What is meant by “safety?” What are the critical safety periods for adult and child victims of violence? Should supervised visitation centers (centers) focus entirely on the visit itself, or should the focus extend beyond the walls of the center? Will one approach to safety work for every adult and child being served by the center? These are some of the questions an audit team (Team) explored as they examined the notion of safety within the context of supervised visitation.

In July 2004, the Team assessed each of the three Safe Havens: Supervised Visitation and Safe Exchange Grant Program California demonstration site communities. They explored the extent to which the centers were producing safety for the adults and children they served. The Team concluded that through carefully constructed philosophies, policies, and protocols, centers can provide safety for all people served; both in the immediate context of the visitation and away from the center. The following is an excerpt of the audit report which highlights the themes, recommendations, and guiding questions that emerged throughout the audit process.

“Safety” Defined

The Team established a uniform definition of safety to use in assessing the degree to which centers were achieving safety. Initially, the definition was limited to what happened immediately prior to, during, and following visitation. Centers were generally equipped to address safety in the following context: structured intake, entry and exit procedures to avoid contact between parents, attention to gifts or food that were brought into the center; and monitored conversations with attention to non-verbal cues between the parent and the child. However, conversations with demonstration sites led to the expansion of the Team’s definition of safety to include protecting adult and child victims from continued abuse, coercion, and threats over time.

The Team considered the panoply of dangers inherent in post-separation violence and the reality of ongoing relationships between parents and other family members involved with the child. It was within this framework of safety that the Team developed what is referred to as the “2-2-20” approach to safety—how a center can promote safety for the two hours of the actual visit, for the two years following separation, and on a more permanent basis (20 years into the future). The Team analyzed the California sites based on this 2-2-20 approach.

THE KEY THEMES

(1) The centers received incomplete information from judges and custody evaluators about the level of potential danger. Centers did not generally receive information upon which individual safety measures could be based. Regardless of the specific history of abuse, arrests, or protection orders, the team found that most referrals to the center provided identical information about the families.

(2) Victim parents using the center did not consistently receive clear information about the safety precautions put in place around arrivals, departures, and visits. The Team found a gap between the information that victim parents received about the center and the visitation process, and the information that victim parents felt they needed to feel safe, such as how to remove their child safely from the center during an emergency. The Team suggested that inadequate staff training contributed to the gap between what victim parents expected and what they experienced.

(3) Visitation monitors’ work was not structured to account fully for battering behaviors and how those behaviors may inadvertently involve the center in collusion with the battering parent. Frequently, monitors overlooked the subtle manipulation and control that may take place through acts such as gift-giving; or they neglected to document certain behaviors as harmful or potentially harmful to the victim parent or child. Some centers failed to determine whether the custodial parent was in fact the victim parent.
(4) The centers collected and recorded a large volume of information without a clear sense of purpose or emphasis on safety and risk in the context of battering. Documentation of visitation-related information was inconsistent among centers, and lacked a process for regular review and update. Information about why services were ordered was unavailable. A lack of continuity among monitors’ observation notes and logs, and few notes about behaviors before and after services, existed.

(5) The centers did not have an ongoing, active dialogue with the parent who had been battered, the children, or the battering parent. Concerns by the battered parent about behaviors in and out of the center received little follow-up by staff. Some staff noted that they were uncomfortable speaking to or being alone with the battering parent, and that certain policies impinged on their ability to talk to some children, because of the child’s age or because there was pressure to maintain time schedules.

(6) Monitor training, preparation, and skill level inadequately prepared monitors for supervision and exchange cases involving battering. Limited salary, training resources, and odd hours of work impacted hiring, preparation, and retention. Centers experienced high staff turnover, affecting training and experience, particularly in understanding and identifying battering tactics. Community-based advocacy organizations were not setup to share resources beyond their own agency or to offer training to visitation centers.

(7) Community-based advocates, batterer intervention programs, and visitation centers were poorly linked. Advocates and batterer intervention programs often knew little about the center’s services, and vice versa. The Team noted very little formal involvement across programs.

(8) The role of the center to respond to post-separation violence and safety had not been clearly articulated or explored. Most staff believed that, once a couple separated and supervised visitation was ordered, the danger from violence was over. In the event staff had concerns about safety away from the center, they were unaware of their authority to plan around it, or how to work within the system to challenge the terms of judicial orders or terminate visitation.

Steps Toward Change

The Team determined that a single, predetermined safety map that fits every victim parent and child using the center does not exist. Safety requires individualized attention and ongoing assessment of all persons using the center—adults and children alike. To promote safety, centers need to re-examine their case file management, orientation, staff training, and feedback procedures. Because visitation centers are part of a larger community system of safety for domestic violence victims and their children, collaboration with advocates, batterer intervention programs, and courts is critical.

Safety is highly nuanced in domestic violence situations. Seemingly innocuous or benign behaviors can carry a different and dangerous meaning in this context. The most significant outcome of the safety assessment was the recognition of the need to shift conceptual practices to recognize the gap between intentions and commitment to safety and the day-to-day organization and processes of supervised visitation and exchange.

Footnotes:
1. Throughout the report, the term “centers” is used rather than identifying specific centers or particular staff.
2. The three centers were 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).
3. The audit team was comprised of California visitation center representatives, a Santa Clara County superior court judge, Santa Clara County counsel, domestic violence advocates, and Safe Havens technical assistance providers.

Editor’s Note: This article was excerpted and adapted from the executive summary for Exploring the Question: How does the work of a visitation center produce or not produce safety for everyone involved? A Report from the California Demonstration Site Safety Audit, funded by the Office on Violence Against Women, U.S. Department of Justice and prepared by Praxis International, Inc., in consultation with the Family Service Agency of San Mateo County, the Walnut Avenue Women’s Center of Santa Cruz County, and Community Solutions of Santa Clara County. To read the full text of the report, please visit http://www.praxisinternational.org/vista_ta_frame.html.