The Praxis Safety and Accountability Audit

Praxis International has developed and pioneered the use of the Safety Audit process as a problem-solving tool for communities that are interested in more effective intervention in domestic violence cases. The Safety Audit is tool used by interdisciplinary groups and domestic violence advocacy organizations to further their common goals of enhancing safety and ensuring accountability when intervening in cases involving intimate partner violence. Its premise is that workers are institutionally organized to do their jobs in particular ways—they are guided to do jobs by the forms, policies, philosophy, and routine work practices of the institution in which they work. When these work practices routinely fail to adequately address the needs of people it is rarely because of the failure of individual practitioners. It is a problem with how their work is organized and coordinated. The Audit is designed to allow an interagency team to discover how problems are produced in the structure of case processing and management.

Philosophical Overview

When a woman who is beaten in her home dials 911 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 something that institutions can act upon. Her experience has become a domestic assault case.

Over the next twenty-four hours, up to a dozen individuals will act on her case. They hail from as many as five agencies and represent four levels of government. Over the next year, the number of agencies and people who work with her case—and therefore her safety—will more than double. 911 operators, dispatchers, patrol officers, jailers, court clerks, emergency room doctors and nurses, detectives, prosecuting attorneys, law enforcement victim specialists, prosecutor's victim specialists, child protection services workers, civil court judges, criminal court judges, family court judges, guardians ad litem, family court counselors, therapists, social workers, probation officers, shelter advocates, children's advocates, legal advocates, and support group facilitators at the local shelter may all become involved in a chain of events activated by her original call for help.

In the past twenty years, every state and hundreds of communities have initiated criminal and civil justice reforms in order to improve victim safety and offender accountability in that chain of events. Laws have been changed, policies written, procedures revised, and training conducted. Domestic violence coordinating councils, task forces, and response teams have been formed. Are communities now safer for domestic violence victims and their children? Are offenders held accountable for violence and coercion? Have our good intentions and reforms helped or hurt?

The Audit helps answer these questions from the standpoint of battered women and their children. While the Audit team is compelled to ask questions from the standpoint of women who are battered, the team itself is made up of practitioners in the system and domestic violence advocates and experts. It is a way to look at how a woman's experience is retained or disappears in the handling of the case and whether or not safety and accountability are incorporated into daily

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

The Audit is not a review of individual performance or effectiveness, but a close look at how workers are institutionally coordinated, both administratively and conceptually, to think about and act on cases. The Audit team uncovers practices within and between systems that compromise safety. The team examines each processing point in the management of cases through interviews, observations, review of case files and an analysis of institutional directives, forms, and rules that shape a worker's response. The team's analysis provides direction on specific changes in technology and resources, rules and regulations, administrative procedures, system linkages, and training. The analysis also accounts for how, in attending to the safety of the victim, institutions account for diverse social status factors that affect safety and accountability—for example, race, class, addiction, employment, literacy, immigration status, language, and sexual orientation.

Methodology

The Safety Audit uses a local team to look at how work routines and ways of doing business strengthen or impede safety for victims of battering.[1] By asking ***how*** something comes about, rather than looking at the individual in the job, an Audit discovers systemic problems and produce recommendations for longer lasting change. The Safety Audit is designed to leave communities with new skills and perspectives that can be applied in an ongoing review of its coordinated community response.

The Safety Audit is built on a foundation of understanding 1) institutional case processing, or how a victim of battering becomes "a case" of domestic violence; 2) how response to that case is organized and coordinated within and across interveners; and, 3) the complexity of risk and safety for each victim of battering. To learn about victims' experiences and institutional responses, the Audit team conducts interviews, including victim/survivor focus groups; observes interveners in their real-time-and-place work settings; and, reads and analyzes forms, reports, case files, and other documents that organize case processing. Over a series of debriefing sessions, the team makes sense of what it has learned in order to articulate problem statements, support them with evidence, and frame the kinds of changes that need to occur.

Since the Safety Audit focuses on institutional processes rather than individual workers, there are no systematic sampling procedures. Instead, interviews, observations, and text analysis sample the work process at different points to ensure a sufficient range of experiences. Interviews and observations are conducted with practitioners who are skilled and well-versed in their jobs. Their knowledge of the institutional response in everyday practice and their first-hand experience with

[1] Praxis International, Inc., (651) 699-8000; www.praxisinternational.org. Over forty communities nationwide have used the Safety and Accountability Audit to explore criminal and civil legal system response to domestic violence, the intersection of domestic violence and child abuse, and the role of supervised visitation and exchange in post-separation violence.

the people whose cases are being processed supply many of the critical observations and insights of the Audit.

Safety Audit data collection and analysis pay attention to eight primary ways that institutions standardize actions across disciplines, agencies, levels of government, and job function. These "Audit trails" help point the way to problems and solutions.

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. 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.

In a Safety Audit, the constant focal point is the ***gap*** between what people experience and need and what institutions provide. At the center of the interviews, observations, and case file analysis is the effort to see the gap from a victim's position and to see how it is produced by case management practices. In locating how a problem is produced by institutional practices, team members simultaneously discover how to solve it. Recommendations then link directly to the creation of new standardizing practices, such as new rules, policies, procedures, forms, and training.