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## DOMESTIC VIOLENCE ENHANCED RESPONSE TEAM

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Police often have been frustrated that after they have intervened at a home where domestic violence has occurred, other parts of the criminal justice and social service system seldom followed through. In 1987, the City of Colorado Springs was one of several communities around the country selected by the National Institute of Justice to replicate an earlier experiment in Minneapolis where police responded to domestic violence incidents with one of several alternative actions, one being the then novel idea of arresting the perpetrator. Out of this early start grew a series of community initiatives that have drawn in an ever-widening group of collaborative agencies.

The Domestic Violence Enhanced Response Team (DVERT) is an interdisciplinary group of professionals from 11 agencies who are located in a common space and coordinate their agencies' response to cases of domestic violence. Agencies contributing staff include probation, a battered women's program, two police and one sheriff's department, the Humane Society, and legal services. The Team has been expanded to include professionals working with children exposed to violence, including local child protective services and the court-appointed special advocates (CASA) program.

The team maintains several levels of intervention. Referrals are received from a variety of sources, and the first level of intervention involves a confidential intake conducted by a victim advocate who is assigned to work with the victim from beginning to end. Cases moving beyond intake are also assigned a law enforcement detective who works with the victim and the advocate to ensure the victim's safety over time. Another level of intervention involves problem-oriented policing, in which officers visit the victim's home to provide additional information and support in the community. Finally, the DVERT coordinates a variety of community resources in support of the adult and child victims' safety.

*Jeffrey L. Edleson*

*See also* Coordinated Community Response; Family Justice Centers

### Web Sites

Domestic Violence Enhanced Response Team: <http://www.dvert.org>

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## DOMESTIC VIOLENCE FATALITY REVIEW

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In the United States, approximately 1,600 women are murdered each year by their current or former partners. Domestic violence deaths often display predictable patterns and causes. Many experts in the field believe that many of these homicides are preventable. When a woman is murdered by a partner, the public often wants to know why the woman was not protected and the homicide not prevented. A recent and increasingly popular approach to preventing these tragedies is the formation of domestic violence death (fatality) review committees (DVDRCs). The effort of a DVDRC is comparable to that seen in the airline industry in reducing aviation disasters or in the medical profession in learning from deaths occurring in hospitals under questionable circumstances. DVDRCs are interdisciplinary teams of domestic violence experts who are dedicated to understanding how and why domestic violence deaths occur through a detailed examination of individual cases. Each committee utilizes the benefit of hindsight to recommend what could have been done in their community to prevent each fatality, with the goal of preventing future deaths. There is emerging evidence supporting the utility of DVDRCs in assisting the overall effort of reducing domestic violence fatalities and domestic violence, in general, through the implementation of their recommendations.

### History

One of the first publicly documented fatality reviews, known as "The Charan Investigation," was conducted in 1990 in San Francisco, California. The investigation was driven by the Commission on the Status of Women at the request of the San Francisco Domestic Violence Consortium. Joseph Charan murdered his wife and committed suicide in front of numerous schoolchildren and teachers. The killing occurred 12 days after

Mr. Charan received a suspended sentence for felony domestic assault and malicious mischief. Relatively soon after the official report was released in 1991, Santa Clara County in California started one of the first regularly operating DVDRCs (1994). At the end of 1994, jurisdictions in two states had committees conducting regular reviews. In 1998, nine states had jurisdictions with DVDRCs. By 2003, 27 states and the District of Columbia had committees operating or planning to operate at county or state levels, and 18 of these states had passed legislation or given directives on making the formation of DVDRCs and consistent reviews a mandatory practice. In September of 2002, the Ontario government publicized the formation of Canada's first DVDRC through the Office of the Chief Coroner, making fatality reviews an international practice. Another important development in the field came in 2004 with the launch of the National Domestic Violence Fatality Review Initiative. The purpose of the initiative is to provide technical assistance with reviews by providing a clearinghouse, a resource center, and several other unique services.

### Structure, Mandate, and Process

DVDRCs vary in their compositions, directives, and procedures, largely due to the amount of funding they receive (many operate on a volunteer basis). Most are comprised of coroners, medical and mental health professionals who specialize in domestic abuse, criminologists, prosecutors, judges, shelter staff and women's advocates, law enforcement staff, and representatives from child protection services. The typical cases teams are charged with identifying and reviewing include intimate partner (a) homicide, (b) homicide-suicide, (c) attempted homicide followed by suicide, (d) attempted-homicide followed by related accidental death (e.g., the perpetrator was killed in a car accident during a police pursuit), and (e) attempted homicide followed by related homicide (e.g., the perpetrator was killed in a police shooting). Reviewed cases may include those involving multiple deaths (e.g., familicide) or the deaths of any individuals connected to incidents of domestic violence, such as third-party interveners, friends, neighbors, coworkers, new partners, extended family members, and children. DVDRCs operate under the philosophy that the perpetrators are ultimately responsible for the deaths and do not assign blame to individuals or agencies involved in the cases under examination. Generally, a fatality review is the process by which a DVDRC uses multiagency data

and interviews with families, friends, neighbors, and others to document, analyze, and report on the history of the victim, perpetrator, their relationship, and their family. Teams also track risk factors associated with lethal intimate partner violence in each case to aid in enhancing the predictability of the tragedies. They examine the effects of all interventions that took place before the deaths, consider changes in relevant prevention and intervention systems to address gaps in service delivery, and develop recommendations for coordinated community plans. Broadly, recommendations stemming from reviews address (a) increasing awareness and education of domestic violence; (b) enhancing assessment and intervention practices with victims and perpetrators; (c) improving training and policy development within target agencies; (d) increasing resource development for victims, abusers, and their families; (e) advancing coordination of services among agencies servicing at-risk families; (f) legislative reform; and (g) increasing and improving prevention programs for those at risk of becoming victims and perpetrators. DVDRCs report their findings and recommendations annually to enhance public, professional, and policymaker understanding of domestic violence death.

### Current and Future Directions

To date, there has not been a systematic evaluation of the DVDRC initiative. Based on the annual reports of individual committees, there would seem to be a high level of community engagement and collaboration inherent in the process. Individual communities and states often refer to their DVDRC as a rationale for new practices or legislation. For example, in Ontario, Canada, there has been a broad-based initiative to educate friends, family, and neighbors about lethal domestic violence, in light of all the common warning signs overlooked in many homicides. Some jurisdictions monitor specific recommendations such as the Santa Clara committee highlight of the fact that there were no deaths in the 5,337 domestic violence cases referred to the district attorney's office for prosecution in 2004. It was also noted that 2004 was the third year in a row their community had been without police-assisted suicides (i.e., "suicide-by-cop"). Many committees report that in their view, fatality reviews save lives. We can expect more empirical studies to test this hypothesis in the future.

*Peter G. Jaffe and Marcus Juodis*

*See also* Danger Assessment Instrument; Familicide; Femicide; Intimate Partner Violence; National Domestic Violence Fatality Review Initiative

### Further Readings

- Ontario Domestic Violence Death Review Committee. (2006). *Annual report to the chief coroner*. Toronto, ON: Ministry of the Attorney General. Retrieved from [http://www.mpss.jus.gov.on.ca/english/publications/comm\\_safety/DVDRC\\_2005.pdf](http://www.mpss.jus.gov.on.ca/english/publications/comm_safety/DVDRC_2005.pdf)
- Santa Clara County Domestic Violence Council. (2004). *Death review committee final report*. San Jose, CA: County Government Center. Retrieved from [http://www.growing.com/nonviolent/council/pubs/dvc\\_intro.htm](http://www.growing.com/nonviolent/council/pubs/dvc_intro.htm)
- Websdale, N. (1999). *Understanding domestic homicide*. Boston: Northeastern University Press.
- Websdale, N. (2003). Reviewing domestic violence deaths. *National Institute of Justice Journal*, 250, 26–31.
- Websdale, N., Town, M., & Johnson, B. (1999). Domestic violence fatality reviews: From a culture of blame to a culture of safety. *Juvenile and Family Court Journal*, 50, 61–74.

### Web Sites

- National Domestic Violence Fatality Review Initiative: <http://www.ndvfri.org>

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## DOMESTIC VIOLENCE IN ASIAN AND PACIFIC ISLANDER POPULATIONS

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Asians and Pacific Islanders are people who trace their origins and/or ancestry to the countries or diasporic communities of the region and identify as Central, East, South, Southeast, or West Asians; Native Hawaiians; and Pacific Islanders.

In community-based studies compiled by the Asian Pacific Islander Institute on Domestic Violence in San Francisco, 41% to 60% of Asian women reported experiencing physical and/or sexual violence during their lifetime. This is higher than the prevalence rate found in the National Violence Against Women Survey for other Asian and Pacific Islander (API) women or any other group.

Domestic violence in API communities has some distinct patterns, forms, and dynamics of abuse, warranting distinct approaches to prevention and intervention. The similarities between all battered women's

experiences are not enumerated in this entry. Some dynamics occur in one ethnic group, and some are common to many, thus cautioning against stereotyping or universalizing API cultures. Gender violence is experienced in the context of gender oppression as well as oppressions based on race, ethnicity, age, sexual orientation, gender identity, type of labor performed, level of education, class position, disability, and/or immigration or refugee status. Domestic violence in the lives of API women may involve physical abuse, multiple batteries, push and pull factors, sexual abuse, abuse of mothers, same-sex violence, immigration-related abuse, and isolating sociocultural barriers and victim-blaming community norms,

*Physical abuse* can include culturally specific forms such as abuse by multiple perpetrators, severe isolation compounded by immigration, abandonment, hyperexploitation of women's (including elderly women's) household labor, withholding health care, and the mistreatment of widows. Domestic homicides include murder by an intimate or family member, honor killings, contract killings, dowry (bride price) related deaths, targeting a woman's family members in the home country, and/or being driven by the marital family to suicide (abetted suicide).

*Multiple batterers* in the home can include members of a woman's family of origin, members of her partner's family of origin, or her partner's ex- or new wives. The implications of multiple batterers include greater or more severe injuries; family collusion and increased impunity; legal remedies requiring protection orders against several individuals; deeply internalized victim blaming and devaluation by survivors; diminished credibility afforded to battered women by systems, families, and communities; and uncomprehending systems that respond inadequately.

*Push and pull factors* are experienced by many API battered women: "push" factors, such as being pushed out of the relationship by a partner (e.g., "Leave the house, I'm divorcing you after 3 months of marriage, I can always find another wife"; "I don't want you and these children around"), may be more frequently experienced than "pull" factors (e.g., "Come back to me, I won't do it again") back into the relationship. These factors affect how women's agency is understood—about "decisions" to stay or leave; how often, if at all, women return to their abusive partners; if they leave with or without their children; and how dangers