Exploring the Question: How does the work of a visitation center produce or not produce safety for everyone involved?

A report from the California Safe Havens Demonstration Site
Safety Audit

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Safe Havens: Supervised Visitation and Safe Exchange Grant Program

Prepared by

Praxis International, Inc.

In consultation with

Family Service Agency of San Mateo County

Walnut Avenue Women's Center of Santa Cruz County

Community Solutions of Santa Clara County

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A story

One spring day, members of the California Safe Havens Demonstration Site safety audit team gathered around a table to read several supervised visitation/exchange case files together in order to better understand how safety for victims of battering and their children was visible in or absent from the documentation before us. One of the visitation center directors shared this story.

> A father arrived at his regular visit with his children, carrying a basket with Valentine's Day candy and a plush toy dog nestled in the center. The monitor, as was the center's practice, examined the basket to make sure that there were no hidden notes or dangerous objects. Everything checked out and the basket went home with the children at the end of their visit.
>
> The next day the children's mother called the director, extremely frightened, upset, and angry that the monitor had allowed him to bring the basket into the center and leave it with the children. The toy dog resembled the dog that her former husband had killed in front of her. He had also recently left the same toy on her sister's doorstep.
>
> This mother had been terrorized by the visiting father during their marriage and the threats to harm or kill her continued after their separation. The visitation monitor saw candy and a cute toy, provided by an attentive father as a holiday gift. Its significance and the reason visitation had been ordered in the first place were deep in the case file, back among its many pages, a few lines lost in the construction of the file and turnover of the center staff.

Our story is not meant to say that a visitation center can never allow gifts, but to show that in domestic violence cases a visitation center – like the courts, churches, synagogues, mosques, and the child welfare system – can become a vehicle for continued abuse. Had this mother not spoken out the center would have given occasion to more abuse without documenting its continuation. Her story and others like it compel us to ask how we are giving equal regard to the protection of adult victims in the center's design. Thus, we began the audit process with this question: *How does the work of a visitation center produce or not produce safety for everyone involved?*

The most innocuous and benign-seeming behavior in one everyday context carries an entirely different and dangerous meaning in the context of battering. As a result of our collaborative work and exploration, we are moving to build that understanding throughout the work of our visitation centers, and across our collaborative partners and the wider communities in which we are located. We are moving toward providing supervised visitation and safe exchange in ways that account for different levels of violence and different needs for protection. Our inquiry has led us away from a single, generic model of visitation and exchange and toward approaches that better account for the complexity of risk and safety in people's lives. It has led us toward placing equal regard for <u>everyone's</u> safety at the center of our work.

Background

As part of their participation as a demonstration site for the Safe Havens Supervised Visitation and Safe Exchange Grant Program,[1] three visitation centers applied the methods of the "safety and accountability audit" to the question of how the design, processes, and procedures of visitation and exchange account for safety in the context of domestic violence cases.[2] The centers included: Family Access Program of Santa Clara County (Community Solutions); Santa Cruz Safe Connections for Kids (Walnut Avenue Women's Center); and, Family Visitation Center (Family Service Agency of San Mateo County).

The demonstration site assembled a local team to work alongside Praxis consultants and collect and analyze data. Following a two-day training in September 2003, the team gathered information at the participating sites between November 2003 and May 2004. Debriefing sessions on-site and via conference call were conducted at seven points during this time. The team read center policies, forms, and twenty-four supervised visitation and exchange case files which included intake forms, observations notes, phone logs, family court records, and reports to the court. We conducted ten focus group interviews with battered custodial parents, battering non-custodial parents, domestic violence victim advocates, and batterer intervention program facilitators. We conducted nineteen individual interviews with agency and program directors and supervisory staff, monitors, and administrative staff. At each center the team observed intakes, visits, exchanges, and the physical design and work space. This report draws on information gathered with the three current demonstration site partners, plus earlier interviews and case file reviews at a fourth.[3] (Appendix 1)

This report refers to *centers* throughout rather than identifying a specific center or particular staff. Our concern was the overarching question of whether and how visitation centers are organized to account for battering and the safety of all who cross the threshold. Local team members addressed any concerns that were particular to an individual center and community. While some findings were more applicable to one center than to another, all faced some variation of the problems and questions highlighted in the following pages. Our interest was to recognize gaps between the safety needs of families using the centers, in the context of battering and domestic violence, and the ways in which the centers' work is organized and structured to close

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[1] The Safe Havens Grant Program, established by the Violence Against Women Act of 2000, provides an opportunity for communities to support supervised visitation and safe exchange of children, by and between parents, in situations involving domestic violence, child abuse, sexual assault, or stalking. The four Demonstration Sites (encompassing the three California centers, three in Chicago, four in Michigan, and one in Kent, WA) have paid close attention to visitation and exchange in the context of domestic violence, and to collaboration between visitation centers, domestic violence advocacy organizations, and the courts.

[2] The Safety & Accountability Audit is a method of assessment and analysis for exploring institutional response to domestic violence: how workers within agencies and systems are organized and coordinated to think and act on cases. This approach has been developed by Praxis International, an OVW-designated technical assistance provider for the Safe Havens Supervised Visitation and Safe Exchange Grant Program: www.praxisinternational.org; 651-699-8000.

[3] The Supervised Visitation Program of Community Human Services of Monterey County participated in the initial assessment activities.

or widen those gaps. We were not looking for nor did we find that problems rested with a specific staff member or intervener's skill or abilities.

Supervised visitation is an important resource for battered parents and their children. Participants in focus groups conducted during the safety audit emphasized the role of the visitation center in providing a reliable, safe place for children to visit their fathers, or a process for unsupervised exchanges that did not require persuading a reluctant law enforcement agency to assist. "A new lieutenant came in and discouraged [me] from doing the exchange there because volunteers at [law enforcement agency] didn't want to deal with possible violence,"[4] was how one mother described that experience. While battered parents were candid in expressing their concerns about different aspects of supervised visitation and exchange, and frustration with court orders that they felt did not take their experience into account, they wanted to keep visitation centers readily available.

What do we mean by "safety"?

Over the course of the assessment, the team had repeated discussions about what we meant by safety. Initially, our tendency was to focus on the immediate experience of visitation: on what happens within the one or more hours during which children and adults arrive, stay in, and leave the center. We found that the centers were largely well-organized to address safety in this immediate context. Center staff paid attention to who was coming and going where and how; they emphasized rules about *being within visual sight and sound of the supervising monitor at all times* and *no whispering, passing notes, hand signals, or body signals with the child(ren)* during the visit. Centers structured intake, entry, and exit procedures to avoid couples seeing each other. They were alert to and prohibited potentially harmful conversations between visiting parents and their children. They paid attention to who could visit, what gifts, toys, or money could be exchanged safely, and procedures to follow should a visiting parent leave the center with a child. Overall, the centers recognized how the visit could be an opportunity to strike out at the child or the other parent.

Critical Safety Periods

As we dug deeper, however, and had the opportunity for conversations with our colleagues in the other Safe Havens demonstration sites,[5] we found ourselves thinking about a wider notion of safety, taking into account the dangers of post-separation violence and the reality of an ongoing relationship between parents around the lives of their children. We recognized from our own experience, both generally and via the assessment, that there were many aspects of supervised visitation and exchange in domestic violence and battering cases that we needed to think about.

[4] Throughout this report, statements from individuals appear in quotation marks; excerpts from printed material appear in italics.

[5] In particular, the work of the Michigan Safe Havens Demonstration Site contributed to our discussions of safety as it explored the question of the role of a supervised visitation center. That report is available at www.praxisinternational.org.

- The period after separation is very dangerous for battered women. It is when victims of abuse are most vulnerable to a sudden increase in violence and a shift in or intensification of abusive tactics. (Mahoney, 1991; Campbell, et al, 2002, 2003) Some post-separation safety factors are particularly relevant to the work of a visitation center:

    - The likelihood of an abuser shifting control tactics to use of children increases greatly after separation.
    - Batterers use a variety of tactics to instill fear and control both the mother and the children, such as smashing and throwing things, destroying favorite toys, harming or killing family pets, threatening to harm the mother, and threatening to abduct the children or seek custody of children.
    - Batterers use a variety of tactics to harm the mother-child relationship, including belittling her, encouraging divided loyalties, and treating her with disrespect. (Bancroft and Silverman, 2002)

- Battering has a deep impact on a victim's cognitive, psychological, physical, and spiritual well-being. She may appear to visitation center staff as being resistant, controlling, obstructive, overly emotional, or "out of control."

- All of a victim's relationships are impacted by the violence and coercion, but the most significant impact is most likely on her relationship with her children.

- A battered parent may become overly authoritative with her children as a mechanism to cope with the violence and protect them.

- Many conditions of life circumstances and social position make victims more vulnerable to harm, such as race, class, immigration status, mental illness, religious beliefs, alcohol or drug use.

- Batterers routinely attempt to engage interveners, such as police, the courts, and visitation centers, into supporting their attempts to coerce and threaten the victims of their abuse.

As one mother in a focus group explained, "the longer I ignore him, the more desperate he seems to get." He brought her in and out of court, challenged the visitation order, and constantly switched appointments so that "none of the monitors can get a handle on how he really is."

Safety is the protection of children and victims of battering from continued physical, sexual, and emotional harm, coercion, and threats, over the span of time. It is not only what happens within the one or two hours when a parent and child are in direct contact with the visitation center. As we observed visits, read case files, and interviewed center staff, we began to think about how those working in visitation centers were organized to think about and act on issues of safety over three distinct time periods:

1. Safety during the exchange or actual visit (2+ hours)
2. Safety during the two years following a separation (2+ years)
3. Safety on a permanent basis (20+ years)

What we found across all sites was that the work of a visitation center was shaped almost exclusively by attention to safety during that "2+ hours" when parents and children are physically present in the facility. Safety, in other words, equaled the safe visit.

Safety during these two-plus hours is undeniably critical and important to everyone involved: children, visiting parents, custodial parents, and center staff. It is vital that visitation centers pay careful and close attention to the design of their space, the ways in which parents arrive and leave, and the kind of conversations that occur during a visit or exchange. At the same time, our assessment raised questions about the implications for safety across the longer time period from immediate to permanent separation, a span of months to years that can involve visitation and exchange orders. It brought recognition that visitation centers have not been organized to attend to safety in the context of battering, and that changes in rules, policies, documentation, training, linkages, mission, and purpose are necessary in order to do so.

As one team member noted, "I think it was a surprise to us, the extent to which philosophy around this issue didn't hold true to practice around the work. We can talk about being here to keep victims and children safe, but in practice our thinking didn't go through to how the work impacts victim safety."

We also recognized that safety has multiple dimensions. People's lives are complex and the factors that reinforce or diminish risk and safety are also complex. How supervised visitation or exchange can best work for those in need of protection involves understanding not only the danger that an individual batterer poses to a victim, but how immediate life circumstances, aspects of culture, and institutional response also contribute to risk. Figure 1 (see page 8) provided a framework for our discussions about the complexity of risk and safety.

This paper reports on what we learned during our safety audit, and our efforts to shift our perspectives and practices as a result. We recognized early on in our inquiry that many visitation practices did not fully account for safety in the context of battering. The question and challenge was what to <u>do</u> with that recognition. What had to change in visitation and exchange practices? How could we accomplish that change? Who should be at the table in crafting those changes?

Figure 1.

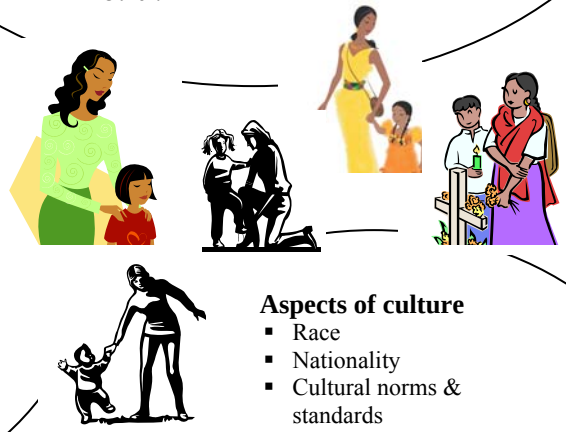
RISKS FOR BATTERED WOMEN & THEIR CHILDREN

Risks from batterers
- Physical Violence
- Sexual Violence
- Psychological cruelty & manipulation
- Using children to control
- Undermining mother's parenting
- Threatening to interfere with custody
- Using institutions (i.e., police, CPS, Visitation Center) to control
- Abduction
- Exposure to violence against mother
- Battering as role model
- Forcing children to intervene
- Other:

Institution-generated risks reinforce batterer risks

Immediate circumstances may increase vulnerability & may be used by batterer to control

Immediate Circumstances
- Immigration status
- Income
- Professional or social position
- Limited English proficiency
- Disability
- Mental illness
- Alcohol/drug use
- Rural isolation
- Other:



Institutional Response
- Forcing women into divorce mediation
- Ignoring violence in custody issues
- Unsupervised visitation
- Supervised visitation
- Joint parenting groups
- Coercing victim to get Order for Protection
- Damaging relationship with children
- Other

Aspects of culture
- Race
- Nationality
- Cultural norms & standards
- Childhood socialization
- Community practices
- Language
- Class
- Religion
- Other:

Aspects of culture can increase safety, but can also increase vulnerability & may be used by batterer to control

Immediate circumstances and aspects of culture influence the nature, availability, and impact of institutional response

Adapted from "Assessing Social Risks of Battered Women," by Radhia A. Jaaber and Shamita Das Dasgupta, Domestic Abuse Intervention Project, 2002; *Safety Planning with Battered Women: Complex Lives/Difficult Choices*, Jill Davies, Eleanor Lyon, & Diane Monti-Catania, Sage Publications, 1998; and work of the Battered Women's Justice Project.

A framework for inquiry and change

Case management in institutions puts in place methods that standardize practitioners' thinking and actions across disciplines, agencies, levels of government and job function. While they vary depending on the kinds of actions undertaken, there are eight core methods that institutions use to direct and influence workers into acting in authorized and acceptable ways. A visitation monitor does not get to make up his or her job, but operates within a framework shaped by these means of organizing and coordinating the work of a visitation center.

While every practitioner is organized and coordinated to think about and act on cases in institutionally authorized or accepted ways, none of the primary systems that intervene to protect victims of battering were designed with the unique characteristics of this social problem in mind. Instead, they have adjusted and adapted existing case management routines and long-standing practices, which often means creating a gap between the realities and risks in victims' lives and the institutional response.

Intervention in child abuse, and not the distinctive aspects of battering, has largely shaped the policies and practices of supervised visitation and exchange centers in California and throughout the country. The methods directing the work of a visitation center have historically emphasized parent-child interactions and parental access, rather than the danger posed by an abusive adult to his partner and their children in the context of separation violence and the use of children as a tactic of battering. Hence the overwhelming emphasis in the observation forms, for example, on parent-child behavior during the visit, but little attention to abusive or intimidating behaviors directed toward the children and non-battering parent in between visits.

Discovering and understanding these methods of organizing and coordinating work were central to the approach used by the California Safe Havens team. They also provided a framework for identifying the kinds of changes that might help address the gaps in safety that we discovered.[6]

1. **Rules and Regulations:** any directive that practitioners are required to follow, such as policies, laws, memorandum of understanding, and insurance regulations.

2. **Administrative Practices**: any case management procedure, protocols, forms, documentary practices, intake processes, screening tools.

3. **Resources:** practitioner case load, technology, staffing levels, availability of support services, and resources available to those whose cases are being processed.

4. **Concepts and Theories:** language, categories, theories, assumptions, philosophical frameworks.

5. **Linkages**: links to previous, subsequent, and parallel interveners.

[6] Adapted from *The Praxis Safety and Accountability Audit Tool Kit*, Ellen Pence and Jane M. Sadusky, Praxis International, Inc., 2005.

6. **Mission, Purpose, and Function**: mission of the *overall process*, such as criminal law, or child protection; purpose of a *specific process*, such as setting bail or establishing service plans; and, function of a worker in a *specific context*, such as the judge or a prosecutor in a bail hearing.

7. **Accountability**: each of the ways that processes and practitioners are organized to a) hold abusers accountable for their abuse; b) be accountable to victims; and, c) be accountable to other intervening practitioners.

8. **Education and Training**: professional, academic, in-service, informal and formal.

Table 1 illustrates at a glance the primary areas of change that address the safety and accountability assessment findings. It is followed by a more detailed discussion of each theme. Ultimately, the themes and methods are intertwined. Shifting documentary practices to account for battering, for example, does not stand separate and distinct from information about the level of danger that comes from referral sources, which in turn reflects how courts and custody evaluators see their roles in relation to the visitation center. Nor are the methods highlighted for each theme necessarily the only elements of change that might be involved. Rather, they signify the primary locations or anchors for action. Articulating the visitation center's role in post-separation violence and safety, for example, is an over-arching question that is likely to "require change everywhere," as one director noted. Addressing gaps in arrival and departure precautions that best fit each family's safety needs, in contrast, may require only a few procedural changes and staff training.

At the conclusion of this report we return to these methods of organizing and coordinating a visitation center's work when describing the changes that have occurred as a result of the safety audit.

Table 1. California Safe Havens Demonstration Site
Safety Audit Planning Assessment – Findings and Areas of Change

What the Safety Audit found. . .	*Requires change in . . .*							
Finding	**Rules & Regulations**	**Administrative Practices**	**Resources**	**Concepts & Theories**	**Linkages**	**Mission, Purpose, & Function**	**Accountability**	**Education & Training**
1. Visitation centers receive incomplete information from judges and custody evaluators about the level of potential danger.		√			√	√	√	
2. Families using the visitation center do not always receive clear information about safety precautions put in place around arrivals, departures, and visits.		√		√	√		√	√
3. The work of visitation monitors is not organized to fully account for battering behaviors and how those might be used to engage the center in inadvertently colluding with the battering parent.		√	√	√		√	√	√
4. Visitation centers collect and record a large volume of information without a clear sense of its purpose or importance to safety and risk in the context of battering.	√	√		√	√	√	√	√
5. Visitation centers do not have an ongoing, active dialogue with the parent who has been battered, or with the children or the battering parent.		√	√			√	√	√
6. Monitor training, preparation, and skill level can leave monitors inadequately prepared for supervisions and exchange cases involving battering.		√	√					√
7. Community-based advocates, batterer intervention programs, and visitation centers are poorly linked.		√	√		√	√		
8. The role of the visitation center in relation to post-separation violence and safety has not been clearly articulated or explored.				√	√	√	√	

What we learned: key themes

1. The visitation centers received incomplete information from judges and custody evaluators about the level of potential danger.

The team found that the referral process tended to present every client as equally appropriate for visitation. Recommendations submitted by custody evaluators[7] often carried the same wording and directions to each parent, regardless of the battering behavior that was reported or noted elsewhere in the case file.

Although the referral source may have had information about past violence, multiple arrests, and protection orders, it was not included in the information presented to the visitation center. The centers were missing the case issues that were relevant to the safety of a child or parent in the supervised visitation program. They were missing the impressions, allegations, or evidence of risk that made the case rise to the level of needing supervised visitation services from the court's perspective.

From the document review and staff interviews we learned that information available to the court, such as records of 911 calls, police reports, and order for protection affidavits, was either not consulted or not shared with the visitation center. None of the case files that referenced a domestic violence related arrest, for example, included a copy of the police report or any notation from the referring source that provided an indication of how dangerous visitation might be for the battered parent and her children. Case files routinely had a copy of any restraining order in effect, but did not include the affidavits or petitions on which the order was based and which would have provided a more complete picture of the violence. It was often difficult to see who was in danger from whom. Was the greatest danger to the children, to the battered parent, or to both?

2. Families using the visitation center did not always receive clear information about the safety precautions put in place around arrivals, departures, and visits.

As we heard from participants in the battered parents' focus groups, safety precautions are important to them, but they did not necessarily understand what had been put in place. From our interviews and observations we saw a gap between families' safety concerns and the centers' role in addressing those concerns. For example, one of the focus group participants did not see where and how the man who had battered her arrived at the center, and how that differed from where and how she arrived. She needed more information about what the monitors knew and did to ensure her safety, and an opportunity to express what she needed to feel safe. Another needed reassurance after the visiting parent called her and said, "I know how to get the kids out of the center."

[7] Different counties use different terms to refer to the individuals who make custody recommendations to the court: mediators, custody evaluators, court psychologists.

We also found that referring organizations and centers were assuming in general that all battered women needed the same safety features in place to be or feel safe. They did not ask individual women what they needed in place to feel and be safe. Centers were also not organized to re-examine with women how they needed to feel safe over time. The assumption was that what was put in place at the time of visit one would meet her safety needs at time of visit number twenty.

The person assigned to arrive via a center's "back door," whether the visiting or custodial parent, often described it as demeaning, suggesting that staff may have not always been prepared to do a thorough job of explaining why it was arranged this way, or why arrival and departure times were staggered. Our observations suggested that staff did not always provide victims with a clear sense of the safety features in place, and were not necessarily equipped to answer questions about them. For example, a staff member in one center did not know why the non-custodial parent had to use the back entrance and could not provide a satisfying answer to the parent who was upset that he had to come to the back door. In another instance the center staff did not have complete knowledge about the site's safety features, such as an overhead paging system, walkie-talkies meant for security backup, and an on-site panic button.

The team encountered situations that would reinforce a battered parent's anxiety about her safety. For example, one Saturday morning a team member arrived at the center when the building was open but no staff member was present. She was able to go anywhere in the building without being asked to identify herself and her reason for being there. Most of the doors were unlocked or open and if a door was locked it could easily be circumvented by using an alternate route. Another team member had a similar experience at a different center, where it was easy to walk into the visitation center space from the outside. While center policies require at least two staff members on site during scheduled visits, we found examples where monitors ended up alone with a family if someone called in sick or if a volunteer did not show up as expected. The resources available to centers and training and supervision of staff all contributed to this kind of gap between what some battered parents expected and what they experienced. Centers took prompt measures to close gaps in security that came to their attention via the safety audit.

3. The work of visitation monitors was not organized to fully account for battering behaviors and how those might be used to engage the center in inadvertently colluding with the battering parent.

Batterers use tactics of intimidation and manipulation with visitation center staff just as they do with their families. Focus group participants cited gift giving as an example of a frequent avenue for batterer manipulation and control. They expressed concerns that monitors missed the significance of the visiting parent bringing frequent and expensive gifts (outside of special occasions such as birthdays and holidays): "They seem to allow the gift rule to be violated on a regular basis. The monitors don't seem to know what the parent is all about." While gift giving rules were enforced in sexual abuse cases, there did not seem to be a similar understanding of the ways in which gifts could be used in the context of battering.

Mothers in the focus groups offered other examples to illustrate their concerns about whether monitors were always well-prepared to recognize and respond to tactics of battering. One woman

described how the children's father left roses for her at the door to the visitation center. Mothers across the groups expressed doubts about whether some monitors had the maturity and training to recognize manipulation: "He is charming and charismatic." "[Monitor] is too young to handle my husband."

Another focus group mother observed that as the center had more contact with the visiting father, "it seems less concerned," where there was a sense of urgency and concern about the visits in the beginning.

A batterer's behavior was often documented in the case files as it related to the staff or program, but not how the behavior was dangerous, unsafe, or potentially harmful to the victim or child. For example, the reason for termination was listed as *failure to comply with visitation center rules*, without making clear how the rules in question related to a victim or child's safety. Not following scheduled arrival and departure times was documented as *displaying difficult behavior*, without articulating the implications for safety, when such actions might signal stalking behavior.

Monitors expressed feeling conflicted and ill-prepared to respond to a victim of domestic violence who is the visiting parent. When a battered woman was the non-custodial parent it did not change the visitation center's protocol about who arrives when, who leaves when, or who waits where. A batterer who was a custodial parent could come and go without scrutiny.

We saw that the person who was assigned the category of custodial parent, regardless of whether he or she is the batterer, was instructed to come to the site after the visiting parent (victim) and leave the facility first at the conclusion of the visit. This resulted in allowing batterers to not be accountable for their whereabouts during the time the victim was arriving and leaving the facility. Batterers who were the custodial parents were also given authority to dictate aspects of the visit, such as which guest were allowed, gift restrictions, and restrictions on bringing food to the visits.

4. The visitation centers collected and recorded a large volume of information without a clear sense of its purpose or importance to safety and risk in the context of battering.

At all three sites, when monitors were asked why supervised visitation was ordered, there was no consistent response, and even opening the file did not necessarily help answer question. As one team member observed, files were "either so overstuffed with information it was hard to tell what was important and what wasn't important, or contained little or no case history information." Staff was expected to read the file, but the team read files that were two or three inches thick without finding a clear explanation of the reason for and safety issues around supervised visitation or exchange. Case files had examples of custodial parents relaying concerns to staff, and monitors noting a father's agitated and confrontational behavior, but it was unclear whether the information went any further than the case note or phone log. A focus group participant spoke to this gap: "There are things that happen that just aren't documented! My ex got community service as part of the sentence in the criminal case. He called the center to try to get to do his community service here!"

When visitation or exchange services begin, center staff collects specific data for the client file, but we did not see a process for routinely updating this information, such the batterer's vehicle description and license plate or current restraining orders and court orders, particularly for cases that the visitation center served for several years. The lack of accurate information becomes a safety problem when it limits the understanding of what is occurring within the longer period of separation, when tactics of battering and the risk of abduction can escalate.

Battering was largely invisible in the centers' documentation. We found that there was often no way to readily know why a family was at the center. It was difficult to determine who was in danger from whom, and how and why. Lack of continuity from week-to-week and monitor-to-monitor, coupled with case files that provide little information about the history and context of violent and coercive behavior mean that each visit became a largely isolated event. What happened during that two-hour window was not connected to the reason for the visitation order or to the behavior before, during, or after previous visits. The significance of repeated behavior and broken promises before, during and after visits was also missed. One case file showed a batterer telling a child during eleven different visits that he would bring pizza for him at the next visit. Over the course of five months of supervised visitation he never provided pizza to the child, despite the child asking for it at five of those visits.

We saw during the safety assessment that intake forms attempted to obtain this information, but via a largely indirect, abstract process. Each parent received a copy of the same form to complete prior to their intake appointment. It included the following questions, though the order in which the questions appear varied between the centers, along with slight variations in wording. For example, one center asked the person completing the form to *describe the last contact* while another asked for the *date the child(ren) last saw or talked to the visiting party*.

- *Date of last contact between visiting party and children*.
- *Please describe this contact.* (in two lines)
- *Please give us any additional information about you and your child(ren) that* [SV Program] *staff should be aware of. Please include the reason the agency services are needed.* (in five to nine lines)
- *Are there restraining orders in place? _____ If yes please supply us with a copy.*
- *Have the police ever been called to enforce the order? _____.*
- *If yes, when was the order most recently violated? _____.*
- *Please give us a brief history of any violence* (in one to three lines).
- *Are there abduction concerns?* _____ (in two to five lines).

The degree to which a battered parent is able to and comfortable with completing such forms influences how much of the picture she or he provides. Parents were asked to fill out the intake form prior to having any relationship established with the center. If a battered mother does not trust that the information is going to be kept safe, or does not have a clear understanding of what the visitation center needs to know about her experience, she is unlikely to volunteer it. Circumstances of literacy and language influence how a form gets completed. The space available, one to three lines, directs the information. It is as if the form says 'tell us this much and nothing more.'

The assessment team found that intake forms overall had sketchy information about the kind of battering tactics that might have been used or were currently in use, and the intake interview was not organized to follow up with questions that were anchored in a battered parent's experience. For example, one mother reports *he was violent with me during pregnancy*, but we do not know how violent. Was she hospitalized? How frequently? How severe was the violence?

Center staff assigned the task of completing the intake process usually had an hour or less to do so, and spent most of that time reviewing the rules and procedures, obtaining signatures on forms, arranging payments, and developing a visitation or exchange schedule. As designed, the intake process did not answer questions such as: What are you concerned about? What are you afraid of? What do you need? How might he or she use the center to get at you, to threaten or scare you? The intake form and interview were not structured as a dialogue, but as a process to meet the needs of a center as an institution: to complete the list of required forms, obtain the necessary signatures, arrange the schedule, and confirm payments. It is not that logistical and managerial details are unimportant, but that they dominated the monitors' interactions with parents. Building relationships or trust with parents was not a function of the intake.

Observation notes and logs assessed parent-child interactions over a brief time period in a controlled, artificial setting, but they did not allow the reader to consider parenting in the context of battering. Notes and logs contained a wide array of arbitrary comments about a visiting parent or child's demeanor in one particular visit.

There was often a clear picture of how a child was dressed but no picture of what else was going on, or how the behavior noted as 'appropriate' had any relationship to parenting in the context of battering. It was unclear what someone would have to do to get an 'inappropriate' mark. The language used to describe visits was largely disconnected from the reason for visitation. This can contribute to an imbalance in the impact of a report that reads *the child seemed extremely excited* to see the non-custodial parent when there is no reciprocal observation for the custodial parent. For the most part, observation notes only contained information regarding visiting parent-child contact. These reports also lost the significance of the case history and why the case was ordered to supervised visitation or exchange in the first place. We could speak to what Bancroft and Silverman state in *The Batterer as Parent*: there is an assumption that a batterer will do well with parent/child contact in a supervised setting. What was lost was the continued battering behavior that was witnessed by staff or directed towards staff before and after visitations.

Another safety-related element missing from the documentation was the observation of behavior before and after services. For example, in one case center staff received two phone calls from the battering parent in which he yelled, swore, and hung up, followed by a call shortly after this behavior in which he apologized, minimized, and justified his behavior. This information appeared in the phone logs, but did not make it into the report that was provided to the court.

Here is an example that captures the sense of much of the notation that appeared in observation and exchange logs completed by visitation center staff. It is a compilation from a variety of files across all of the demonstration site centers. The only adjustment has been to change child to children in a couple of excerpts. Observation notes across the twenty-four case files included in

the assessment read largely the same, with one comment largely interchangeable with another, focused on parent-child interaction.

Visit 1
VP says hi to the children as they walk into the [room] . . .VP asks if they want McDonalds next time. Both games end. VP asks if they want chicken nuggets. Child 1 pays w/ the sand. VP and Child 2 put the Stratego game away . . .

Visit 2
VP smiles and says hi to the children as they walk into the [room] . . . Asks how they've been this week . . . Child 2 walks over to the bookshelf and grabs the Stratego board game. Child 1 sits down in front of the coffee table and begins to set up game. VP sits down on chair across from Child 1 . . .Child makes a move and looks at VP w/ a smile…

Visit 3
Tuna sandwiches, rice, pickles, bread, macaroni and cheese . . . VP then told Children to join playing a puzzle game and they both played . . . VP insisted that children wash their hands and walked out to the bathroom w/sup . . .

Visit 4
VP arrived on time for visit . . . VP and children greeted each other with hugs and kisses . . . VP encouraged children to eat a balanced lunch, but they ended up eating a brownie and macaroni salad. They drank soda, but each only drank half a small mug …

Visit 5
Sup, muffin, corn dogs, sandwich, macaroni, strawberries, cheese, corn . . . Children arrived with two target bags. VP said "hello, what you got there?" Children said soccer stuff. . . While coloring children told VP they wanted the color black but it was missing. VP asked sup if we had a pencil or blk pen and sup handed a black pen. Then they continued to color . . .

Visit 6
VP and children greeted each other w/hugs. All sat in visitation room. Children opened a package that VP had brought for them. The package contained a few small toys . . .

Visit 7
They were all glad to see each other . . . VP had corn dogs and only Child 1 ate. Child 2 just wanted to play w/ VP. They played blocks, barbies, and cars.

Visit 8
Children walk into [room]. VP says "hey guys, how are ya?" Children say hello to VP. Children smile. VP, "I brought some burgers for you guys." . . . VP leaves to the bathroom. Child 1 eats burgers. VP returns. All eat hamburgers . . . VP and Child 2 engage in discussion about computers and internet. Discussion is appropriate . . .

Visit 9
Children walk into [room] and say hello to VP. VP says hello & asks children how they are doing . . .All engage in appropriate conversation about beef jerky . . . All engage in appropriate conversation about family heritage . . .

What **should** centers document in the context of supervised visitation and exchange? When might documentation have the unintended consequence of reinforcing battering tactics? California visitation standards require access by both parents to any information: *a copy of any report should be sent to all parties.* From our interviews we learned that staff members often have concerns about battering behavior before, after, and between visits, but that information tends to stay with the individual monitor and is not necessarily reflected in the record. Center staff was reluctant to make notations that could be accessible to a battering parent.

We also found that the reason why the court sent the family to supervised visitation in the first place was lost. Centers routinely reported back to the court on parent-child contact during the visits. In further examination of cases that moved from visitation to exchange, it appeared that courts then lost the original reason for concern and made decisions for unsupervised contact based on *appropriate parent-child contact* during supervised visitation. Across the twenty-four files reviewed during the safety audit, we saw that the documentation of parent-child contact consisted largely of descriptions of what children wore, ate, and played.

5. The visitation centers did not have an ongoing, active dialogue with the parent who had been battered, or with the children or the battering parent.

As reported by parents in the focus groups, they often arrived at the visitation center with little information from the court about what it was they were getting into and would be expected to do. "The court didn't give us handouts our anything with information about the center" (a custodial mother). "I didn't know <u>what</u> to expect when I first went to the center" (a visiting father). One of the monitors we interviewed noted that "a lot of the clients never send the [intake] packet back; I wonder what happens to them?"

Once at the center, "it's easier to align with the batterer than to see the battered woman and child," was one team member's description. Visitation center staff spent more time with the non-custodial parent. Contact with the custodial parent was largely limited to drop-off and pick-up times. There was even less contact if a friend or family member was the person bringing the child to the center. There was no mechanism in place to learn about ongoing coercion, threats, or violence that might have been occurring outside of the window of the visit. It was not a matter of monitors who were indifferent to the ongoing experiences of battered parents and their children, but rather that centers were not designed so that workers could be in continuous dialogue with either parent. The focus has been on the act of visitation or exchange, the time period in which a child moves physically from one parent to another.

One file, for example, had multiple statements over a three-month period that *the exchange went well*. This was at the same time that the visiting father was repeatedly late arriving for the exchange and returning the child, appeared at the custodial parent entrance more than once, and

left the center against the staff's direction at least twice. *Staff informed Ms. X that the incident would be documented and that staff would speak with Mr. Y.* The mother was concerned about him not following center policies and *was afraid that Mr. Y might shoot her because of his mental problems*. Two months later she was still *concerned for her safety* and *worried he will wait for her to come out of the building and follow her to see what type of car she drives*.

Throughout this period, the exchange report began with *exchange went well*. The focus was on the actual movement or transition of the child between one parent and the next. Staff noted the mother's concerns, but there was little indication that there was much ongoing dialogue about her past experience with stalking or anything occurring outside of the center that made her particularly concerned about his actions and the safety of her and her child. What was the basis for the new restraining order two months into the visits, for example?

From early on, this mother repeated that *the exchanges were supposed to be supervised visits*. The court documentation seemed to support this, in spite of some initial confusion, but it did not appear that the center had the kind of ongoing dialogue with her that would have given credence to her claim and prompted another look. The content of the court mediator's findings and report supported supervised visitation, but the recommendations to the court read supervised exchanges. The center lacked a clear understanding and process for how it could provide advocacy that might promote another look at the court's order.

Dialogue with battering parents was restricted in some instances by staff discomfort in working with, talking, and "being alone" with a batterer. Most visitation center staff had received little if any training or mentored practice that would prepare them to interview a batterer. There seemed to be a misperception that some batterers will attack staff at any moment and the only way to control this situation is to ensure that all the rules are followed under all circumstances. Under these conditions, respectful conversation can get lost. In situations where a batterer asked a question it was sometimes seen as challenging the monitor, versus the possibility that it might have been a clarifying question.

Focus groups with advocates in domestic violence programs reinforced the need to pay more attention to aspects of language and culture that influence whether parents and children understand supervised visitation, its purpose, what the center offers, and what is expected of them.[8] "If you translate 'supervised visitation,' sometimes it seems weird . . . It's a foreign concept. Or there might be fear for what the batterer is going to do to the child and her." "The center should have bilingual staff because it's not easy for parents to communicate with a language they are not comfortable with."

One of the centers has an orientation for children five years and older, in order "for the child to see the center alone and to talk to the staff about what is going to happen." Beyond that, however, we found little discussion with children about the purpose and procedures of supervised visitation and exchange. While some custodial parents bring the children to the intake appointment, two of the centers actively discouraged that: "they are asked not to bring children." It was common for monitors to first meet the children at the time of the initial visit with the non-

[8] The Chicago Safe Havens Demonstration site explored how supervised visitation and exchange centers can more fully account for aspects of culture in their work. Report available at www.praxisinternational.org.

custodial parent. One monitor noted that she had never met with a child prior to a visit and never had a child want to talk to her before a visit.

From our interviews and observations we learned that while there is time to talk with children before and after each visit and exchange during the transfer period (five to fifteen minutes), staff did not always feel it was acceptable to take the time. They reported that they felt pressured from both parents to stay on schedule. Parents, in turn, were bound by center rules that required them to arrive and leave within a specific window of time. Unless the child was visibly upset, staff typically did not spend time talking to children without a parent present.

6. Monitor training, preparation, and skill level sometimes left monitors inadequately prepared for supervision and exchange cases involving battering.

The three visitation centers described their difficulties recruiting and retaining experienced monitors. Most people willing and available for the positions are new to the field; for many it is their first job, or often a part-time job held while attending a university. Limited salary and training resources and the odd hours of work impact hiring and preparation. Due to high staff turnover, most new staff received ad hoc training with a large component of job shadowing and on-the-job training. Training and supervision of weekend staff and volunteers, who often included social work or counseling practicum students, was also challenging for the centers to accomplish because of turnover and scheduling hurdles.

Prior to the Safe Havens demonstration project there had been few resources and little training specific to domestic violence and post-separation violence. This left many monitors ill-equipped to recognize battering tactics and to avoid inadvertently colluding with batterers. Focus group participants raised concerns about some monitors' lack of professional demeanor, age, poor interaction with children, and susceptibility to a batterer's manipulation. "My husband likes to make them mad …[monitor] is too young to handle this bright fifty-two year old." (See discussion under Theme 3.) Monitors welcomed the training they had received via the Safe Havens grant and were eager for more.

We also found that the community-based organizations in each county were not organized to share training resources outside of their own organizations. Training opportunities existed in each community, but were not organized to include participation by other programs, such as the visitation center.

7. Community-based advocates, batterer intervention programs, and visitation centers were poorly linked.

One team member described a "real disconnect" in communication, training, education, and information between these key community interveners. Advocates and batterer programs typically did not know much about the visitation center's services. Even where advocacy and visitation services existed within the same organization, there was limited contact and

communication back and forth.

In our interviews we learned that visitation center staff could often identify one or two individuals who seemed to have contact and information about supervised visitation, advocacy, and batterer intervention, but there was no institutional protocol in any of the three counties for communication across these programs.

It also became clear that very few cases in supervised visitation involved an advocate or batterer intervention program. Advocates may have been used early on in the initial crisis phase, but there was little sign in the case file reviews and interviews that there was much on-going post-separation support or advocacy being provided by domestic violence programs.

We found that most of the court orders to a batterer intervention program happened at the criminal court level, while most of the referrals for supervised visitation and exchange happened in family court. Batterer intervention program staff could not recall ever having regular discussions with men about visitation with their children and could not recall having men in their groups who were using a supervised visitation center. One facilitator noted that "if children were hurt, then OK, it's obvious the need for the center," but he did not acknowledge the visitation center as having a principle role in protecting a battered parent. Some of the batterer intervention program staff expressed doubt that visitation center staff could handle working with a batterer, and they had no knowledge of the kind of training center staff received.

8. The role of the visitation center in relation to post-separation violence and safety had not been clearly articulated or explored.

When asked about the role of supervised visitation, staff often did not convey that they were there to keep victims and children safe. They were more likely to describe their role in terms of ensuring a positive visit, "to help and give parenting suggestions," "facilitating the bonding between parents and children," or "bringing a family together." As one team member observed, the rule that parents must not talk with their children about what brought them to the center carries over to the monitors and "pushes monitors to have a happy experience, to document those 'good visits.'" They clearly wanted the experience of the visit to go well, but their gaze was primarily on what occurred within the walls of the center. This focus reflected the historical organization and development of visitation centers nationwide around the immediate, physical visit or exchange itself – hence the emphasis on "two-hour safety."

The team's discussion around supervised exchange illustrates this uncertainty about the center's role. "It gets lost, that the purpose of exchange is keeping the mother safe," noted one member. "Once the court action gets underway, violence gets put in the *past*, and the focus shifts to parenting. In the observation reports for exchanges there is a place to document what kids are wearing, but not what has occurred that might be a safety risk." The exchange order itself can set the stage to minimize the ongoing need for safety and protection. "Families using the center just for exchange probably need more support, since [the battering parent] now has unlimited access to the children." Because some courts may not see exchange as serious a situation as

visitation – or articulate the purpose of exchange as protection of battered mothers – center staff may take that perspective as well.

Over the course of our information gathering and discussions, every member of the safety audit team said at one point or another, "the question is really: what is the role of the visitation center?" Which was often followed by "what is the role of the center in relationship to the courts?" In reading case files, interviewing monitors, and conducting focus groups we saw many gaps between what battered parents and their children experienced in building safety and what the centers were able to provide. For example, one mother, whose *marriage was brief and violent*, is suddenly dealing with her child's father, who has not *made any attempts to see her since her birth* (nine years ago), whose *second wife had obtained a restraining order against him citing the same type of manipulative and abusive behavior*, and who *has the ability to be very covert & violent, threatening*. Should the center convey to the court that visitation is inappropriate in this case? What kind of ongoing dialogue should the center have with the battered parent? These discussions brought forward the larger question of advocacy and the role that a center should or could play, both in individual advocacy and system-wide advocacy.

We found many instances where center staff were concerned about the safety of battered parents and their children outside the center – within the period of separation and beyond – but did not know what their role should be in supporting it. At each center staff could recall cases where they faced the thorny question of whether visitation should have been ordered in the first place, whether it would be more or less dangerous for the battered parent and children without a visitation order, and whether the center could or should challenge the order. In our interviews we heard from visitation center staff about the struggle in responding to batterers who displayed inappropriate behavior (such as throwing money at staff at time of payment, arriving late, and leaving early), but where they felt that terminating services might result in the court missing the connection between inappropriate and unsafe behavior, and ordering unsupervised contact or moving the family to another visitation program in a surrounding county.

The three California centers face the same questions as visitation centers across the country: When do the courts decide that the harm to a child who is continually drawn into an abuser's web of coercion, control, intimidation, and abuse is a price worth paying for the goal of allowing the parent to exercise parental rights and the child to have an ongoing relationship with a parent?

What the California partners changed … or hope to change

In asking how the work of a visitation center produces or does not produce safety for everyone involved, the California Safe Havens Demonstration Site undertook an inquiry of great complexity and significance. Our assessment brought forward the recognition that we can have "good visits" within the span of two hours, but noting "good visit" on report after report may reinforce a batterer's attempt to engage interveners in inadvertently supporting ongoing coercion and threats. Not a single monitor in any visitation center wanted to be in that position. Nevertheless, in our assessment we saw ways in which the structure and organization of their work might have that consequence. Using the information from the safety assessment, we began a process of shifting our perspective and practices to strengthen the centers' role in ensuring safety for battered parents and their children, and for all who come through the doors.

Our first step was to ask: If I was a battered parent walking through the doors of the center, how would this record, process, or procedure make it safer for me and my children? How does it account for the risks in our lives? What would I want to know about what happens in supervised visitation and exchange? How would I want someone to talk with me and my children? We took into account all of our safety audit work – the focus groups, the conversations with monitors, the reading of files – and applied these questions.

What we realized above all was that **there can be no single, predetermined safety map that fits every victim of battering walking through a center's doors**. Asking the questions from the standpoint of a battered woman, we recognized that "you can't tell me what makes me feel safe, but you can tell me what you can offer. Doors and panic buttons may not make me feel safe; I might want someone to walk me to my car." It cannot be a process of asking once. It requires an ongoing dialogue that accounts for changes in risk and safety from one visit to the next. In other words, it requires a response that takes into account the dangers of post-separation violence and the reality of an ongoing relationship between parents around the lives of their children: safety in "2 hours – 2 years – 20+ years." Locks and bolts will be important to some victims' safety and well-being, but so will knowing whether or not a violent parent has been arrested between one visit and the next or whether the final divorce hearing has been scheduled.

This recognition led us to consider a range of possible <u>changes within our centers</u>.

- Change our case file management (our documentary practices) to address confidentiality, information sharing, and safety.
- Redesign the orientation/intake process to remove the "business paperwork" and focus the time on developing a dialogue with the parent and children.
- Determine how to ask questions about safety; explore different approaches, such as a menu of safety options based on conversations about who is in danger and what has precipitated post-separation violence, such as another move in the divorce action or court appearance.
- Redevelop and implement documentation and reporting tools, such as the center database, observations and activity logs, and incident reports.

- Develop local training for visitation center staff on topics of domestic violence, batterer behavior and working with batterers, child abuse, child sexual abuse, stalking, and child development.
- Redesign written client policies and staff handbook.
- Develop a user-friendly written tip sheet for parents to use in preparing themselves and their children for visitation services.
- Develop and implement a client check-in process with mothers, fathers, and children.
- Examine, develop, and implement policies and programming when victims of battering are the visiting parent.
- Develop an interview with visitation center clients to provide feedback on how programs can make services more comfortable and welcoming to diverse communities.
- Improve the site layout and safety features at each visitation center.
- Improve center safety protocols, procedures, and communication with clients about safety features.
- Strengthen staff skills and comfort level in working with batterers in a respectful, supportive manner.

Visitation centers do not sit alone in their communities, as emphasized by the Safe Haven demonstration initiative's attention to collaboration and partnership.[9] The local collaborative and its consulting committee were critical partners in determining how to initiate change and provide the leadership, advocacy, and intervention that will support safety in ways that meet the real circumstances of peoples' lives. Our plans included components specific to the visitation centers' partnerships with domestic violence advocacy programs and the courts.

For the centers' and their domestic violence agency partners this included:

- Develop a forum for battered women to provide regular and on-going feedback to visitation programs.
- Strengthen relationships and collaboration between domestic violence programs and supervised visitation and exchange programs.
- Develop protocols for case referrals and case consultations between supervised visitation and domestic violence programs, sexual violence programs, and legal services.
- Develop and implement voluntary programming for battered women at supervised visitation sites.
- Provide training to domestic violence organizations on post-separation violence and abuse.

For the centers and their court partners it meant:

- Develop, pilot-test, and redesign a court referral form to be used consistently with all supervised visitation and exchange referrals.
- Develop judicial collaboration and training to improve the relationship between courts and visitation programs.

[9] The national collaboration through the Safe Havens Supervised Visitation and Safe Exchange Grant Program – Demonstration Initiative has been an important part of the California Demonstration Site's local work.

- Develop promising practices in the court system to improve safety for victims of battering.
- Provide training to judges and court staff about decision-making on issues of who is in danger from whom, and how; determining when supervised visitation and exchange are appropriate and not appropriate; options when they are not appropriate; and, visitation centers' dilemmas in terminating cases that might result in a court granting unsupervised visits.
- Improve when, how, and what program information (documentation and reporting) is provided to the court.

A cautionary note

We are describing ongoing work and a process of investigation, analysis, relationship-building and change, grounded in different communities. It is a process that involves multiple voices and perspectives: victims of battering, centers and their staff, courts, community advocates, and others with a stake in safe supervised and exchange. It is not about simply drawing up a new form and plunking it down on a visitation center or court. We caution other grantees about using these findings apart from this understanding.

Within the California Demonstration Site's own collaborative, not every center has made every change listed, or will make every change. The ideas will be altered and refined, and some discarded, as the centers and their partners continue to enhance their understanding of how to structure supervised visitation and exchange in ways that adjust to the complexities of individual lives and the dynamic nature of risk and safety in the context of battering.

We began this report by noting how the eight key methods that institutions use to organize and coordinate work provided a framework for our inquiry and pointed to the kinds of changes that might help address the gaps in safety that we discovered. As illustrated broadly back in Table 1, any one of the key themes involves changing several of the ways in which the work of a visitation center is put together. The centers are changing how they link with parents, the courts, and community-based advocacy and batterer intervention programs. They are redesigning administrative practices around court referrals and parents' introductions to and contacts with the centers. They are training center staff and the Safe Havens collaborating partners, both to introduce new administrative practices and to strengthen knowledge of battering and its implications for supervised visitation and exchange. They are introducing the challenging discussions of mission and purpose, including the complex issue of neutrality. They are shifting conceptual practices around parent contact ("orientation" rather than "intake") and the concepts of "active dialogue" and "trust-building" relationships.

As 2005 came to a close we took stock of where we had come since the safety audit and thought about some of the challenges and dilemmas in making the changes we had initially identified and in the work yet to come. This summing up is presented in Table 2.

There is a large measure of challenge and dilemma in what the three centers have experienced in the shifts in perspective and practice sparked by the safety audit. Confidentiality and documentation remain intertwined, complex, and ongoing questions. The issues of what to record, what to share, and with what agencies and courts do not have ready answers. Remaining open and respectful to a battering parent while at the same time challenging battering behavior requires careful attention by center staff. One director described the shift at her center, and the resulting dilemma, this way: "the battered parent is thrilled and feels very safe, while there has been an increase in complaints from the battering parent, who perceives that the center cares only about victim parents and children."

Next steps

In our post-audit work we have put in place redesigned court referral and intake forms. It is not the forms themselves that are the most significant product of our safety audit, however, as much as the relationships and work behind them. Developing a form and its related processes in ways that are true to what we learned – namely, that who is at risk from whom is different for each person walking through the center's door, and protection must be built around that reality – requires that we come together in new ways with our court and domestic violence agency partners and change our local practices. We are setting the stage for tackling even more complex questions about safety in supervised visitation and exchange. How might concepts about neutrality in parental conflict work against safety for those most in need of protection? What should a safe visitation and exchange program document? Who should have access to that documentation, and under what circumstances? What should remain confidential between the center and a parent? How do we craft a safe transition away from supervised visitation and exchange?

The most significant outcomes of the safety assessment have been the shift in conceptual practices and our recognition of the gap between our intentions and commitment to safety and the day-to-day organization and processes of supervised visitation and exchange. This shift in thinking is the stepping off point for our ongoing discussions and deliberations, and for closing those gaps.

- Safe supervised visitation and exchange must have equal regard for <u>everyone's</u> safety, for the safety of an adult victim of battering, as well as a child's safety.

- Active protection in the context of domestic violence and battering requires that centers re-examine the role of strict neutrality in parental conflict as it might contradict the role of protection.

- Providing services based on "active dialogue" with all involved is a key mechanism for building safety.

We have, of course, added a certain complication to our work. In putting equal regard for everyone's safety at the center of our work, we have to move away from a generic, one-size-for-all approach to visitation and exchange. The very idea of safety gets more complicated, in what we document and what we report about whom, and what we report to whom. Equal regard, however, is the only way to ensure that our philosophy – "to keep victims and children safe" – will "hold true to practice."

Table 2
California Safe Havens Demonstration Site – Safety-audit inspired changes … challenges and dilemmas

A cautionary note: We are describing ongoing work and the results of a process of investigation, analysis, relationship-building and change, grounded in different communities. It involves multiple voices and perspectives: victims of battering, centers and their staff, courts, community advocates, and others with a stake in safe supervised and exchange. It has not been a matter of simply drawing up a new form and plunking it down on a visitation center or court. We caution other grantees about using these findings apart from this understanding.

Abbreviations used in this table: SV/E, Supervised Visitation and Exchange; VC, Visitation Center; DV, Domestic Violence; CP/VP, Custodial Parent/Visiting Parent.

How far have we come?	***Challenges & dilemmas***
1) SV/E programs received incomplete information from judges and mediators about the level of potential danger.	
√ Judges and court staff recognize the importance of on-going and regular communication with SV/E program staff. √ Judges and court staff agree SV/E programs need to be informed of the reasons why supervised visitation and exchanges are being ordered. √ Developed and implemented a court referral form for every family ordered to SV/E services. √ Developed program information sheets for judges and court staff that would inform the court and parents about services, safety features in place at each site, the referral process, and hours and fees for service. √ Developed a link that places the reasons for referral at the forefront of every visitation center report to remind both visitation center staff and court staff why SV/E services were needed in the first place.	♦ Determining the goal and purpose of ongoing and regular contact between SV/E programs and the courts. ♦ Confidentiality remains a significant issue. For example, questions have been raised about whether the Family Court Services programs may be breeching their confidentiality with parents if they disclose information (i.e., about the history of violence, threats to a parent or children) that was received during the screening and not in open court. Some of the ongoing issues around confidentiality include: ♦ Developing a court protocol for passing confidential case information to SV/E providers. ♦ Determining how impressions, allegations, or evidence of risk that are relevant to the safety of a child or parent in the SV/E program can be legally presented to SV/E providers. ♦ Determining how SV/E providers can legally be provided with a layer of protection to hold the court referral form confidential.
2) Families using SV/E services did not always receive clear information about the safety precautions put in place around arrivals, departures, and visits.	
√ Implemented a safety feature improvement plan at each site that includes automatic locking doors, panic buttons, increased lighting, cameras, intercom system, and improved separate parking and waiting areas. √ Developed a new orientation process that creates a way for SV/E staff to have an active dialogue and build a relationship with a battered parent; provide a facility tour to explain the safety features in place	♦ Determining the key elements in building trust and developing individual safety plans around SV/E services to include in a redesigned parent orientation. ♦ Responding to adult victims who inadvertently compromise safety by not following certain directions related to safety procedures. ♦ Reassuring adult victims who may feel services are organized only for parental access and not for

How far have we come?	*Challenges & dilemmas*
at the center; and, develop a plan centered on the features she needs to help her feel safe. √ Implemented a new orientation for relationship and trust building for the violent parent, and with each child. √ Provided staff training on issues of safety, including safety plan options; the reasons for and use of safety features for visitation and exchange; and, how to respond when a client challenges them on the reason or need for the safety features.	safety of a battered parent or the children.
3) The work of visitation/exchange monitors was not organized to fully account for battering behaviors and how those might be used to engage the center in inadvertently colluding with the battering parent.	
√ Developed new documentation to organize SV/E programs to pay attention to and account for battering behavior before, during, and after visits and exchanges. √ Changed VC protocols that automatically assigned parent entrance/exit and arrival/departure by court assignment of CP/VP. Now staff works with victims of battering to create individual arrival/departure plans. √ Redeveloped principles/policies to be consistent with the mission and philosophy to provide equal regard for the safety of adult victims and children. √ Held training on understanding battered parents' possible reactions to violence and how parents may appear to center staff as a result.	♦ Respectful and humanizing interactions are sometimes misconstrued as colluding. ♦ For some staff, their fear of men who batter makes it particularly difficult for them find the balance between being respectful and being able to challenge them about their behavior in the centers. ♦ Providing ongoing training on how to work with men who batter in order to better understand behaviors and increase staff comfort. The centers want to decrease the use of over-controlling, inflexible, and cold staff responses to all clients. ♦ Determining the core principles/policies that best fit each SV/E case. ♦ Continuing a dialogue with the collaborative partners around programming issues such as gift giving, food, and guests during visits.
4) The visitation centers collected and recorded a large volume of information without a clear sense of its purpose or importance to safety and risk in the context of battering.	
√ Developed a more effective way to collect and store client information that clearly outlines the items that visitation providers will capture in a client record. Developed a protocol for staff to use in determining when information fits into the items that are to be captured in the client file and when information is unsafe or inappropriate to keep in a client record. √ New attention to behavior in the context of battering at the center and to documenting such behavior. A shift away from only recording and reporting out during the visiting parent and child contact time; bringing battering behavior to the forefront of reporting forms. √ Developed a client check-in process to support ongoing and regular dialogue with mothers, fathers, and children in every family. √ Developed a parent orientation process that emphasizes active dialogue and avoids the previous overdependence on clients filling out a form to	♦ Changing documentation practices has presented one of the biggest challenges. It has been difficult to move longtime staff to change their practice and recognize they did not have to document every thing they were told. ♦ Some staff is bound by different codes and professional ethics around documentation and it has been challenging to discern what is applicable for which profession within in the context of visitation. ♦ The client check-in process presented a dilemma in record keeping, confidentiality, and reporting. Parents now provide information that they may not have disclosed to VC staff in the past. This required developing a clear, understandable document that distinguishes the items that are to be recorded and those not to be recorded in a client record. The client check-in has also required careful consideration of how clients are informed of what information is recorded and what the center is

How far have we come?	*Challenges & dilemmas*
provide all of the necessary case information.	required to report out. ♦ Developing a way programs can reasonably and regularly update their files with information initially gathered at registration with the SV/E program, such as vehicle identification, current court orders, and restraining orders.
5) The visitation centers did not have an ongoing, active dialogue with the parent who had been battered, or with the children or the battering parent.	
√ Developed a client check-in process to support on-going and regular dialogue with mothers, fathers, and children in every family. √ Developed a new orientation process that supports an active dialogue with parents over an administrative function of the center. Orientation includes mothers, fathers, and children. √ A new record keeping system will allow programs to easily and efficiently communicate with the court on battering behavior and safety concerns. Key pieces of information will not get buried in the client file. √ Developed a plan with each site for providing a forum for battered women to help inform SV/E programs on a regular basis.	♦ Helping SV/E programs develop a clear sense of how they can advocate for individual and system change. ♦ Now that center staff are building better relationships with the parent who is being battered there are dilemmas around documentation and confidentiality. ♦ With the increased knowledge regarding the experiences of the battered parent, staff are struggling with remaining open and respectful to the parent who batterers. Balancing the increased understanding of the issues while remaining open to the battering parent has been difficult. ♦ Developing a stronger relationship with DV programs around post-separation advocacy.
6) Monitor training, preparation and skill level can leave monitors inadequately prepared for supervision and exchange cases involving battering.	
√ Held numerous trainings for SV/E staff during the past three years on the issues of domestic violence, stalking, and child abuse. √ Provided pre-packaged training materials for SV/E providers. √ Engaged judges and court staff in providing regular training on court processes to SV/E staff. √ Each site has developed a relationship with their DV program to allow all SV/E staff to attend the 40-60 hours of DV training. √ Held brainstorming session on ways to acknowledge staff contributions to the programs. √ Implemented a monthly audio training and support call for all front line staff at each center.	♦ Extremely high, ongoing staff turnover continues to be a major challenge. Each time it is as if we start from the beginning. ♦ Building a sustainability plan that addresses the lack of resources needed to maintain quality staff and provide adequate on-site training.
7) Community-based advocates, batterer intervention programs, and visitation centers were poorly linked.	
√ A collaborative effort has facilitated ongoing dialogue between SV/E programs and DV programs on a monthly basis. √ Organizations that have in-house SV/E and DV programs have instituted cross-program support meetings.	♦ Developing a stronger link with <u>all</u> DV programs in each county. ♦ Defining what post-separation advocacy means. ♦ Creating strong post-separation advocacy services that are readily available in each community. ♦ When SV/E and DV programs are not within the same organization, determining how DV program

How far have we come?	*Challenges & dilemmas*
	staff can provide regular and ongoing case consultation and training to SV/E staff, and vice versa. ♦ Resolving the confidentiality and firewall issues around regular cross-program case support and consultation between SV/E and DV (whether in-house or external programs). ♦ Addressing the disconnection and distrust between advocacy and visitation programs.
8) The role of the visitation center in relation to post-separation violence and safety had not been clearly articulated or explored.	
√ Court and community views have shifted to see SV/E as a service to keep battered women and children safe, rather than only a parental access-based program. √ The collaborative partners and program staff have held ongoing dialogues about the role of SV/E services and the thinking that guides our work. √ Discussions with key judges have led to acknowledgement that courts should not be using SV services as an intervention for behavior change. (Namely, ordering SV services and then three to six months later using the visitation record to determine if unsupervised visitation can take place.) Cases that have risen to the level of a SV order also need a judicial order that requires batterers to focus on their abuse and violence. √ The court referral form has been updated to call attention to the other services courts are ordering in addition to SV services.	♦ Getting DV agencies in all communities to take up supervised visitation as an important service for adult victims and an essential element in keeping battered women safe. ♦ Having a collaborative dialogue on creating ways to meet post-separation safety needs for those populations not using SV/E services and those that would not feel comfortable using services despite the centers' best efforts. ♦ Developing training and ongoing support for outside supervision (friends, relatives, and private supervisors). ♦ Assisting in developing a program the courts would embrace and order the violent parent to attend in addition to SV services.

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Appendix 1

California Safe Havens Demonstration Site
Safety Audit Planning Assessment – Data Sources

San Mateo Site

Focus Groups	Observations	Interviews	Text Files
▫ 1 BIP group ▫ 1DV advocates group ▫ 1 Victims – Custodial Parent group ▫ 1 Batterer – Non-Custodial Parent group	▫ Staff work area ▫ Lobby ▫ Back entrance ▫ Parking area ▫ 1 Supervised Visitations ▫ 2 Supervised Exchanges ▫ 1 Intake interview	▫ 1 interview with the Assistant Director ▫ 2 interviews with monitors ▫ 1 interview with a therapeutic monitor ▫ 1 interview with the intake staff ▫ 1 interview with an administrative staff	▫ 7 Supervised visitation case files reviewed ▫ 2 Supervised exchange case files reviewed

BIP: Batterer Intervention Program

Santa Clara Site

Focus Groups	Observations	Interviews	Text Files
▫ 1 BIP group ▫ 1 DV advocates group	▫ Staff work area ▫ Lobby ▫ Back entrance ▫ Parking area ▫ 3 Supervised Visitations ▫ 5 Supervised Exchanges ▫ 2 Intakes ▫ Second site in San Jose	▫ 1 interview with the site Coordinator ▫ 2 interviews with monitors ▫ 4 interviews with monitors/intake staff ▫ 1 interview with a custodial mother	▫ 5 Supervised visitation case files reviewed ▫ 2 Supervised exchange case files reviewed

Santa Cruz Site

Focus Groups	Observations	Interviews	Text Files
▫ 1 BIP group ▫ 1 DV advocates group ▫ 1 Victims – Custodial Parent group ▫ 1 Batterer – Non-Custodial Parent group	▫ Staff work area ▫ Back entrance/parking ▫ Front entrance/parking ▫ 1 Supervised Visitations ▫ 1 Supervised Exchanges	▫ 1 interview with the Site Coordinator ▫ 4 interviews with monitors/intake staff	▫ 6 Supervised visitation case files reviewed ▫ 2 Supervised exchange case files reviewed