In this issue, Robin H. Thompson concludes her article on the ways that domestic violence fatality review teams are making a difference. Robin’s analysis of team reports contained so much valuable information that we split her article in two parts, with the second portion appearing here. Next Michelle Mueller and Dave Sargent, of the Maryland Network Against Domestic Violence present an article on Fatality Review in Maryland. Finally, Neil Websdale presents Some Thoughts on Domestic Violence, Religion and Spirituality. We hope this issue stimulates thought and answers questions. We encourage readers to submit newsworthy items for future issues!

Important Note: There will be no National Conference this year!


By: Robin H. Thompson, JD, MA

12 Ways for Fatality Review Teams to Effect Social Change

Here are some general guidelines and examples of how a fatality review team might focus its work and shape its report so that it makes the greatest impact.

1. Trumpet the differences you have made.

The team and its members have a unique opportunity to describe and publicize how a team’s work has created or supported social change. Social change includes formal systems reforms and community action as well as informal member, institutional, and personal improvements. Every report should describe how the community has changed, how members have improved the way they do their jobs, and how their organization’s practices have changed and improved. Examples include knowing new things about a host of community responders, being able to leverage their own resources better, working more closely with others on domestic violence, and co-training. Simply put, teams need to describe how responses to domestic violence have changed and improved because of their work. Teams must include the less data-driven and informal, but very important, impacts fatality review team reviews have had. Frustratingly, these are absent from most reports, but could offer rich accounts of how a team’s work has made important differences in communities.

Here are some good examples of teams’ reports that did trumpet some of their successes. In Santa Clara, CA, the very title of the reports from 2002-04, Speak up-Save Lives, comes from the team finding that:
♦ For 2 years, no case reported to the DA ended in a death
♦ In one year, no children died/were killed due to domestic violence; and
♦ From 2003 to 2004 the number of domestic violence deaths decreased from 21 to 6.

The team said that these improvements in domestic violence related deaths are evidence that the work of the fatality review team and their collaborations are making a positive difference.(1)

In the Virginia Colonial Area’s report, the team recommended that key agencies be trained on the lethality factors that they had identified. They also suggested the
Teams can trumpet the differences they have made simply by report organization and presentation: Maine puts large check marks next to recommendations that have been implemented or are in the process of implementation.(3) Teams that review and reprint recommendations from past years also can give readers an at-a-glance picture of the scope and impact of the team’s work.

2. **Communicate in clear, simple, straightforward and user-friendly ways.**

Prior to doing its report, the team should decide the primary audience for the report. Is it the public at large? The team’s members and agencies they represent? Will policymakers use it? Will it be released to the public in a press conference? The report must be easy to understand for those who are unfamiliar with the details of domestic violence issues if the team intends to distribute it to the general public.

It is also important that the information be presented in a format that can be easily adapted and used by the intended audience. For instance, Washington State’s report includes easy pull out information on findings and statistics so that the media, policymakers, legislative staff, team members, and others can readily use them. Chesterfield, Virginia sets up each of its nine recommendations in the same format: fact, conclusion, recommendation, targeted groups, discussion, and other information (such as a relevant law or definition).(5)

Don’t use the passive voice. Phrases like ‘consideration should be given to…’ or ‘discussions were had…’ and ‘it was decided’ dilute a recommendation’s power, are vague, and make the report less useful: how can you hold someone accountable when you cannot tell who was responsible?

3. **Prioritize and limit recommendations.**

If a team’s goal is to direct public attention to its recommendations, it should take care to prioritize and limit recommendations. It is very difficult for the unschooled to sort through dozens of recommendations without guidance and without a sense of where the team felt there was the greatest need for attention. For instance, the first two reports issued by the New Jersey Domestic Violence Fatality Board had only four recommendations, with each recommendation buttressed by a brief description and action steps.(6)

If a team has a large number of recommendations, it would be better to highlight them in terms of priorities. For instance, Washington State identified eight ‘Key Recommendations’ in the Executive summary to its 2004 report, and followed that with eighty recommendations, divided by the sector responsible for implementation.(7) This way, everyone from bail commissioners to the Legislature sees what his or her role is in implementing suggested changes, but also has a sense of the most urgent priorities.

4. **Be rigorous in stressing accountability.**

Creating system-wide accountability is one of the reasons teams do reviews and team members should work hard to hold one another—as well as systems they represent—accountable. Team reports should offer specific recommendations and describe who is or should be appropriate to carry out the recommendations and establish a way to continue follow-up. It is also important to track the recommendations over the years because so many recommendations require ongoing implementation and monitoring. For example, New Hampshire’s reports make recommendations each year, and then in the following year shows the responses of the agencies tagged with carrying out the recommendations. While one year’s report attempted to track recommendations from two years’ prior, the New Hampshire team now only gives implementation information for the prior year’s report, as there are virtually hundreds of recommendations.(8) Delaware’s reports are similar in that those responsible for carrying out the recommendation report on their status.(9)

Because so many recommendations cannot be fully accomplished in one year, or some require ongoing implementation (recommendations for training or for the distribution of information, for instance) it is also important for the team to make sure that the recommendation is implemented completely. Teams should also take care to rigorously hold those responding accountable. For instance, after a death a team may recommend that a certain protocol provide for greater safety for victims. If the agency responsible says “our protocols have mandated this for several years,” the team should not call it done: rather, it must ask, “Does this protocol need to be stronger? Is it truly effective and if so, why did this victim slip through the cracks?” Problems can arise when the agency in charge of the change “reports” on the change or is the sole actor in determining how the change is going forward. Their hands may be tied to do anything more critical of their own organization’s work – but team members might gently assist them in greater movement forward.

It is also important to note those recommendations that are ignored or are not being addressed. Maine found it just as important to say, “we have made this recommendation for several years and it hasn’t happened” and to note why not, as it is to identify recommendations that have been implemented.(10) Santa Clara County, California makes the same recommendations each year if they are not fully accomplished and annually reports on any progress made.(11)
Some teams insulate their members from making politically unpopular or risky recommendations. For instance, in Washington and Miami-Dade County, Florida, a body different from the one making findings and doing actual reviews makes recommendations for action. (12) It may be a delicate balance for team members deciding to continue team participation if they are feeling too challenged and teams have to weigh these matters carefully.

Many teams want the media to pay attention to their findings and as such it is important to give the media clear information about needed reforms, like what the reform is, how much it might cost, and who is in charge of allocating the resources (time, money, personnel, etc.) to carry out the recommendation. Teams should make it clear that things are changing and improving and designate a member to communicate these changes clearly to the media.

5. Follow up regularly on recommendations.

One team suggested going back every five years to see if what was noted as “accomplished” was still being done. For instance, if a court protocol has been changed, are all judges following it? If information on workplace violence was distributed during October to all state employees, is it still happening after there is a change in political leadership?

6. Make the report and other products useful to the field.

Reports and any other information released from the team should be useful to team members so that they can work within their own organizations to promote changes as well as to the community. The Washington State report contains a chapter on implementation of recommendations and the Washington State Coalition Against Domestic Violence (WSCADV) conducts outreach not just on what the reports says, but how it can be used to incite changes. WSCADV has made itself available to communities across the state to discuss and present its findings. Often, they tailor outreach to specific groups, targeting recommendations and findings to particular audiences, such as health care providers. Washington State also has produced a toolkit to make their reports useful to the field and offers “how-to’s” on using the report to promote change, including the message to: “Read it; Share it and Download it; Focus staff meetings on a discussion of it; Give it to your boards of directors; Use it as a spring board for community discussion groups; Share it with local domestic violence task forces; and Use it to educate the media and in grant proposals.” (13)

7. Work with the media: establish credibility and relationships.

The media is an invaluable partner in implementing changes and improvements – this is clear from the large number of reports that call for “public awareness” on a wide range of topics from domestic violence in general, to the risk of suicide when there is domestic violence to public information for friends and family about domestic violence resources such as hotlines and emergency shelters. In addition to making the reports user-friendly to the media, with easily read and copied fact sheets and information about domestic violence, the fatality review team should consider building relationships with the local press. Again, Washington State has used its reports as media education tools and has seen changes occur. Reporters now quote statistics from the fatality review team reports and cite them after a domestic violence homicide. As one team staff person said, “the media now puts crimes in the appropriate context so they can see domestic violence as a pattern versus an isolated event.” (14)

8. Ground the work in reality – talk to community (victims) and incorporate their voices.

Teams often are comprised of system representatives. They are challenged to have either a seat for survivors at the table or a way to incorporate the reaction to their findings from survivor groups or family and friends of the decedent or from others like the community group of which the family was a part. New Jersey addressed this challenge by holding a focus group with survivors whose batterers were law enforcement personnel; the fatality review team noted that a high number of cases involved law enforcement perpetrators in New Jersey and the state lacked a formal policy in all New Jersey law enforcement jurisdictions. (15) Focus groups of survivors or members of particular religious or ethnic groups to which victims belonged could help ensure that the recommendation is appropriate and useful.

9. Have a long term vision – this won’t happen overnight.

It is important to remember that, in general, change takes time and bureaucracies can be very sluggish. In one jurisdiction, the team recommended that the Bar educate attorneys about domestic violence. The first committee formed by the Bar failed to act, was then reconstituted, and now is looking at the issue several years after the team first made the recommendation. This showed the importance of long-term attention to the issues.

10. Link findings and recommendations to reviewed cases.

When the fatality review team links its recommendations to case reviews, these recommendations become more relevant and urgent. In one report, the team made a recommendation that when a state agency sends information regarding child support to a domestic violence perpetrator, the victim be notified. Next to this recommendation was a quote: “The defendant told his friend that if his ex-wife contacts DHS or DHS gets involved in child support or her divorce that he would kill her. She was dead within a month.” (16) This recommendation involved working with DHS to create a protocol that also would include sending information to domestic violence victims about resources and safety issues.
11. Designate “ambassadors” for talking to the media, doing training and technical assistance (both to state and to members’ constituent groups).

Not everyone on a team is able to speak to the public or media or has the skills or desire to do so. As part of the fatality review team’s organizing work, it makes sense to assign these duties to people who are trained and capable of doing outreach training programs and media work.

12. Be informed by the work of other fatality review teams.

Your findings and recommendations have a greater impact when they are the same or similar to other states. Few teams can review every death or have a statistically representative sample of domestic violence related deaths. Some teams may only be able to look at cases over three years old (due to pending prosecutions) or only murder/suicides. Nonetheless, teams can look to other jurisdictions for support that the recommendations they are making are valid because they are the same or similar to other jurisdictions’ findings. Team reports are available at www.ndvfrl.org under “state information.” For instance, Delaware’s findings in its 2003 report found, like many other teams, that:

♦ 82% died while in the process of leaving
♦ Only 20% had contact with victim services
♦ 37% were survived by children. The state had no authority to mandate counseling or services for these children.(17)

Santa Clara County, California each year lists the compelling “red flags” that characterized a significant number of their reviewed cases. These routinely include: threats of homicide/suicide, separation, prior domestic violence, mental health issues of perpetrator (not as prevalent), stalking, handguns present, universality (people from all socio-economic levels, ages, genders/sexualities, die and kill), perpetrator “unravels” in front of everyone, obsessive jealousy, and the perpetrator had “controlling behavior.”(18)

Conclusion

As domestic violence fatality review teams grow in number and sophistication, it is vital that our work be cumulative and reflective. The strategies I have outlined represent the “best practices” of teams around the country working in various contexts with different levels of resources and unique challenges. Fatality review teams have already accomplished significant changes in attitudes, policies, and practices. This success should reinforce our dedication and enthusiasm for evoking social change to end domestic violence fatalities.

12. To see findings from these two teams, go to: “Tell the World What Happened to Me: Findings and Recommendations from the Washington State Domestic Violence Fatality Review,” 2002, p. 83 and Florida Domestic Violence Review Team Annual Reports, 2001-2005. For more details on how these teams operate, you can contact Kelly Star in Seattle, Washington, Kelly@wcadv.org or Lauren Lazarus Sabatino in Miami-Dade County, Florida.
then spent eight months developing a protocol and refining its review process, with the assistance of the MNADV. Domestic violence fatality review then began in Maryland. In 2004, Calvert County followed suit, using the same process as Anne Arundel, and fatality review had taken a firmer hold. Both teams relied on the “public record” to conduct reviews, and both teams began to experience difficulties with agency participation and information sharing, to the point that their success was hindered and they requested legislative support.

Legislation
Accordingly, in 2005 the MNADV, assisted by the two fatality review teams, drafted legislation that unanimously passed both houses of the Maryland legislature. The law, enacted on July 1, 2005, authorizes counties to establish teams and provides confidentiality and liability protections for team activities. The law permits the domestic violence program, state’s attorney, or the lead law enforcement agency in each county to initiate a team. It also covers near-fatals, which is helpful for counties that have experienced few fatalities.

Teams
Since September 2004, Anne Arundel County has reviewed 14 fatalities and has completed one annual report, and they are currently preparing their second report. Since September 2005, Calvert County has conducted 6 reviews, and they are preparing their first report. We all recognize that the keys to these reviews are the quality of recommendations and the changes that result. The task of developing recommendations has proven more challenging than expected.

Six new jurisdictions have organized or are preparing to organize teams: Baltimore City and Montgomery, Frederick, Queen Anne’s, Prince George’s and Baltimore Counties. While the MNADV’s goal is for all 24 jurisdictions in Maryland to have fatality review teams, the operating and committed locations account for 75% of Maryland’s domestic violence fatalities.

Technical Support
The MNADV has used the two-year process of assisting Anne Arundel and Calvert Counties to refine how it provides technical support. The technical support we provide takes two forms:

♦ A “start-up kit” that is given to prospective teams. It contains a detailed document suggesting step-by-step ways of setting up and maintaining a team from initial organization to preparing an annual report; samples of work documents such as agendas, minutes, and letters of confidentiality; a sample work binder for individual team members; and a model protocol, with numerous “how to” appendices.

♦ The MNADV’s advisory participation in team development meetings. With each meeting, we seem to learn more as a state. For example, based on a recommendation by Dr. Neil Websdale, we have included domestic violence survivors as team members. We even incorporated survivor membership in our legislation. One of our new teams—Montgomery County—began discussions about bringing two survivors onto its team. However, that team has raised questions about the “type” of survivor that should be included and whether the survivor should be separated from her abuser. Montgomery County has caused us all to reconsider how we view survivor participants.

Maryland Domestic Violence Fatality Review Council
Because each county is independently authorized to establish a fatality review team, there has been no centralized oversight body. In February 2006, the chairpersons, vice-chairpersons, and other representatives of operating and committed teams formed the Maryland Domestic Violence Fatality Review Council. The Council will meet semi-annually to share information, discuss issues facing local teams, make recommendations of “best practices,” and review annual reports for statewide trends. The Council will also publish a quarterly fatality review newsletter entitled “Remembering and Responding” that will highlight local and national aspects of fatality review. The newsletter will support existing teams, will serve to encourage other counties to form teams, and will be posted on the MNADV website.

NDVFRI Website
We promote the NDVFRI website regularly with the teams and call attention to the publications there, which have been distributed to team members at meetings. The Calvert team has assigned various articles to team members who will inform the team about them for training purposes and to keep current with the larger fatality review community.

“Texturizing” Reviews
We owe a debt of gratitude to Neil Websdale. In the infancy of fatality review in Maryland, he made two visits to offer guidance to our Anne Arundel County team. One of the most important things we learned was the need to, using his word, “texturize” the life and death of victims. We state in our start-up document that teams “…should remember that the point of a review is to ‘humanize’ the victim’s life and death so that the best possible findings and recommendations will result. The protocol, and all the administrative and other processes, should work toward that end.”

We suggest to teams that they have a photo of the victim to ensure that team members remain focused on the person, not the “case.” In Anne Arundel’s very first review, we noted that members began the review process by referring to “the victim,” then to “Mrs. Smith,” then, as she became more real to them, to “Lisa” (not actual names). The Anne Arundel County Domestic Violence Fatality Review Team had “texturized” Lisa’s life and death. That is our hope for every review that Maryland teams conduct.
Some Thoughts on Domestic Violence, Religion and Spirituality.

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The last quarter century witnessed a rapid proliferation of research on domestic violence. Unfortunately, little of this research addressed the religious and spiritual dimensions and implications of domestic violence. Notwithstanding the social, economic, and political significance of domestic violence, it is vital to explore fully its theological, spiritual, and metaphysical dimensions and implications. Recently scholars began such an exploration, mirroring in some ways a growing number of articles in the mainstream media on the relationship between domestic violence, religion, and spirituality.

At the NDVFRI we have always encouraged members of faith communities to join fatality review teams and in some cases this has happened. However, for a variety of reasons faith community members remain largely marginal to fatality review. In what follows, I summarize some recent research findings that point to the importance of religion and spirituality in the lives of battered women. These findings might cause some fatality review teams to reconsider their relationships with their faith communities.

Scholars have identified various statements from the Hebrew Bible, Christian scriptures and the Quran that contribute to or appear to justify a man’s right to beat or discipline his wife (see for example, Fortune and Enger, 2005; Muslim Women’s League, 1995; Gray-Reneberg, 1996; Hassounneh-Phillips, 2001). With respect to Hinduism, Singh and Unnithan (1999) suggest that cultural norms that see marriage as a sacrament underwritten by religious values lie at the heart of the rare practice of wife burning. Many of these same scholars also point out that these same religions also condemn intimate partner violence and abuse and recommend harmonious and respectful relations between partners (see especially, Fortune and Enger, 2005; Gray-Reneberg, 1996).

Andrew Weaver (1993) contends that family violence is the primary mental health problem facing the contemporary church. His observation does not mean family violence is more prevalent among those attending church. In fact, the opposite appears true. According to Ellison and Anderson (2001) there is an inverse relationship between church attendance and family violence. These researchers find that this inverse relationship also holds true when they control for social integration and social support, alcohol and substance abuse, and low self-esteem and depression. Examining the behavior of evangelical men, including their deployment of physical violence, W. Bradford Wilcox (2004) concludes that the lowest rates of reported domestic violence were among active church going husbands as opposed to those who attend church less regularly.

A small body of research highlights the meaningfulness of religion and spirituality in the lives of survivors of domestic violence (see for example, Nason-Clark, 2000). Using a survey questionnaire, Gillum, Sullivan, and Bybee (2005) interviewed a community sample of 151 battered women. These authors note that 97 percent of their sample of battered women reported, "spirituality or God was a source of strength or comfort for them" (2005: 245). However, as the authors acknowledge, they did "not ask women to identify their religious affiliations nor to provide information about how their religious communities had been supportive or unsupportive of them" (2005: 248).

We do know that victims of such abuse face challenges that sometimes lead them to question their faith, their sense of hope and purpose, their capacities for love and forgiveness, and their much broader sense of what it is to live meaningful, purposeful, compassionate, and liberated lives (Nason-Clark, 2000). Using in depth interviews with five survivors of domestic violence, Giesbrecht and Sevcik (2000) note the way conservative Christian evangelical women use their spiritual and religious beliefs to negotiate recovery and healing. In particular, the authors report the way the women’s faith operates as a socially situated system of meanings that either "engender shame or guilt or inspire hope and empower transformative change" (2000: 229).

According to Mattis, some African American women deploy religion and spirituality, "to cope and to construct meaning in times of adversity" (2002: 309). The 23 women interviewed in this qualitative study identified intimate partner violence as one form of adversity they faced. Mattis randomly selected interviewees from a larger convenience sample of 128 African American women surveyed to learn how they coped with stress. Although Mattis does not address the specific links between intimate partner violence and religion/spirituality, she does identify connections between religion/spirituality and coping that have clear relevance to the way survivors of domestic violence might negotiate their own situations. Specifically, she notes, "contrary to traditional social scientific perspectives that posit that individuals use religion and spirituality exclusively as sources of emotional comfort or to shield themselves from the realities of their circumstances, the participants in this study suggested that religion/spirituality help them to confront and accept reality. Religion and spirituality are described by these women as analytic devices that promote rational and critical thought" (2002: 317).

At the moment we know little about if and how faith, religiosity, and spirituality influence the coping, resilience, survival strategies, and long-term health and security of survivors of family violence. Put simply, the relationship between religious and spiritual beliefs, the emotional configuration of intimate relationships, and the paths to social and economic wellbeing remains obscure. Some key questions spring to mind: (1) How do intimate partner violence and abuse affect religious
and spiritual beliefs and sensibilities? (2) How do religious beliefs, commitments, and practices affect, influence, mediate, or shape one’s resilience to abuse and violence? (3) In what way, if at all, are religiosity and spirituality linked to coping skills? (4) How might religious beliefs or sensibilities contribute to the reproduction of violence against women? (5) Among survivors, how important is faith in fostering hope, forgiveness, meaning, purpose, well-being and even reconciliation? For some, these questions may be unpalatable, politically incorrect, or take us to places we would rather not go. Nevertheless, we need to explore or at least be sensitive to survivors’ meaning making and decision making in order to grasp the complex relationship between religious, spiritual, and otherworldly beliefs and domestic violence.

If we can begin to make sense of these complex relationships we may be able to parlay our knowledge into innovative intervention strategies and fine tune and better deploy those existing interventions that have hitherto been reluctant to acknowledge the role of religion and spirituality or have been unable to work with survivors around these issues. Increasing our sensitivity to the part played by religion and spirituality in the lives of battered women affects all those players at the fatality review table including advocates working in shelters. As Gillum, Sullivan, and Bybee (2005) helpfully remind us, “Currently many domestic violence shelter staff distance themselves from discussions of spirituality with shelter residents... The end result is that the shelter provides a haven for physical safety but fails to provide an environment for spiritual healing” (2005: 248).

We may argue shelters ought not be in the business of providing spiritual healing. However, it is difficult to sustain a position that either ignores or dismisses the reported realities of battered women themselves. Those critics of religion who frame it as part of an oppressive and exploitive structure of patriarchy have often been the same people who have highlighted the problem of domestic violence by resurrecting the (long silenced) voices of women who spoke out about violence and abuse. If such concerns about giving voice to the silenced are genuine, then it is difficult, if not logically inconsistent, to dismiss women’s voices when they speak to the importance of religion and spirituality or to criticize them or write them off as just one more expression of false consciousness.

References


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