children and Community Services Act 2004*. This section comes into operation on 1 March 2006, and its provisions are in some ways much broader than those relating to restraining orders in terms of what information can be exchanged and to whom it can be given. It includes, potentially, any individual person or non-government agency. It effectively allows the DCD to release information relevant to the wellbeing of a child to any relevant person or agency. It also permits (but does not compel) any relevant person or agency to release information to the DCD, if the DCD requests it, without any civil or criminal liability or breach of any ethics or confidentiality. However, it only deals with the flow of information to and from the DCD and only deals with information or persons relevant to a child. Therefore it could not, for example, be used in a family violence situation where there were no children.

Common Law — Tort of Negligence and Duty of Care

Beyond these statutory provisions, there is also, arguably, an ability to disclose information in situations of family violence in order for individuals, agencies and government departments to comply with their common law duty of care. In other words, under the common law relating to the tort of negligence, it is arguable that information sharing/disclosure might be permitted or required under a general duty of care in order to avoid being negligent.

There are a limited number of Australian authorities (decided cases) in this area. However, legal academics often refer to the American case of Tarasoff v. Regents of University of California. The case suggests that common law duty of care might only impose a duty to disclose where there is a clear and immediate risk to a person's safety. However, how the duty of care would be assessed and applied to different situations in the area of family violence is difficult to predict. This might well be a fluid and evolving concept, reflecting decided cases and prevailing community understandings of risk assessment, family violence and the damage done by family violence.

It must also be kept in mind that there may be a conflict between the common law duty of care and other statutory provisions. For example, the law in relation to negligence may suggest that

the DCS should provide all relevant information to non-government agencies contracted to perform risk assessments on offenders being assessed for family violence perpetrator programs. This might include the assessing agency obtaining copies of the offenders' PSI reports. However, this may be in conflict with Section 22 of the *Sentencing Act 1975,* which states that 'a written pre-sentence report must not be given to anyone other than the court by or for which it was ordered and the CEO (Justice)'. This might, arguably, preclude a PSI report being shared with anyone else.

The duty of care might also be in conflict with the various confidentiality provisions contained in some statutes. For example, Section 64 of the *Legal Aid Commission Act 1976* states that information about a person provided to Legal Aid cannot be released without the written consent of the person (and to do so is a criminal offence).

Whether the common law duty of care or particular statutory provisions would prevail in any particular situation is not an easy question to answer, and the outcome may differ from case to case, depending on the wording and intent of each separate statutory provision and the circumstances of the situation.

Consent

Finally, it should not be forgotten that the consent of the person to whom the information relates is usually sufficient in most situations at law to permit information exchange.

The Gordon Report

At the beginning of 2002, the Western Australia Premier appointed Magistrate Sue Gordon, Hon. Kay Hallahan AO, and psychologist Darryl Henry to conduct an inquiry into the Western Australian Government's response to reports of child abuse and family violence in Aboriginal communities. This inquiry was called in response to the release of a coronial investigation into the death in 1999 of a 15-year-old Aboriginal girl, Susan Taylor. During the coronial investigation it was revealed that Susan had previously made a complaint of assault and sexual assault against her uncle.

The terms of reference for the inquiry were:

1 to examine issues raised by the coroner's inquiry into the death of Susan Taylor and the way in which government agencies responded to issues of violence and sexual assault at the Swan Valley Noongar Community

2 to examine how state government agencies respond to evidence of family violence and child sexual abuse that may be occurring in Aboriginal communities generally

3 to report back to the Premier with recommendations on practical solutions for addressing incidents of sexual abuse in Aboriginal communities, including any legislative and administrative measures

4 to examine the activities of state government agencies in addressing reports of sexual abuse in Aboriginal communities, as well as identifying the barriers impairing the capacity of government agencies to address issues of family violence and child sexual abuse in Aboriginal communities

5 to comment and make recommendations on whether mandatory reporting of sexually transmitted diseases occurring among children and juveniles should be introduced, and to comment on the limitations of DNA testing in the Aboriginal community

6 to propose measures for children reporting abuse.

The inquiry ran for a period of six months. During this period, it heard from 45 witnesses. It found that:

- Family violence and child abuse occur in Aboriginal communities at a rate that is much higher than that of non-Aboriginal communities.
- Better responses are needed when family violence and child abuse occur.
- The government needs to provide a coordinated, 'joined-up' approach to service delivery that responds to each community's need for integrated service provision.
- There is a need to increase the capacity of workers to be responsive to abuse and violence in Aboriginal communities and the needs of Aboriginal people.

The resultant final report, *Putting the picture together: Inquiry into response by Government Agencies to Complaints of Family Violence and Child Abuse in Aboriginal Communities*, was released on 31 July 2002. It made 197 recommendations under four main themes:

- strengthening the responses to child abuse and family violence
- strengthening responses to vulnerable children and adults at risk
- strengthening the safety of communities
- strengthening the governance, confidence, economic capacity and sustainability of communities.

The Government responded to the report with *The Western Australian State Government's Action Plan for Addressing Family Violence and Child Abuse in Aboriginal Communities*. This action plan listed responses to each of the Gordon report's recommendations, and $75 million was allocated over five years to implement the plan.

The Family and Domestic Violence State Strategic Plan

In 2004 the State Government launched the Western Australian *Family and Domestic Violence State Strategic Plan 2004-2008*. The plan aims to reduce and, ultimately, prevent the incidence of family and domestic violence in Western Australia. It is a culmination of comprehensive community and inter-governmental consultation to identify priority areas, focus areas and high-level strategies that could achieve maximum results in the community. This strategic framework will guide all government departments in the future planning and implementation of policies and programs aimed at the safety of women and children.

In formulating this plan, the Western Australian Government and the community identified three priority areas to underpin its strategic framework: prevention, protection and provision. Balancing a proactive approach to reducing family and domestic violence with the provision of essential support and crisis care is critical to the creation of a safer community.

Action plans will continue to be developed each year over the life of the plan, in accordance with the strategic framework. This process allows current initiatives to be provided by government agencies on an annual basis. Duplication, overlaps and shortfalls will be identified to facilitate a coordinated approach and to develop new, innovative initiatives.

Provision for the piloting of the domestic violence safety and accountability Audit with ADVIP was included in the *State Action Plan 2004–2005*. The full strategic plan and other publications from the Family and Domestic Violence Unit can be downloaded from:
http://www.community.wa.gov.au/Resources/FamilyDomesticViolence/

Appendix Four:
Eight Audit Trails

Audit Trail #1 – Rules and Regulations

Rules and Regulations include laws; court rulings; legislative mandates; requirements or regulations of federal, state, county and city regulating bodies; agency policies and directives; and policies of related organisations, such as insurance companies and medical facilities. They direct and guide the management of the institution.

- The rules are established by political processes within state legislative bodies, federal regulating commissions, local and county commissions, service agency boards of directors, and other entities.
- Rules and regulations define the scope of institutional responsibility and direct the internal operations of most agencies, significant aspects of service delivery, and methods of communication between and among agencies.
- As you interview or observe practitioners and read files and narrative reports, you will see many examples of the way a rule, law, regulation, or other directive influences case processing.

Audit Trail #2 – Administrative Practices

Administrative Practices include all of the methods that an institution uses to standardize how practitioners carry out its policies, laws, regulations, and mandates. Most administrative processes involve the use of texts, such as screening forms, case documentation forms, matrices, guidelines, report writing formats, routing instructions and protocols, and other examples of what practitioners refer to as "paperwork."

- Think of rules and regulations as mandates and administrative processes as instructions to practitioners on how to carry out those mandates.
- Along with mechanical instructions on case management, administrative processes carry conceptual practices that either centralize or marginalize women's actual experiences and needs for safety. A child protection intake form, a pre-sentence investigation format, and a guardian ad litem's parenting skills checklist are examples of administrative practices that prescribe ways of thinking about and acting upon cases.

Audit Trail #3 – Resources

Resources include the ways that a community allocates and ensures the quality of funding, materials, processes and personnel needed to address the problem-in our case, the problem of woman abuse within intimate relationships. Resources include everything necessary to accomplish the following;

- Workers do their jobs without compromising victim safety or offender accountability. This includes size of case loads, technology, adequate supervision, and support services.
- Victims of abuse position themselves in safer situations, through such means as housing, skilled counselling, financial help, and adequate legal representation.
- Intervening systems hold offenders accountable. This includes adequate jail space, enough time for probation officers to supervise their clients, high-quality rehabilitation services, and practitioners who are well-prepared to work with men of diverse, economic, ethnic, and religious backgrounds.

Audi Trail #4 – Concepts and Theories

Concepts and Theories include language, categories, theories, assumptions, philosophical frameworks, and other methods and ways that institutions organize workers to think, talk and write about the cases and the people whose experiences are being managed as cases.

- Many conceptual practices are readily seen, but most are not. It's easier to see the philosophical frameworks that challenge or undermine the way we think. It's much more difficult to recognize those that mirror our own assumptions.
- It's sometimes very difficult to see how conceptual practices are ingrained in the use of language, assignment of categories, crafting of assessment tools, and assumptions supporting a law, rule, or policy.
- Ask: What concepts operate here? How is this worker coordinated to use this concept? What categories does this worker use and how does that shape his or her thinking about the case? What assumptions are in the form or process or matrix?
- Concepts, theories, assumptions, philosophical frameworks, and so forth are not owned by or specific to an individual; they are embedded in institutional processes.

Audit Trail #5 – Linkages

Linkages include the ways that institutions link practitioners to other workers and other intervention processes; ways that practitioners are linked to the people whose cases they process; and ways that practitioners are linked to process and people outside their community (or *extra-local,* e.g., federal regulating agencies, state legislatures, professional associations.)

- In a misdemeanour assault case, there may be over a dozen workers in a dozen separate agencies at four or five levels of government. Most will never talk directly to each other about the case; in large communities, many will never meet each other. Most of them will never meet the people whose cases are being processed.
- No worker acts independently from those who proceed or follow him/her in the process.
- Each worker is linked to others in a sequence of institutional actions.
- Watch and listen for methods of linking practitioners, such as routing information, referrals, regular meetings, writing reports *to*, receiving reports *from*, and collecting information *on behalf of*.
- Watch for how workers are linked to concepts and theories (see Audit trail #4).
- Watch for how workers are connected to the actual people whose case is being managed. Do they have direct contact, or does the case file stand in for the actual person (and if so, with what accuracy)?
- Links can be strong or weak and can enhance or diminish victim safety and offender accountability.
- The unique needs of victims of battering require that institutions create new linkages and enhance existing ones.

Audit Trail #6 – Mission, Purpose, and Function

- **Mission** concerns the *overall process,* the overarching purpose of a system such as criminal court or child protection. Presumably, every action and case processing step within the institution or agency reflects that mission.
- **Purpose** refers to the institutional purpose of a *specific process* within that overarching mission, such as booking, arraignment, and pre-trial hearings.
- **Function** is the function of a practitioner in a **specific context.**
- An Audit explores how the interconnected mission, purpose, and functions of practitioners within specific systems and institutions account for victim safety and offender accountability.

Audit Trail #7 – Accountability

Accountability holds specific meanings in relationship to the Audit process. It includes the ways that institutional practices are organized to accomplish the following:

- Hold individuals *accountable for the harm* they have done, as well as the harm they are likely to cause without effective intervention.
- Hold practitioners *accountable to the people* whose lives are being managed.
- Hold practitioners *accountable to other interveners* in the system.

Audit Trail #8 – Education and Training

Education and Training include the following:

- The ways different disciplines organize workers (e.g., criminal lawyers, civil lawyers, child protection workers, police, therapists, nurse practitioners) to understand their jobs and the social phenomena related to their work, such as the abuse of women in marriages and intimate relationships.
- Formal ways that agencies train their workers to think about and act on cases.
- Informal ways that workers learn their jobs through experience and training by more seasoned workers.
- Exposure to different concepts, theories, and conceptual practices.
- Ongoing skill building that enables workers to effectively intervene in domestic assault cases involving diverse populations.

Audit Trail #9 – To be discovered…

To be discovered… We have identified eight primary methods by which institutions organize and coordinate workers to intervene in standardized ways. Your Audit team may uncover a method that is particularly influential in case processing but is not included here. Don't let these eight categories limit the boundaries of your investigation.

Appendix Five:

The Praxis Safety and Accountability Audit

Prepared by Ellen Pence and Dorothy Smith for October 26 NIJ\OVAW meeting.

When a woman who is being beaten by her partner calls 911 for help, she activates a complex institutional apparatus – the criminal justice system (CJS). She wants "help." The help she has in mind is specific to her situation. She may well have a definite form of help in mind. Perhaps she wants him removed. She wants her car, or child or tax refund check back. She certainly wants the violence to stop and her call to 911 is a part of her effort to make that happen. The criminal justice system coordinates a number of agencies and individual practitioners to respond to her call as a case to be managed. Her situation, or at least some aspect of her situation, is transferred by the intervening practitioner into a category that makes her experience institutionally actionable.

Her bloody nose and her statement give the responding officer the authority to arrest. The nature of her injury means that, if arrested, her abuser will be charged with a misdemeanour assault. The fact that she told the officer that she threw an ashtray at him after he had hit her repeatedly means she too might be charged with the same crime. Here lies the beginning of a disjuncture between her experience of the violence and the formulation of that experience as a legal case by the state.

Her call is not simply a call to a dispatch centre. It is a call to her community; to the government. While she is calling for help to stop the violence of someone more powerful than she, she is tapping into a system of agencies and institutional processes that will process her call as a single – or, more often, a series – of distinct "cases" to be managed by legal and human service agencies. The coordination of these agency interventions is not linked so directly to her situation as a woman being abused within an intimate relationship as it is to the various functions of these agencies as proprietors of institutions of social management.

Activists seeking to reorient the responses of institutions from the specific missions of these agencies (police to investigate and arrest, prosecution to charge and convict, mental health workers to assess and heal) to their relevance in the lives of battered women have sought to do so by calling for coordinated responses centered on the collective goal of public safety. In these circumstances, public safety translates into the safety of battered women and their children. A strategic goal to secure that safety has been to shift the responsibility of holding offenders accountable for their offences from the victims of their violence to institutions of social control. This goal is talked about in terms of offender and systems accountability. Many communities have taken up the challenge of change by organising coordinated, multi-agency reform initiatives. Increasingly, those initiatives are turning to principles of institutional ethnography to determine how victim safety and offender accountability are either centralized or marginalized at specific points of intervention in domestic abuse related cases.

Institutional ethnography, as a research approach, was developed by Canadian sociologist Dorothy Smith (1987) to explore and analyse institutional organization from the standpoint of the everyday world. By investigating social organization and relationships, researchers in institutional ethnography ultimately produce methods by which practitioners can expand their understanding of the institutional order in which they are involved. Institutional ethnography does not address a given institutional setting from the point of view of its overall organization. Instead, it begins with a particular standpoint – for example, that of a woman who has been abused – and questions the institutional processes that produce a certain outcome from that standpoint. The layers of legal, bureaucratic, and professional structures are not addressed as a whole. Rather, specific processes relevant to the problems women

experience are identified. Institutional ethnography traces those processes as sequences of institutional activity in which people participate at various levels and in various capacities.

Using this approach, agents of social change ask questions in new ways, focusing neither on the individual practitioner nor the subjects of the cases being processed. Instead, the focus is turned to explicating how practitioners' work has been organised to standardise the ways in which they act on cases. The investigative questions become, 'How is the case being put together by workers in the system in ways that produce problematic outcomes for women?' and 'How are workers organised to account for and enhance victim safety and offender accountability?' The Audit team was interested in understanding how victim safety and offender accountability are affected by the ways in which workers are coordinated by institutional processes to assemble cases.

Institutional ethnography encompasses people's everyday activities and experiences as participants in an institutional order (Campbell and Gregor, 2002; Campbell, 1998; Currie and Wickramasinghe, 1998; Devault and McCoy, 2001; Grahame, 1998). This method focuses on the distinct ways in which people's activities are coordinated in the institutional process, rather than on the individuals themselves or on their beliefs, attitudes, or biases. Institutions are viewed as coordinators of people's activities. In so doing, they rely on formalized discourses such as law, medicine, psychology and other scientific and professional knowledge bases, and are mediated by texts and documents (de Montigny, 1995; Mykhalovskiy, 2001; Ng, 1988; Pence, 2001; Rankin, 1998; Smith, 1990; Smith 1999; Smith, 2001; Turner, 2001).

In its application to the field of domestic violence, institutional ethnography has thus far been used primarily by criminal justice practitioners and domestic violence advocates, rather than by academics or trained researchers. Ellen Pence, director of Praxis International, has developed a specific method of conducting an institutional ethnographic study that relies on interagency groups of systems workers and battered women's advocates. These groups are charged with the task of forming an audit team to uncover specific practices that produce poor outcomes relative to safety and accountability. The 'Praxis Audit' asks local teams to focus their inquiry on how the work routines of 911 operators, police officers, jailers, prosecutors, judges, and other practitioners are organised to make domestic violence cases institutionally 'actionable'. Those teams are organised to conduct an assessment or 'audit' that presumes that an opportunity for centralizing victim safety and offender accountability exists at every point of interaction within those institutions.

The research objective is to examine one (eg, dispatching) or a sequence of case processing steps (e. g., dispatching, police investigation, booking, arraignment) with an eye toward uncovering safety and accountability concerns.[52] The team traces and describes a practitioner's work activities and how s/he is institutionally coordinated to act on a case, assuming that individuals in large bureaucracies do not independently decide how to perform their jobs. Instead, every practitioner – from dispatchers to judges – is coordinated by institutional means of standardization embodied in policies, guidelines, administrative forms and protocols (such as 911 coding guidelines, definitions of probable cause, booking forms, bail schedules, supervised release criteria, pre-sentence investigation forms, police report-writing formats and statutory distinctions between misdemeanour and felony).

52 Women who are brought into an institutional existence because of battering or a life experience related to the abuse they are experiencing are frequently being processed as a number of distinct cases in different legal or human service agencies. For example, in one audit of child protection cases involving domestic violence, we mapped five different institutional cases opened in a single name during the period her CPS case was under investigation. (See Appendix 8 for case-processing maps.)

This standardization is both natural and necessary when interacting with and responding to large groups of people, as bureaucracies are charged with doing. However, general standards that are applied to the unique characteristics of domestic violence often inadequately attend to the victim's safety needs. The audit allows the team to scrutinize the impact of every conceptual and bureaucratic process that constitutes case processing. By so doing, an institutional audit examines the very method of standardisation that institutions employ to guide workers' responses and actions. In addition to examining institutional methods of standardising practitioners' actions, the audit is also designed to identify other organisers of practitioners' actions, such as the availability of resources, time, technology and training (see Figure 1 on scope of inquiry).

The administrative practices that standardise practitioners' actions are embedded in ways of thinking about the people whose lives are being managed as a case, about the function of the state in their lives, about the violence, about family relationships. Practitioners are continually required to make sense of the situation they are processing as a case. The professional discourse that is available to the police officer, prosecutor, judge, and/or rehabilitation provider shapes the manner in which the practitioner transposes the situation into conceptual categories that direct the practitioners' analyses of 'what is going on'. The concepts and theories operative in a local community are a crucial determining factor in how practitioners act in the safety interests of victims. For example, the probation officer or sentencing judge who sees the violence in a particular case as the result of poor communication or limited relationship skills may feel a lessened sense of urgency when a couple proclaims they have 'separated for good'. Another judge who understands the violence in that relationship as an attempt to establish dominance by the abuser may understand the same declaration as signalling a period of heightened risk for the victim. The audit uncovers operative concepts and theories active in the management of cases and allows the audit team to look for the safety consequence of employing certain concepts, theoretical assumptions or even language in managing a case.

Methods of investigation are straightforward: (1) focus groups with people whose experiences are being processed as an institutional case; (2) interviews with institutional practitioners about (a) the context of the work they do in the larger process of managing the case, (b) the specific ways they act on cases at each institutional point of intervention, and (c) the texts or reports they use or produce at each interchange between practitioners and the case in the process; 3) observations of practitioners actually doing their jobs; and (4) analyses of all of the administrative and regulatory texts used by the institution to coordinate workers across time and sites of institutional action.

Since the focus is not on individuals, interviews and observations follow the classic field procedures of sociological ethnography (eg, Spradley, 1979; Schwartzman, 1993; Emerson, Fretz, & Shaw, 1995; Holstein & Gubrium, 1998). In large bureaucracies, the 'case file' is a key coordinating instrument, and therefore a primary object of inquiry. Text analysis adds further to the understanding of institutional actions, as texts are situated in and actively coordinate the work of practitioners.

Since institutional ethnography and the audit process characterize institutional processes rather than individuals, there are no systematic sampling procedures. Instead, interviews and observations sample the work process at different points to ensure a sufficient range of participants' experiences. This method gives reasonable confidence that the audit locates the normal institutional function and normal range of cases that are processed. Practitioners along those points of intervention are knowledgeable about routine processes, and interviews tap into this competence. The audit design envisions most interviews and observations of practitioners to be with those who are considered competent and well versed in their jobs. The practitioners interviewed during the audit process are co-investigators with the audit team. Their intimate knowledge of how the institutional processes actually work in everyday practice and their first-hand experience with the people whose cases are being processed supply many of the critical observations and insights of the audit.

Established as a research procedure for sociology, institutional ethnography translates readily into participatory forms of research in which practitioners examine and evaluate how their own work processes, and the work of others, add up to outcomes beyond those they envisage. At the same time, it provides advocacy groups, who often act in a coordinating role for the Audit team, with a non-hostile, methodical, in-depth way of turning the attention of interagency coordinating bodies to a critique of how institutional processes serve to protect victims and hold offenders accountable for their abuse.

This process folds organically into the interagency reform work already begun in so many communities but lacking focus or methods of promoting meaningful change. The process of analysing what's going on frequently points to the obvious solution. For example, let's assume that an audit team has transcribed some 25 domestic related 911 calls, and then traced the flow of written information from the dispatchers, to the ongoing record of calls in the CAD system, to the responding officers, to the final police report (if a report was made).

The team can now review this flow of information from the perspective of a prosecutor, who is representing the safety interests of the victim at the arraignment hearing; a probation officer determining if a defendant on his\her caseload has violated his conditions of probation; a CPS worker who uses the report to screen the case for possible child abuse; and an advocate, who decides whether or not to try and call this victim because of the level of danger she appears to be facing. These perspectives offer meaningful insights into ways in which the ability of practitioners to centralize victim safety and offender accountability can be enhanced or limited in just the first few hours of a case.

The institutional process is assembled by means of work process and key coordinating texts (or by other coordinating mechanisms such as laws, regulations, agency directives, or the role of supervisors). Audit team members arrive at a practical understanding of the means by which institutions produce particular outcomes from the perspective of victim safety. This attention to case management is highly useful in the measurement of safety because it does not presume, for example, that increasing the rate of prosecution alone will make victims safer. At the same time, it reveals concrete reasons for a low prosecution rate.

As a research method, the audit directs researchers and participants to focus on how work *that is properly done* can nevertheless produce undesirable outcomes – through the ways in which workers are institutionally organised to act on a case, are organised to conceptualize a case, and finally are coordinated with practitioners at different sites of intervention.

Focus on institutionalized forms of coordination, particularly texts, has two major merits: (1) because the focus is on work practices, an audit team can identify particular problems in those practices; and (2) problematic outcomes that are caused by institutional organization can be identified. By seeing how a particular conceptual or administrative practice compromises safety or accountability, the team is frequently pointed to a solution.

Institutions are organised and coordinated, for the most part, by means of standardised texts or standardised protocols for producing texts. Policymakers can change the protocol for writing a particular coordinating text such as a police report. On a broader scale, legal professionals can uncover organizational disjunctures such as gaps in communication between the prosecuting attorney's office and the police. Rather than raising issues in arenas that are difficult to change (eg, public opinion or political climate) changes can be introduced at the level of direct interaction or service. Changes at the ground level make the institutional process more likely to produce desired outcomes: in this case, enhanced safety for women abused by their partners, and increased accountability for domestic violence offenders.

Appendix Six:

Example Interviews and Observation Worksheet

Worksheet 3.7: Observations

Our Audit Question:

Observation: ***Date & Time:***

Audit Team Member:

Confidentiality Cue:

The Safety Audit examines institutional responses to domestic violence. It does not assess individual effectiveness or actions. Team members will have access to sensitive information and records in each agency that is participating in the Audit. Do not record any personal identifying information, such as names and addresses, in your notes. Do not remove any forms, files or other records without specific permission. Do not share identifying information or details of the calls and cases you observe with your friends or family.

Watch for:

The 8+ Audit Trails:

1) Rules & Regulations
2) Administrative Practices
3) Resources
4) Conceptual Practices
5) Linkages
6) Mission, Purpose, & Function
7) Accountability
8) Education & Training
9) To be discovered…

Implications for safety and accountability

- In the immediate situation.
- From the retaliation.
- From ongoing abuse and violence.
- From unintended consequences of intervention.
- For which victims of battering? How?
- For which batterers? How?

Notes (continued on reverse):

Worksheet 3.2: Work Practices Interview

Our Audit Question:

Person Interviewed:

Position & Agency:

Audit team Member: ***Date:***

Ask About:

- The details of the practitioner's job, as if you had to go in the next day and do that job.
- How specific tools, equipment, processes, policies, etc. work.
- A specific case and what happens at each step: Describe in detail what happens from when you get the case to when it leaves you.
- Listen for the Audit trails and ask follow-up questions to fully understand how each method coordinates workers' actions and thinking on cases.

Listen For:

The 8+ Audit Trails:

1) Rules & Regulations
2) Administrative Practices
3) Resources
4) Concepts and Theories
5) Linkages
6) Mission, Purpose, & Function
7) Accountability
8) Education & Training
9) To be discovered…

Opening Questions:

1)

2)

Notes (continued on reverse):

Appendix Seven:
Audit Coordinator Job Description

Role of the Audit Coordinator

- ***Sell policy makers on the Audit***
  ADVIP, Police, Department of Corrective Services, Department for Community Development
- ***Decide which intervention steps to assess***
  Focus the Audit and develop an activity timeline
- ***Secure participation of agencies/systems to be audited***
  Explain resource commitments needed for observations, interviews, internal data collection, including providing copies of existing regulations, policies, training curricula etc.

  Determine how system information will be shared with Audit Team (confidentiality issues, data privacy requirements, etc).

  MOU development: Get it in writing and include provision for practitioner workgroup to respond to audit findings/recommendations and develop implementation plan for system reform.
- ***Determine how battered women and advocates will inform the Audit Process***
  Arrange focus groups
- ***Support Training Team***
- ***Coordinate Audit with other community efforts***
  Try to be at every meeting where the topic relates to response to domestic violence
- ***Set up process for text analysis***
  With Audit Team, decide on categories of information to be analysed – what do we want to know?

  Determine what text will be collected, how the sample will be chosen, what information will be redacted.

  Decide who will analyse the text (Audit Team Sub-committee, consultant, both?)
- ***Schedule focus groups, observations, interviews, and debriefing sessions***
  Provide written schedules for Audit Team

  Facilitate follow-up meetings to share information, identify themes, and fill in system map
- ***Compile all data – Identify themes***
  Facilitate small group discussions with auditors, advocates, practitioners
- ***Create Final Report***
  How will you present the information?

  Include recommendations for change supported by examples from text analysis, observations, and interviews.

Selection Criteria

Demonstrated knowledge and understanding of domestic violence based on a gender analysis using the power and control framework.

Demonstrated knowledge and understanding of a criminal justice model response to domestic violence.

Demonstrated knowledge and understanding of community intervention projects.

Demonstrated knowledge and understanding of best practice principles when working with perpetrators and victims.

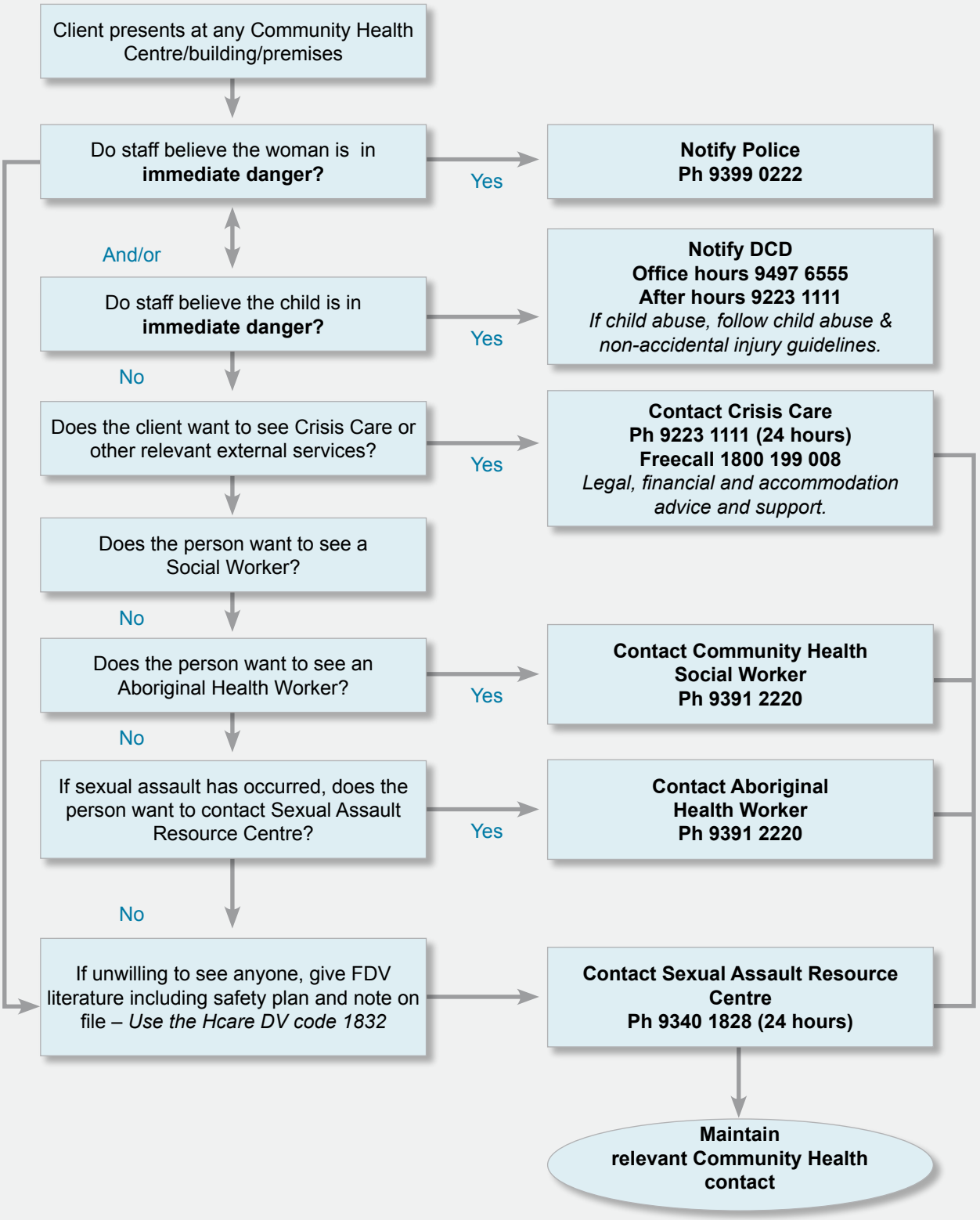
Demonstrated highly developed interpersonal communication skills.

Demonstrated ability to negotiate agreements and resolve conflicts with diverse groups of people.

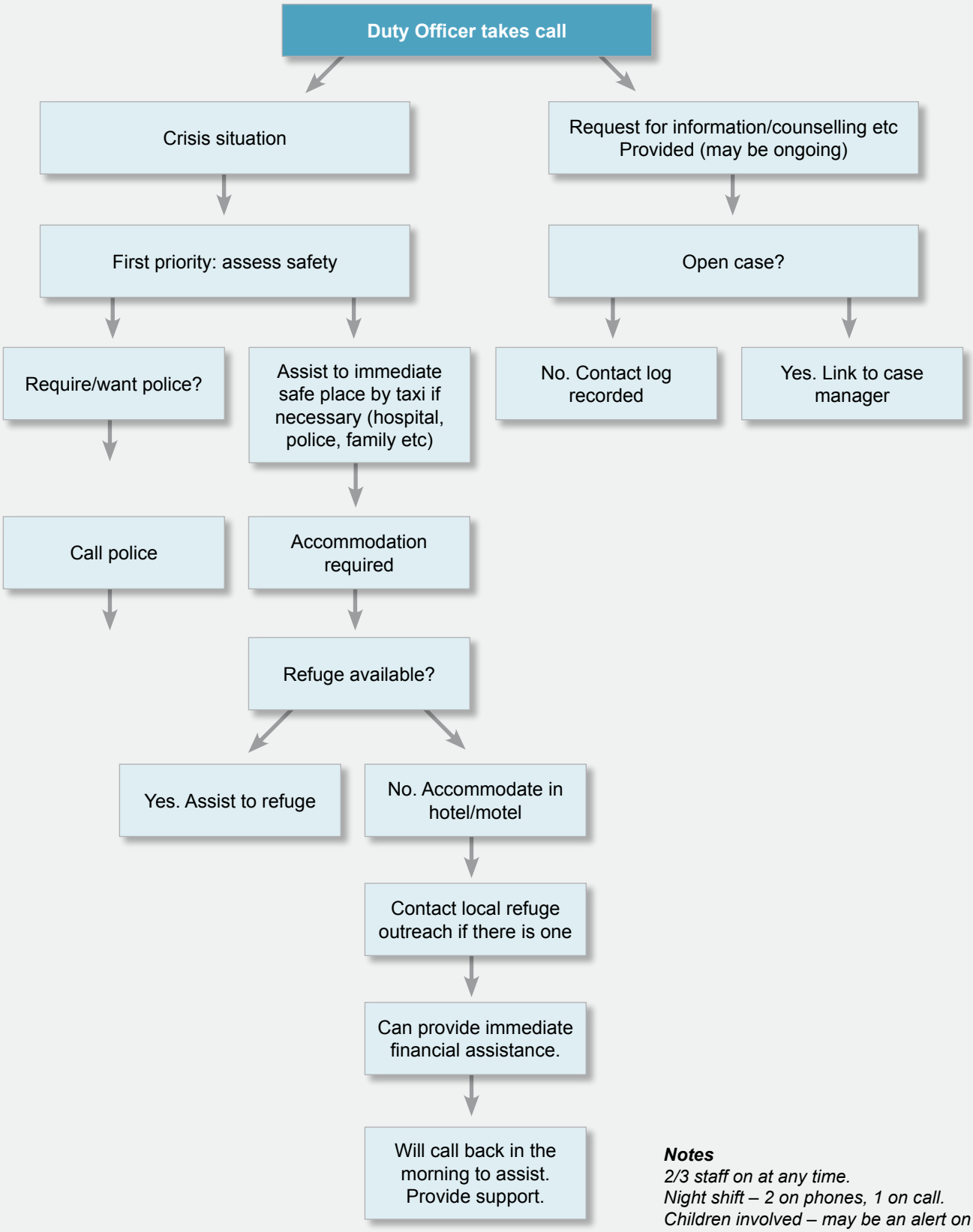
Possess strong analytical organisational and problem-solving skills.

Appendix Eight:
Agency Maps

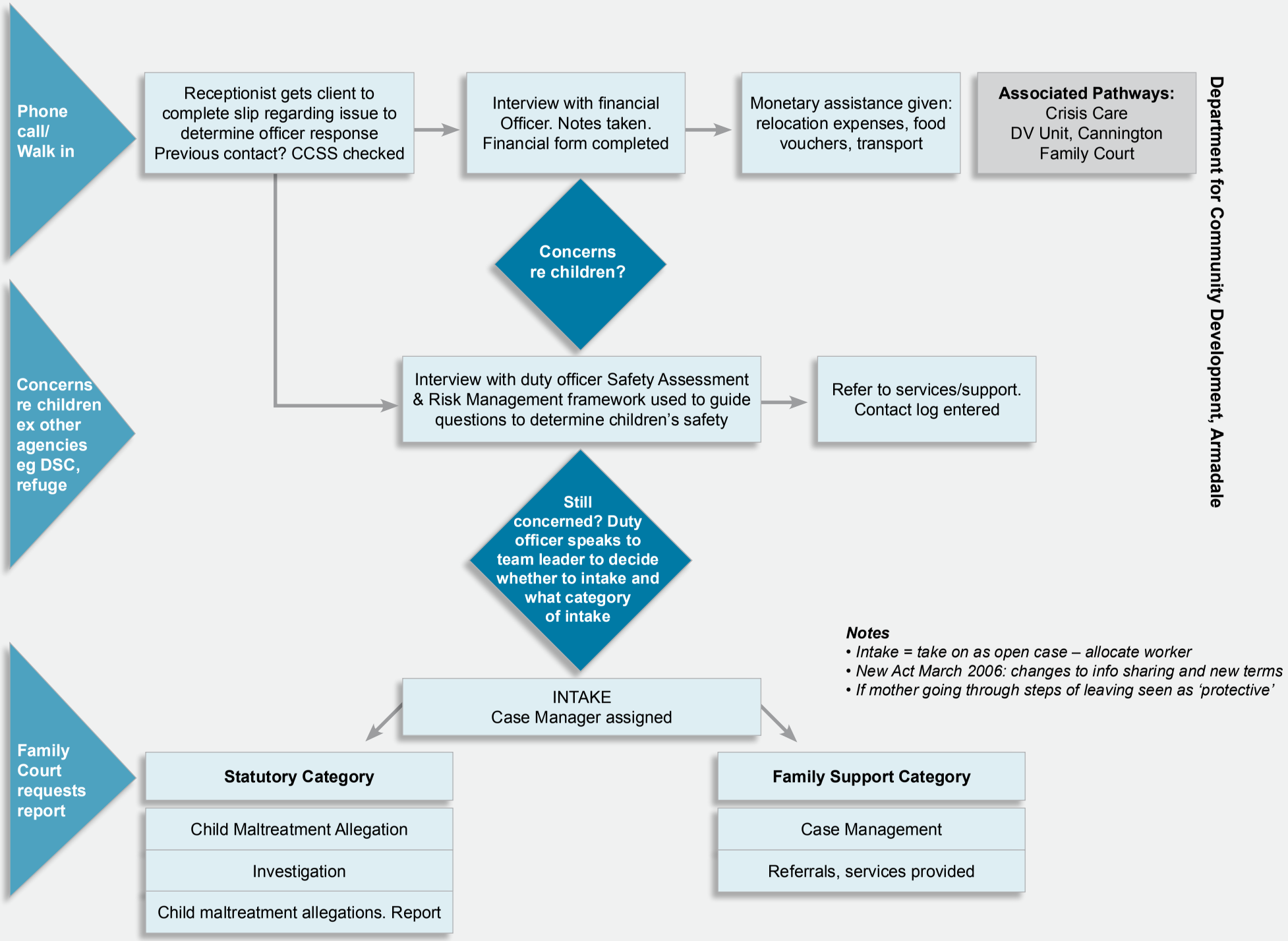
Family and Domestic Violence Response and Referral Flowchart for Community Health, September 2005



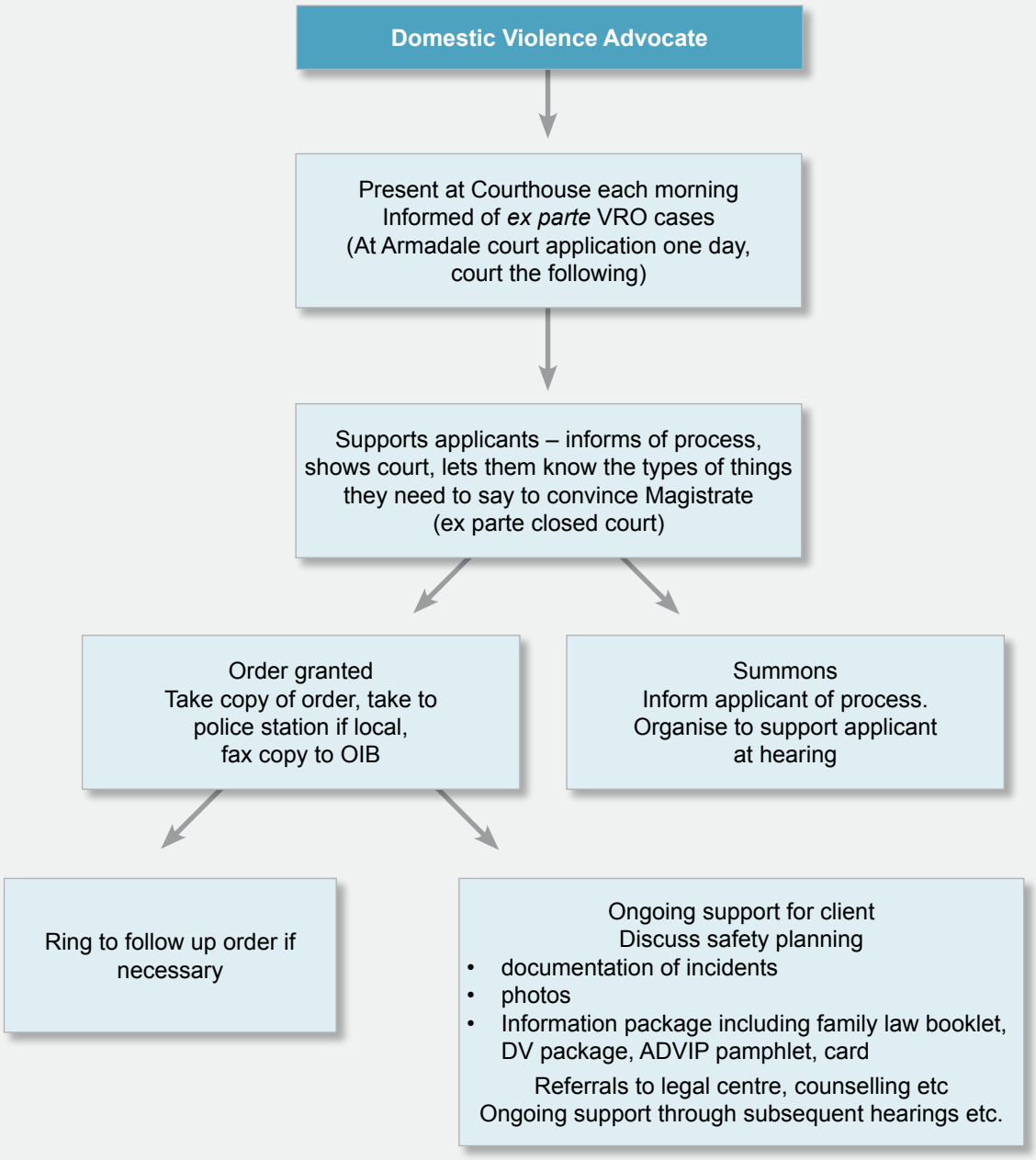
Crisis Care



Notes
2/3 staff on at any time.
Night shift – 2 on phones, 1 on call.
Children involved – may be an alert on system (eg agreement that she will not go back)

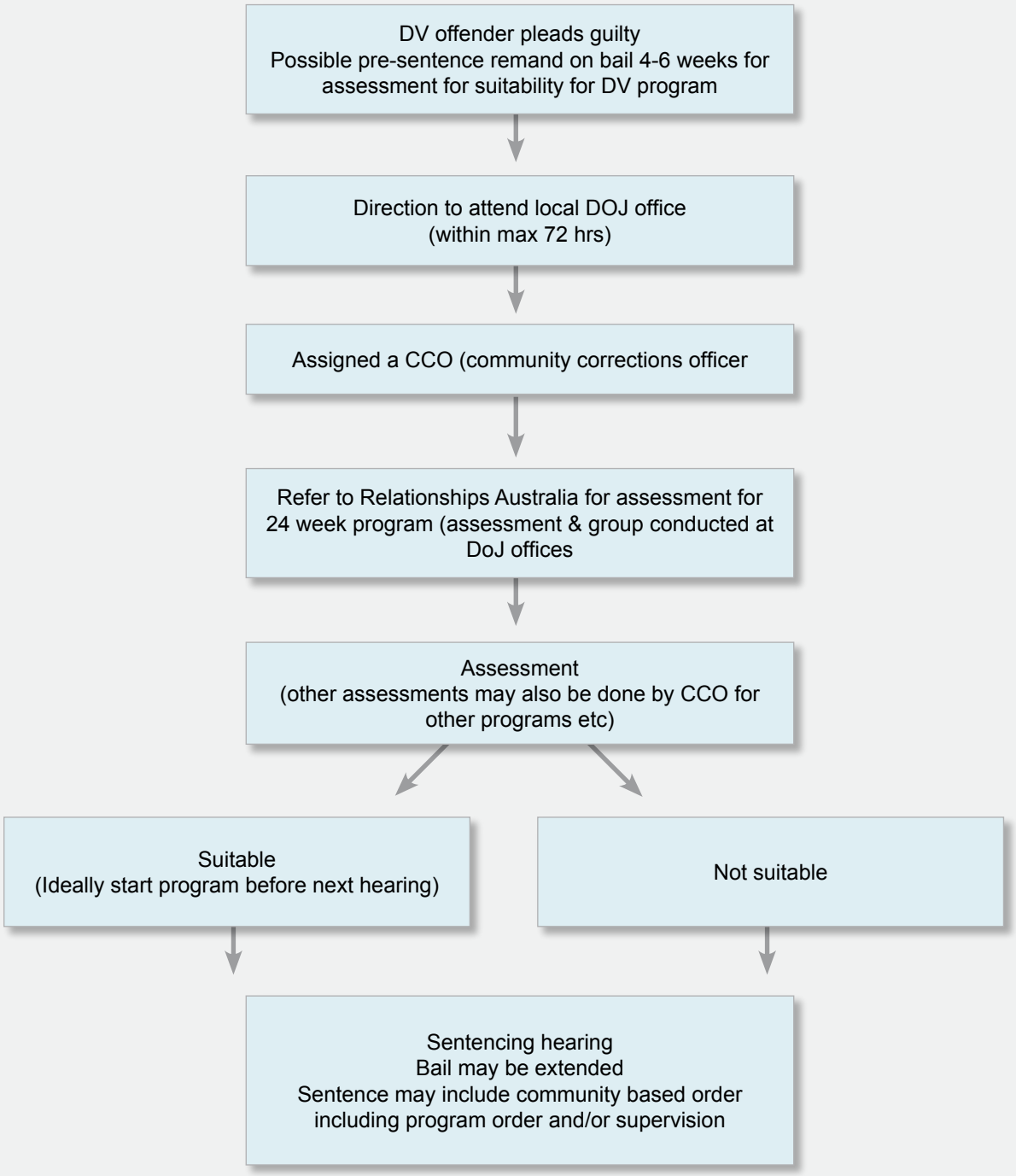

Department for Community Development, Armadale
Phone call/ Walk in
Receptionist gets client to complete slip regarding issue to determine officer response Previous contact? CCSS checked
Interview with financial Officer. Notes taken. Financial form completed
Monetary assistance given: relocation expenses, food vouchers, transport
Associated Pathways:
Crisis Care
DV Unit, Cannington
Family Court
Concerns re children?
Concerns re children ex other agencies eg DSC, refuge
Interview with duty officer Safety Assessment & Risk Management framework used to guide questions to determine children's safety
Refer to services/support. Contact log entered
Still concerned? Duty officer speaks to team leader to decide whether to intake and what category of intake
Notes
• Intake = take on as open case – allocate worker
• New Act March 2006: changes to info sharing and new terms
• If mother going through steps of leaving seen as 'protective'
INTAKE
Case Manager assigned
Family Court requests report
Statutory Category
Child Maltreatment Allegation
Investigation
Child maltreatment allegations. Report
Family Support Category
Case Management
Referrals, services provided

Starick Services Court Advocate



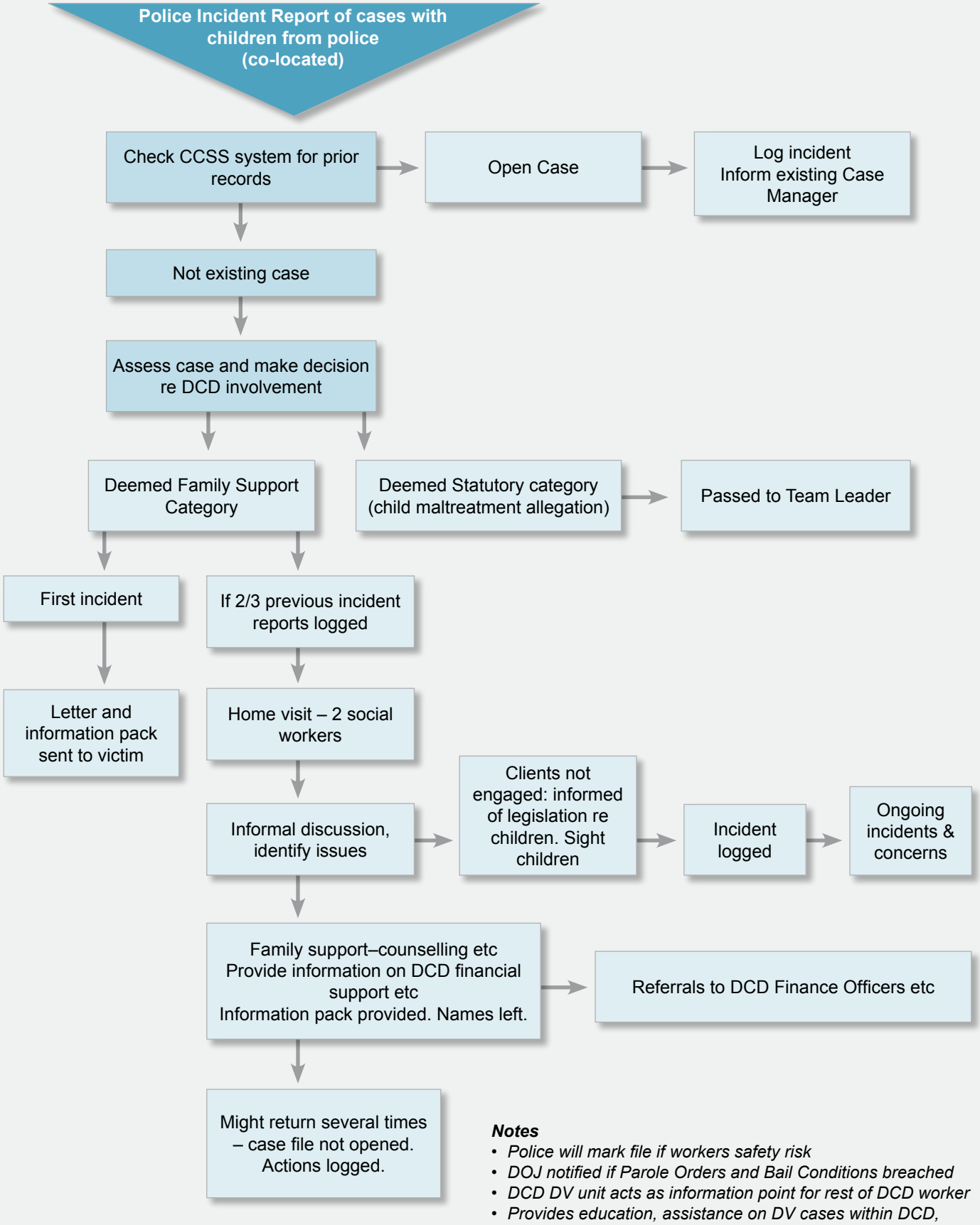
Notes
At Gosnells orders served within 24 hrs, some stations 5, 7 days later.
Cannot apply for legal aid unless hearing date set.
Other duties:
- *Support clients in criminal matters with prosecutor – explain process etc.*
- *Identify trends/problems take to Core Group*
- *Tracking and monitoring of criminal cases*
- *Discuss with respondent and protected person on undertakings, amendments of orders at request of court*

Community Corrections Officer, Department for Corrective Services, Maddington



Notes
Perpetrator signs release of information when attending program so information can be shared with relevant authorities eg ADVIP.
Referrals forwarded to VMU once sentenced. Victim Mediation Unit (specialist unit of DoJ).
Referrals for victims if they are an offender currently on an Order to relevant services (list of ADVIP people good starting point). Also at PSI Report stage CCO should contact the victim and refer if appropriate.
CCO monitors progress in group and takes appropriate action when non-compliance becomes an issue.

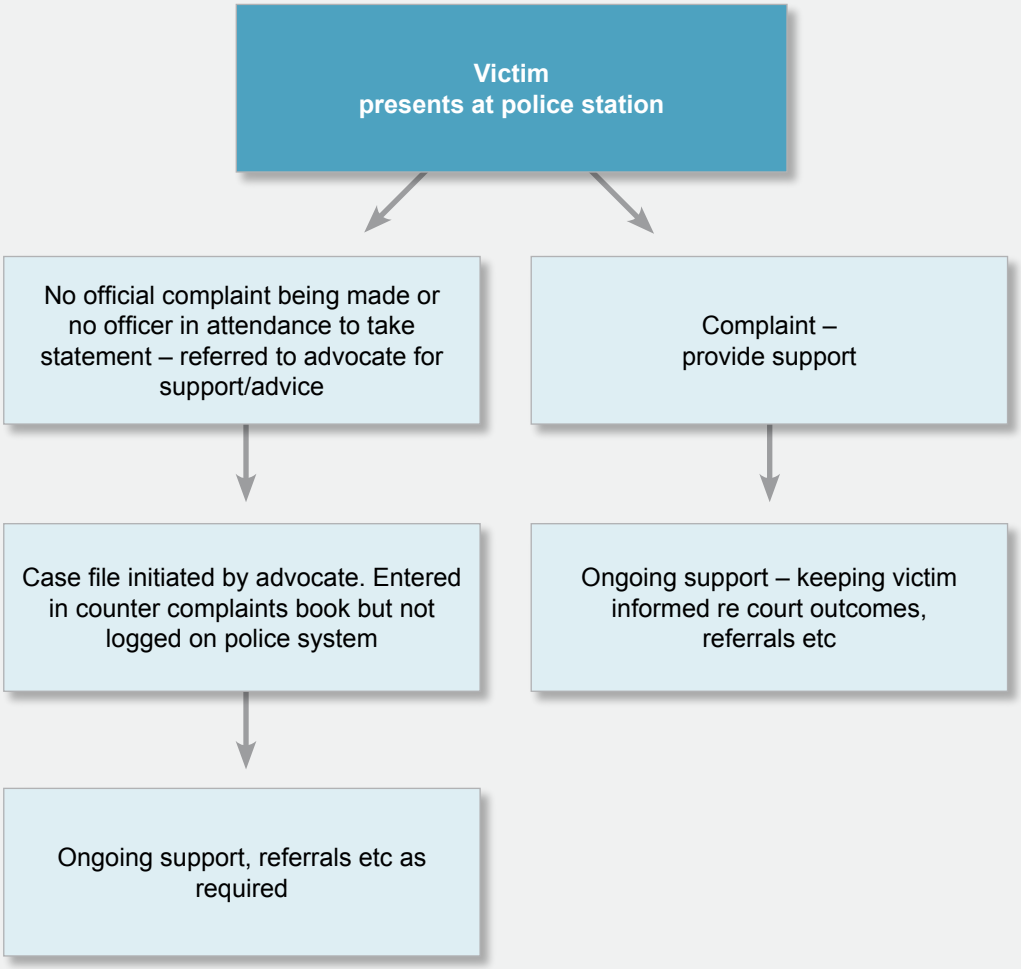
Domestic Violence Unit, Department for Community Development, Cannington



Notes

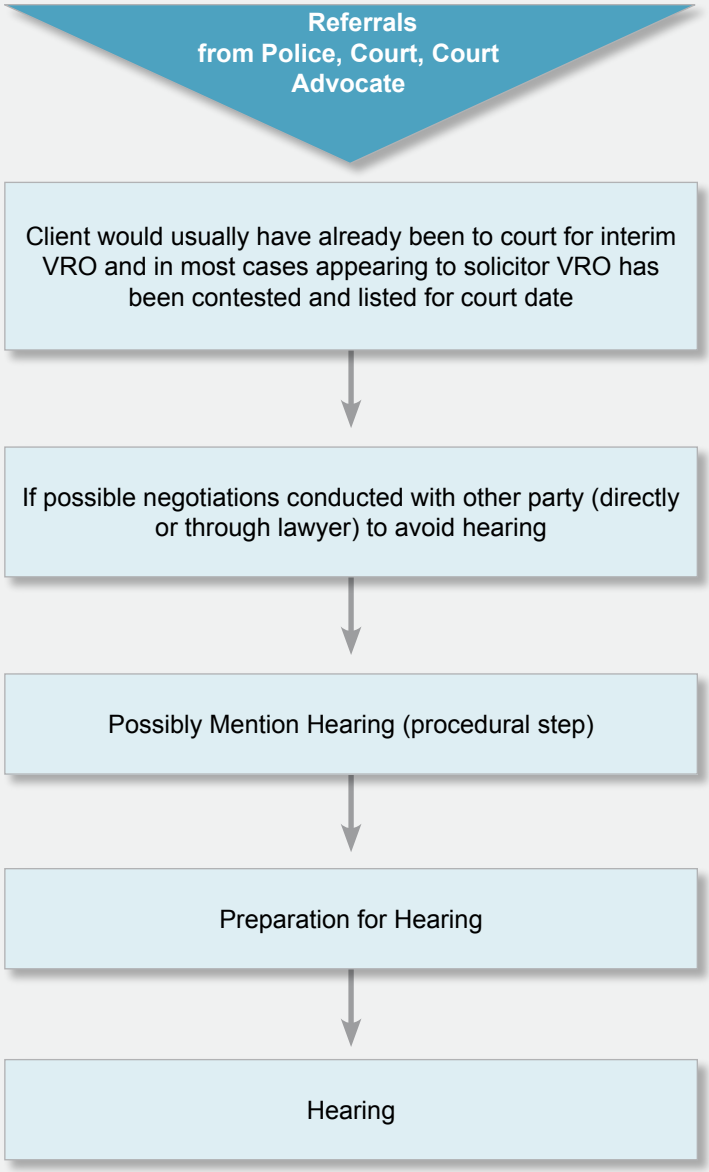
- *Police will mark file if workers safety risk*
- *DOJ notified if Parole Orders and Bail Conditions breached*
- *DCD DV unit acts as information point for rest of DCD worker*
- *Provides education, assistance on DV cases within DCD, community and prisons*
- *Searches of CCSS can be done under name, address, children's names, person believed responsible*

Domestic Violence Unit, Western Australia Police



Notes
Police advocates employed by Starick Services. 20 hrs per week each (9am – 2pm).
Housed at police stations (Gosnells and Cannington)
Provide important service to indigenous women who often do not want to talk to police.
Will let DCD know if concerns re child protection.
Gosnells: Jan – Sept 155 new referrals
Cannington Jan – Sept 177 new referrals
Issue raised re lack of options for VROs for under 18s.

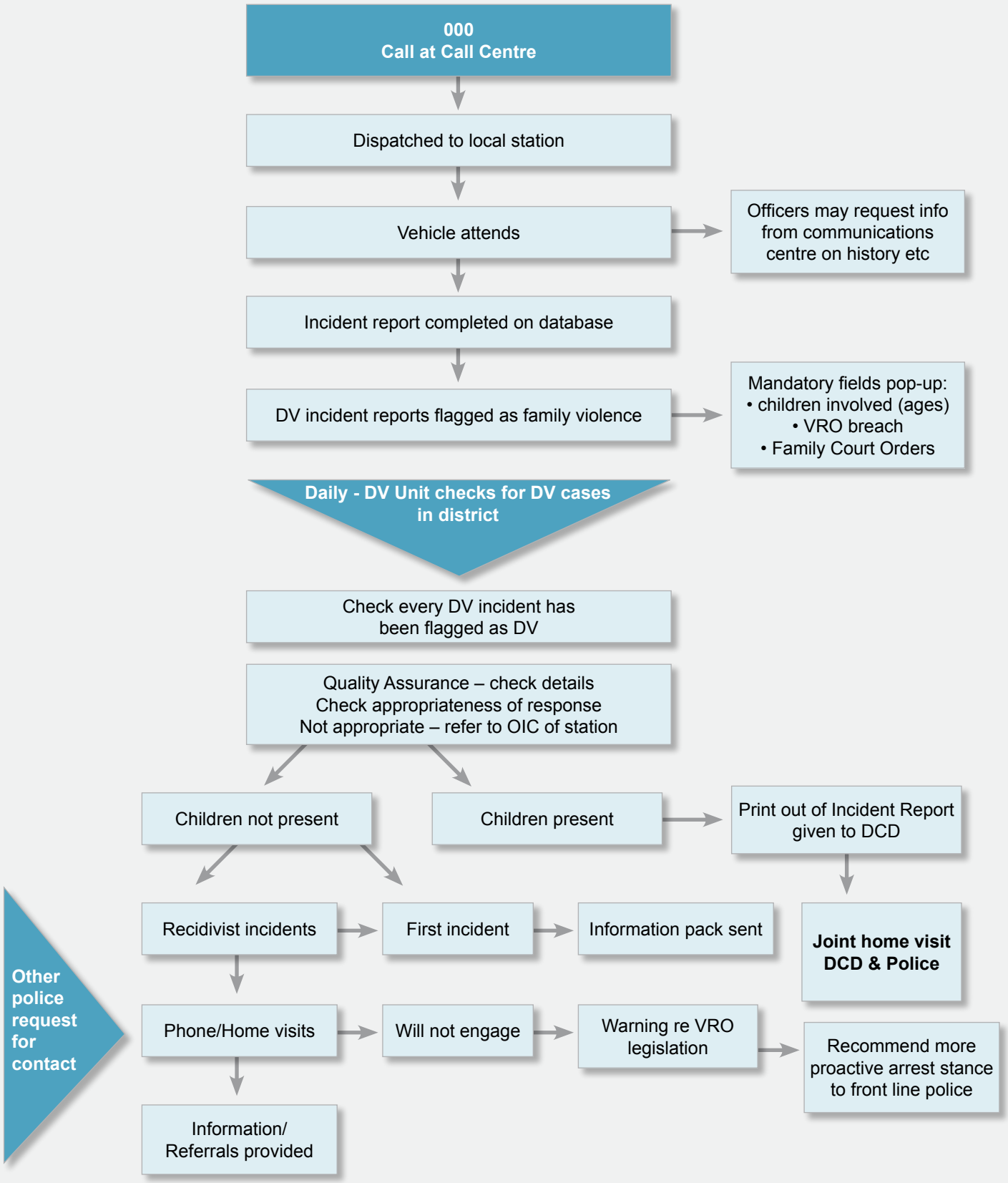
Domestic Violence Unit, Western Australia Police



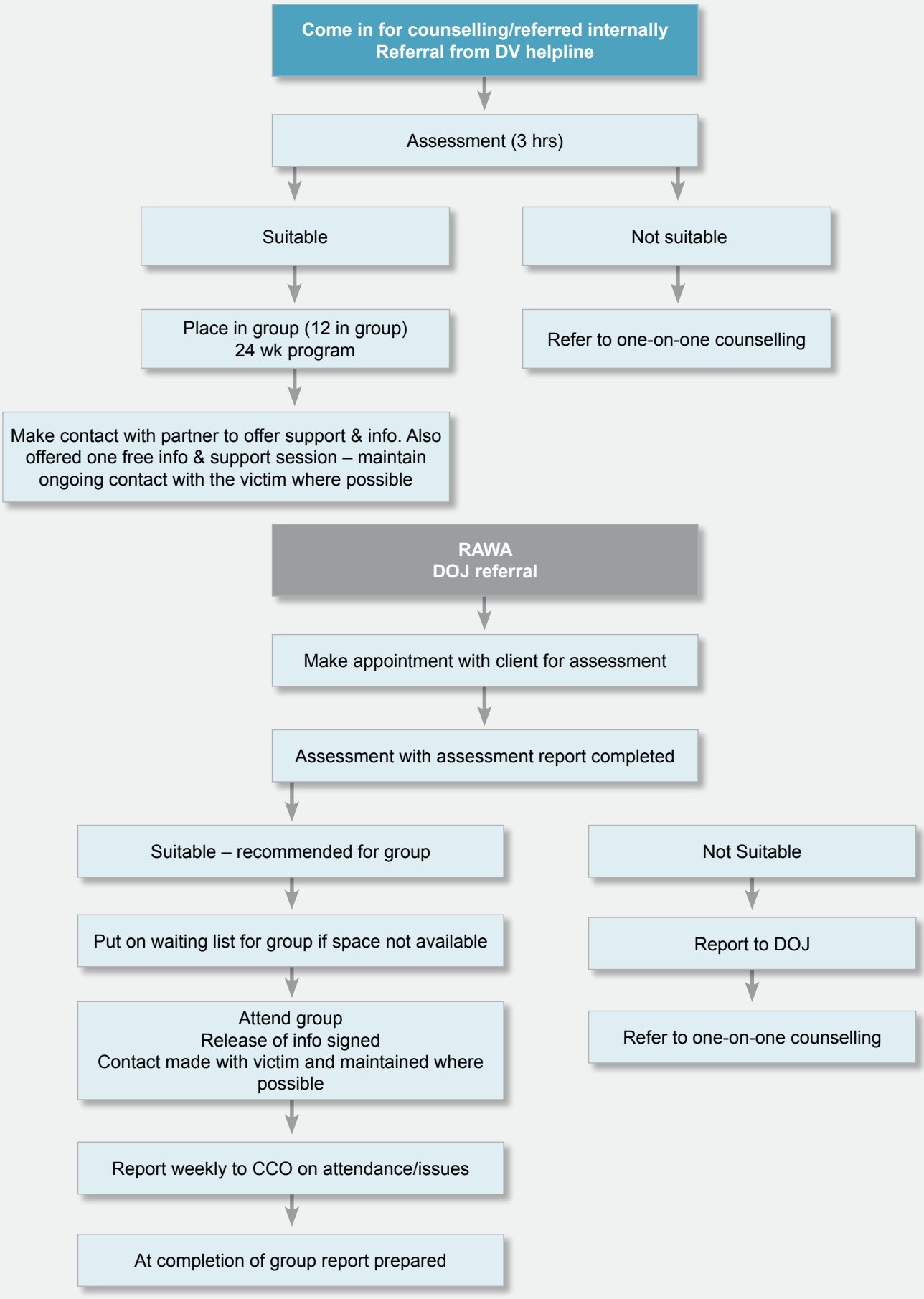
Notes
Funded by Commonwealth Attorney General to assist people to get VROs
Referrals to counselling, health etc, family lawyers
Will assist clients with:
- *accompanying clients to give police statements*
- *practical issues such as security, airfares, removals etc*

Will keep DCD informed on progress of VROS etc (if children are in care this may be taken as evidence that mother being protective)
Will contact police if VRO being breached and no action being taken
Liaison with court support – referrals from them and also to request assistance for support etc.
Can defend VROs (eg if other party applies for one on client)

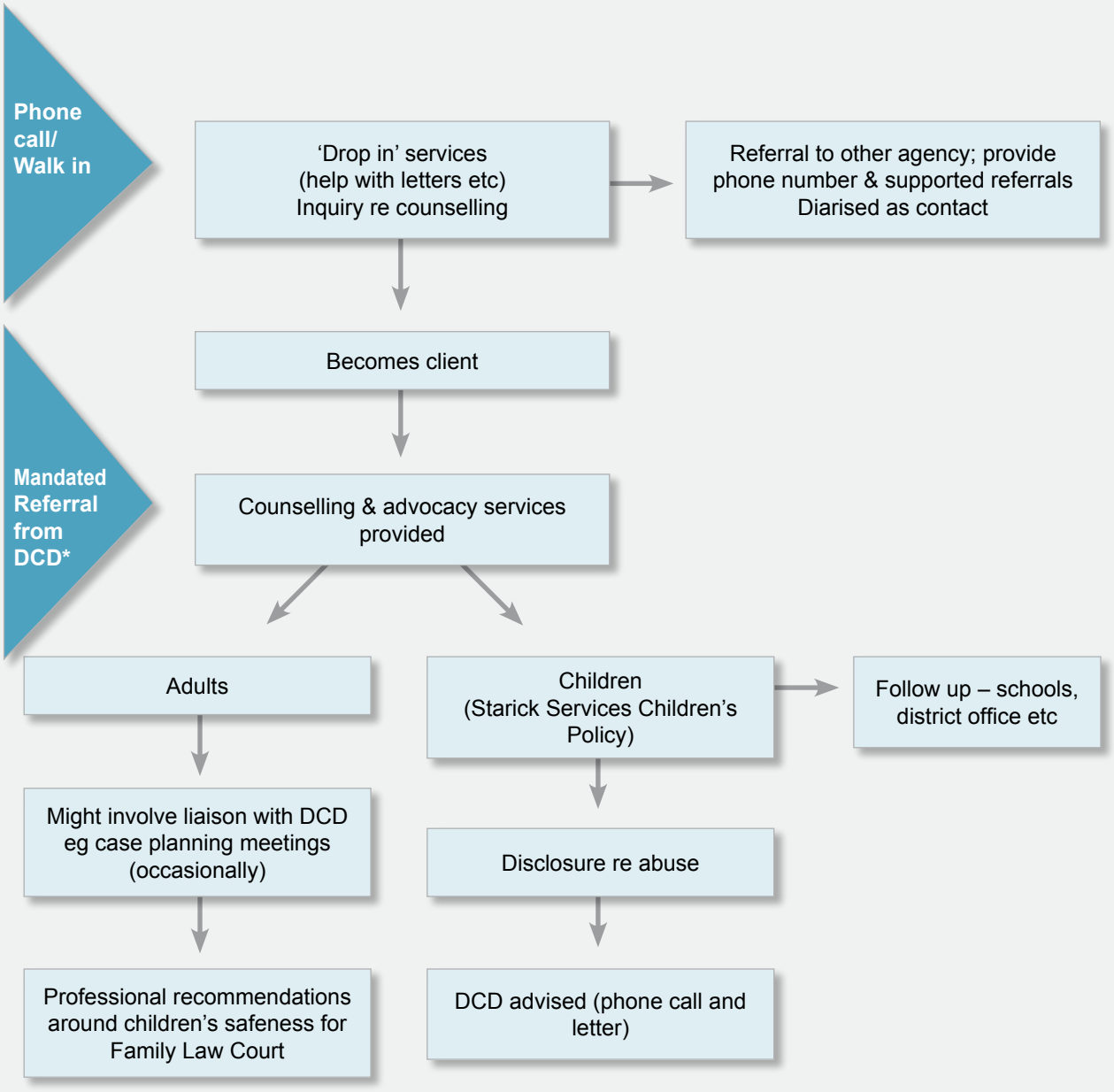
Starick Services Counselling



Violence Restraining Orders



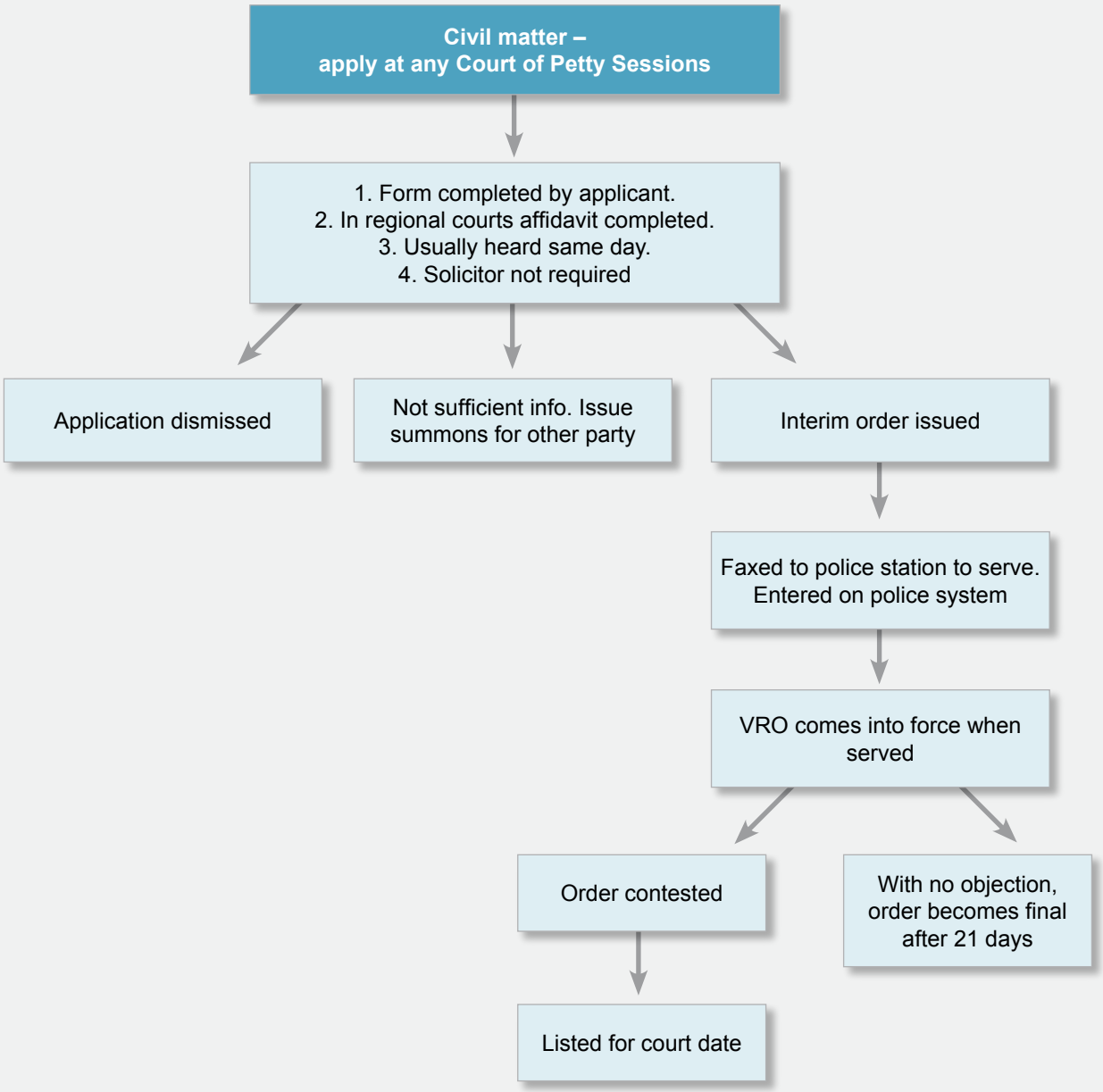
Police

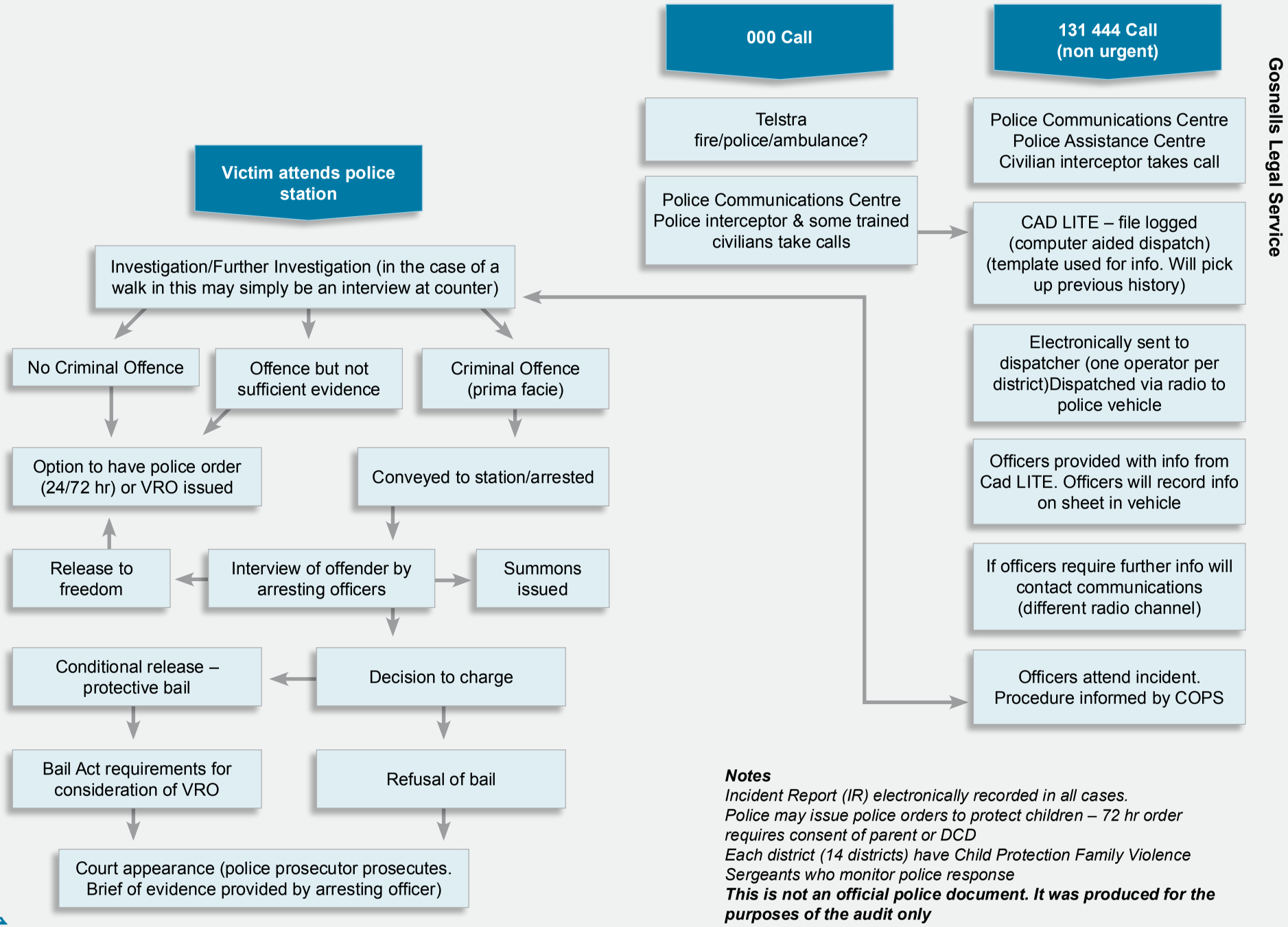


Notes
Counselling funded by DCD
Referrals from:
- *Education Dept*
- *Police*
- *DCD*
- *Hospital*
- *Other Counselling services*

**Mandated referrals only approx 1 in 5 turn up*

Starick Services Police Advocates





Notes
Incident Report (IR) electronically recorded in all cases.
Police may issue police orders to protect children – 72 hr order requires consent of parent or DCD
Each district (14 districts) have Child Protection Family Violence Sergeants who monitor police response
This is not an official police document. It was produced for the purposes of the audit only

Appendix Nine:
Example Memorandum of Understanding

Memorandum of Understanding

Between Armadale Domestic Violence Intervention Project And Starick Services Inc.

I Background:

a This MOU was developed as a result of discussions by the Armadale Domestic Violence Intervention Project (ADVIP) regarding the need to assess how victim safety and offender accountability is centralised in the processing of domestic violence cases within the ADVIP model.

b ADVIP has secured grant funding to conduct a Domestic Violence Safety and Accountability Audit.

c The Domestic Violence Safety and Accountability Audit (hereafter referred to as the Audit) identified in this MOU agreement refers to the process developed in Duluth, Minnesota, by Ellen Pence and outlined in the manual *The Duluth Safety and Accountability Audit: A Guide to Assessing Institutional Responses to Domestic Violence*.

d The Audit is a multidisciplinary, community-based process, and it has several steps: (1) forming and preparing an interagency Audit team; (2) determining which aspects of case processing the team will investigate; (3) determining the scope of the investigation; (4) collecting data from each point of institutional action on a case, including the link or relationship between the data produced at different points of intervention; (5) analysing the data; and (6) preparing findings that lead to specific recommendations.

e Data-collection methods include text analysis (forms, documents, and reports), interviews, observations, and focus groups. Analysed texts relating to each step in the system response will be used to determine interview questions and the focus of observations, and will generally help guide and develop the Audit process.

f A multidisciplinary Audit team will examine how each of the ADVIP participating agencies intervenes in cases of domestic violence and how they organise their practitioners to perform their duties. Rather than attending to the idiosyncrasies of individual practitioners, the Audit looks instead at how, where, and whether their formal and informal practices ensure the safety of victims and the accountability of offenders.

g Audit team members will meet in small and large groups throughout the Audit process to discuss findings and propose changes to system practices that will enhance both victim safety and offender accountability.

h The Audit team will be trained and assisted by Dr Ellen Pence and her assistant Ms Amanda McCormick, consultants from Praxis International (Praxis).

II Roles and Responsibilities

a Audit team participation

- Starick Services agrees to designate and provide time for a staff member who is interested and committed to the goals of this project to participate actively as a member of the Audit

team. The designated staff member will attend an Audit training session, participate in interviews and observations, and participate in Audit team meetings to analyse the data that is collected and to make recommendations for system changes, if needed.

- Team members are required to attend ADVIP Core Group meetings (approx. 4 prior to audit).
- Team members are required to attend 2–3 team meetings prior to 25 November (dates to be advised).
- Team members are required to attend the training of the Audit Team on 25 November 2005.
- The 'blitz' Audit process will take place from 28 November 2005 to 2 December 2005. The Audit process will be conducted over a five-day period, and it is expected that Audit team members will be required to work beyond their normal working hours.

b Text analysis

- Starick Services will provide written information and documents to the ADVIP Audit team, including Dr Ellen Pence and her associate Ms Amanda McCormick, that Starick Services determines is (1) reasonable and (2) will not compromise the safety of victims.
- ADVIP agrees that any documents provided by Starick Services that have features that identify individuals, including officers, will be redacted by Starick Services or by the Audit Coordinator employed by the ADVIP to ensure the anonymity of those involved.
- Redacted reports or documents provided by Starick Services will be kept at the ADVIP central office in a locked cabinet. The analysis will use excerpts from the reports but will not identify any person or agency involved with the cases.

c Observations and interviews

- Starick Services will allow Audit team members and Dr Ellen Pence and her associate to interview and observe practitioners in order to gather information on how domestic violence and similar cases are handled.
- The ADVIP Audit Coordinator will be responsible for arranging and scheduling all interviews and observations. The ADVIP Audit Coordinator will arrange for all observations through a person designated by Starick Services Inc.

d Audit team recommendations

- Audit team findings and recommendations will be presented to ADVIP members. The implementation of recommendations will be determined by ADVIP members.

Signatures:

Chairperson (Interagency)	Chairperson
Armadale Domestic Violence Intervention Project	Starick Services Inc.
By ……	By ……
Date ……	Date ……

Appendix Ten:

Example Audit Team Confidentiality Form

Confidentiality Agreement

During my experience as an audit team member for the Armadale Domestic Violence Intervention Project (ADVIP) Praxis Safety and Accountability Audit:

I understand that I will have access to client information and clients' records. I also understand all government departments and non-government agencies are required by law to keep such information and records confidential.

Therefore, I agree to hold all information concerning any client and all client records in the strictest of confidence, in compliance with the law and my ethical obligations as a member of my participating agency/department.

Furthermore, I agree not to disclose any information discussed during the undertaking of the audit process, except as is necessary in the regular course of the audit process during the week beginning 25 November 2005 and ending 2 December 2005.

At the end of my role as a team member for the ADVIP Praxis Safety and Accountability Audit, I will not use, appropriate, reproduce, or disclose any such information to any third party, unless required by law.

I acknowledge that any breach of confidentiality may result in a report being made to my department/ agency supervisor.

_____

Name of Audit Team Member (print)

_____

Signature of Audit Team Member

_____

Name of Agency/Department

_____

Date

Appendix Eleven:
PSI Report

Pre-Sentence Report

CBIS ID:

NAME:

DATE OF BIRTH: AGE:

PLACE OF BIRTH:

ADDRESS:

MARITAL STATUS:

OCCUPATION:

INTRODUCTION:

PRESENT OFFENCES:

COURT HISTORY:

COMMENT ON COURT HISTORY:

CHARGES PENDING:

PREVIOUS RESPONSE TO SUPERVISION:

(Note all of the above factors are limited to official documentation of the offender's relationship to the state. It does not require the probation officer to document his relationship to the person he has assaulted.)

FAMILY BACKGROUND:

MARITAL SITUATION:

EDUCATION AND EMPLOYMENT:

FINANCIAL SITUATION:

HEALTH:

SUBSTANCE USE:

LEISURE INTERESTS:

SUMMARY:

Insert Officer's Title

Maddington Community Justice Services

FOR: CHIEF EXECUTIVE OFFICER

DEPARTMENT OF CORRECTIVE SERVICES

Appendix Twelve:

Twelve Problematic Features of Institutional Social Management

The twelve problematic features of institutional social management developed as part of the PRAXIS Safety and Accountability Audit are used to analyse information gathered from observations, interviews and text analysis.

1 Fragmentation

2 Textually coordinated

3 Problematic use of categories

4 Operate on a time different to lived time

5 Privilege institutional functions over individual needs

6 Create communication without dialog

7 Engage in conceptual practices that organise how workers think and act

8 Create a fictitious universal person as a standard

9 Mask institutional limitations and failures

10 Have weak systems of accountability to the people whose lives are being managed

11 Use coercion to gain compliance

12 Individualise the social problems[53]

53 PRAXIS International – PRAXIS Safety and Accountability Audit Toolkit

Appendix Thirteen:

The Department for Community Development 'Jones' Case File

Summary: 'Jones' Case File 1999–2003

Demographics of family:

Leanne	mother/wife (29)
Brian	father/husband (42)
Bobby	son (6)
James	son (5)
Lorna	daughter (4)

The 'Jones' case first came to the attention of the Department for Community Development (at this time referred to as Family and Children's Services) in 1999 when a report was received from the school nurse regarding concerns raised by bruising and a burn mark on Bobby. Between 1999 and 2003 the Department's involvement periods were:

- 06-09-99 to 02-02-01
- 14-02-01 to 25-06-01
- 16-12-02 to 07-01-03.

Child protection workers noted that Leanne appeared nervous and distressed in the three interviews. In the interview without Brian present, the worker asked whether Leanne 'felt safe' in talking to her husband about the Department's concerns. Leanne did not answer the question directly.

Leanne says it is she who physically disciplines Bobby and not their father, a statement that is contradicted by Bobby, who states in an interview that only his father hits him. Bobby's speech and behavioural problems lead the Education Support Centre staff to suspect/suggest that he may be autistic. Enquiries are made at the Jones children's day care centre and school, but there is no indication that the other children experience problems. However, it is mentioned that they are 'not very clean at times, clothing dirty/shabby'.

It is documented that Brian has gone to the school at least once and verbally abused staff, who saw him as 'very controlling and manipulative' and 'unreasonable'. It is concluded that the parents have 'difficulty' managing Bobby's behaviour, and that they would benefit from attending parenting education. The case is closed approximately two weeks later; it is resolved that the Education Support Centre will closely monitor Bobby and report any concerns, and the parents will participate in voluntary parent education/family support services. Case closed.

File notes from the Support Prevention Education Advocacy Referral Service (SPEARS, Starick Services) state the severity of Brian's abuse, which includes harassing Leanne at her workplace and causing damage to her property. Leanne seeks a VRO and alternative accommodation, as the refuge is full.

Early in 2000, the Department receives another referral from the school in relation to Bobby and James. Bobby is having behavioural problems, and both children have signs of physical abuse. Child

protection workers ask Leanne directly about domestic violence; Leanne informs them of the current VRO and gives some details of the abuse experienced by her and the children. Child protection workers advise Leanne that she must keep the children safe, and she is asked to pass on information regarding programs to Brian. Leanne must also tell Brian to contact the Department for a suitable interview time.

Child protection workers interview Brian. It is arranged for the family to attend six sessions of family therapy.

The Department write to the Education Support Centre at the school and state that the Department is 'unable to take an active role in this family's life at present', but they ask the Centre to continue monitoring the children and to inform the Department of any indications of abuse or if Bobby is taken out of the centre by Leanne.

In late 2000, the Department receives an Education Support Centre report stating their concerns in relation to a head injury sustained by James and Bobby's absence. The case is reopened. School staff report that Bobby alleges Brian 'kicked him in the stomach and threw him into a prickly bush'. Bobby is interviewed by a child protection worker, who confirms what was in the school report. Bobby also tells the worker that his mother was hit by his father at the same time.

Child protection workers visit the home, where Brian is intoxicated and verbally aggressive. They leave quickly and return with the police officers, who fail to find Brian. Leanne and the children accompany the child protection workers to the police station, where the children are placed in voluntary foster care, as there are no refuge beds available. Leanne finds alternative accommodation that night. Leanne talks to child protection workers about Brian hurting Bobby and herself; she has an injury to her eye and bruising on her arm. Leanne gives an account of police coming to the house when she calls to report breaches of the VRO; she says that the police are often unable to find Brian, or he returns to the house as soon as he is released. She states that she does not believe the police can protect her. Leanne discloses serious escalating violence and threats from Brian, particularly when she invites intervention. Brian keeps her from seeing her friends, has disabled her car and, on occasion, will not let her use the phone. It is noted in the file that she fears for her safety and that of the children, she is afraid of his threats to kill them all, and she cannot stop Brian's violence.

Police call Leanne, who tells them that Brian is living at the house. The police advised that they will inform the Magistrate immediately, and they ask Leanne to attend the police station the next day to give a statement about this situation, as Brian is on protective bail and is not allowed near the house. Leanne stays in a motel over the weekend. A Starick advocate follows up and finds out that Brian is in prison and will be held until a hearing scheduled for December 2000. Leanne returns home.

File notes indicate that, at this time, Leanne is home, awaiting the return of her children. Starick Services inform her that they 'will consider Leanne and her children for refuge if room becomes available'. Child protection workers talk with Leanne about placing the children with her parents, as she is 'unable to protect them from Brian's violence'. Leanne is to have supervised contact with the children, which is to be negotiated with her parents, and she is to provide financial support for the placement. Brian is to have no contact with the children. Bobby is assessed for autism, which reveals slight dyspraxia, a motor-neuron disability.

Brian serves prison time for breaches of a VRO and other criminal activities. He is then released and put on a community-based order. Leanne asks the Department for the return of her children.

She is advised that the children must remain with her parents, as Brian's whereabouts are unknown. Child protection workers reiterate that if Leanne 'resumed her relationship with Brian, significant consideration will be given to apprehension of the children'.

Later, the children are returned to Leanne, on certain conditions: they are to have no contact with Brian, and Leanne is to attend counselling and parenting programs. Another contract is drawn up, reiterating no contact with Brian until he has completed programs for anger, alcohol abuse and domestic violence. Meeting notes say that the Department will speak with Brian and draw up a separate agreement with him. An appointment is made for Leanne to see a psychologist; child protection workers deem this necessary to deal with her 'compulsive lying and inability to say no to Brian'.

The file contains several accounts of Brian breaching a VRO; he is imprisoned several times as a result. Brian attends the Departmental district office, where he makes reference to someone who gassed himself and his children. Leanne files for divorce in the Family Court, and she resides with her children at a new address.

The school again report to the Department that they have reason to believe Brian is residing in the home, as one of the children indicated that 'Dad was looking after us while Mum was at work', and that they believe the Department should 'check it out'. A child protection worker advises the school that they will make a planned approach to the family to minimise any further risk to the children.

The Department report back to the school, advising they have no child concerns, and they ask the school to continue to monitor the situation. The school contact the Department to advise that two of the children are attending another school, and they give the Department the contact details of the principal. A child protection worker contacts the school principal to see whether they have any concerns regarding the children's wellbeing. The school principal states that she is unaware of any concerns the teachers may have; however, they have not been looking for anything, as they were not aware of the Department's involvement until they were contacted.

Leanne contacted the Department in early 2003 to describe an incident in which Lorna was staying overnight with Brian and he had called Leanne while drunk. Leanne went to his house to collect Lorna, and she told that Brian he was not to care for the children while he was drinking. Leanne also describes how Brian came to the house several times and refused to leave on one occasion; she called the police to have him removed. Police attended. While they were searching the house for Brian, they found evidence of criminal activity, and they arrested Leanne. She was released on bail but was worried that she might be given a jail term, and she was concerned about what would happen to the children. Leanne was not jailed for the offence.

The Department made the decision not to become involved with the family at this time, because police were already involved. Later in 2003, the Department received a report from the police 'concerning the welfare of the children'. The report states that the initial call from Leanne was of a 'domestic nature', with Leanne claiming that her ex-husband had been at the house and was refusing to leave. Police attended, and Brian had gone. Police then reported on the condition of the house and the welfare of the children. The Department file notes that, following receipt of the police report, 'there was insufficient information to base the decision to reclassify as a child maltreatment allegation on the observations of the home by police'.

Appendix Fourteen:

Developing Policies and Protocols for Responding to Domestic Violence Cases

(Note: the terminology in Appendix Fourteen has not been edited for purposes of copyright therefore language is presented in an American style.)

Ellen Pence and Coral McDonnell, Domestic Abuse Intervention Project

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 ensuring 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 belief 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 1981–1984 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 counsellors work with offenders in groups or classes and not offer marriage counselling 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-l, 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 boot laces, 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 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 911. 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 were 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 kind 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 seems 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 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 that 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 belief 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 . . . I 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 of ten 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 Phillip 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.

Use Policies to Control the Screening of Cases

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.
- Not every act of domestic violence 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 judgements. 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 judgement 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. 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. Recently, when we introduced the practice 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 Response

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 sheriff's 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 sheriff's 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 sheriff's department that this is not a high risk situation. The sheriff's 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, developed by the probation department in consultation with the shelter advocates and the DAIN staff.

Another example is the development of the emergency response team. In 1996, we organised 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 (eg 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.

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.[11]

Recognize that Victims and Victim Advocates are Allies, not Enemies

It is 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 Policy intent and rationale

II Guidelines for processing cases

   a what the practitioner should do 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 the policy will be monitored by agency

   b steps to ensure compliance

   c record sharing for external monitoring (how, and with whom).

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

- Focus on changing the institution, not the victim.
- Balance the need to standardize against 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 level of danger presented by an offender.
- 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 a future relationship.
- Document the pattern and history of abuse when and wherever possible.
- Account for the ways in which:
    - categories help and hinder the understanding of a case
    - practitioners will get around the intent of the policy
    - offenders will get around the intent of the policy
    - the policy/response will be used against victims of battering
    - different levels of dangerousness and risk require different levels of response
    - punishment/sanction will have an impact on the offender
    - rehabilitation/programming could be used against victim
    - victims use violence against their abusers
    - slowness will impact victim safety
    - children are affected by violence
    - offenders could use children to control victims
    - 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:
    - rules and regulations
    - administrative forms and procedures
    - resources and technology
    - linkages to others in the system
    - training and ways of thinking.
- Make sure the policy covers:
    - what to do under specified circumstances
    - guidelines to put cases into appropriate levels of response
    - methods to ensure practitioner compliance (tracking)
    - guidelines for making exceptions to the policy
    - how to document actions
    - 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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