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DOMESTIC VIOLENCE FATALITY REVIEW TEAMS:
COLLABORATIVE EFFORTS TO PREVENT INTIMATE PARTNER FEMICIDE

BY

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DISSERTATION

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ABSTRACT

Intimate partner femicide, the murder of a woman by her current or former partner, is a serious international problem. Given the gravity of intimate partner femicides, domestic violence fatality review teams have emerged in the North America as collaborative settings aimed at understanding and preventing them. Although domestic violence fatality review teams have been developed rapidly and widely, little is known about the nature of these teams or whether and how these teams actually prevent intimate partner femicide. The goals of this study were to: (1) describe the goals, structures, processes and outcomes of domestic violence fatality review teams; and, (2) identify the critical tensions or issues navigated by these collaborative efforts. The study consisted of three phases. The first phase involved a review relevant literature, discussion with experts in the field, and anecdotal experiences of team members. The second phase involved in-depth interviews with key informants and review of the most recent reports from 35 teams in the United States and Canada to gain a systematic understanding of them. At least one team was recruited from every state or province in which teams were active. Data were analyzed using frequency and content analysis. The third phase involved the use of case study methodology to obtain rich descriptive information about a subset of three teams. The analyses revealed a great deal of diversity across teams with respect to goals, structures, processes, and outcomes, but considerable similarity with respect to critical tensions or issues faced by teams. These tensions included *no blame or shame* versus *accountability*, *freedom of information* versus *individual right to privacy*, *betterment* versus *empowerment*, *biography* versus *epidemiology*, and *understanding* versus *action*. Both the diverse nature of these settings and their navigation of tensions appeared to reflect how teams attempted to promote systems change and, ultimately, how well-positioned they were to achieve this end. The findings have broader implications for

our understanding of how collaborative settings operate, particularly with regard to the implicit and explicit choices they make regarding critical tensions. Understanding the diversity of collaborative settings and the processes underlying their efforts is important for informing future theory and research about collaborative settings and to facilitate improvements to practice and policy in this area.

In memory of all the individuals who have died as a result of intimate partner violence. May we honor them by learning from their lives to prevent future deaths.

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INTRODUCTION

Overview

Intimate partner femicide, the murder of a woman by her current or former intimate partner, is a pervasive international problem (Krug, Dahlberg, Mercy, Zwi, Lozano, 2002). In North America alone, it is the single most common form of murder perpetrated against women, accounting for 30-60% of all culpable homicides of females annually (Browne, 1987; Campbell, 1986; Daly & Wilson, 1988; Polk, 1994, Wilson & Daly, 1992). Many additional individuals are often harmed or killed in the context of intimate partner femicide (Abrams, 2000; Watt, Hart, Kropp & Bain, 2004). Researchers suggest that it may be possible to identify when a woman is at risk of serious or lethal intimate partner violence (Dawson, 2005; Watt & Allen, 2003) and practitioners argue it is critical to identify ways to increase understanding of these events and to develop strategies to prevent or reduce the occurrence of intimate partner femicides (Websdale, Town, & Johnson, 1999).

Over the last fifteen years, domestic violence fatality review teams have emerged in North America as a means of trying to understand and prevent future intimate partner femicides (Websdale, 2003). Domestic violence fatality review teams involve a collaboration among intimate partner violence stakeholders who review cases of intimate partner femicide to identify gaps in the systems response and, ideally, to make subsequent improvements to the system response (Websdale, 1999). The emergence of these teams as a response to intimate partner femicide is not surprising given the widespread development of collaborative settings over the last two decades as a strategy for promoting systems change related a variety of social issues (Berkowitz, 2001). In spite of the popularity of collaborative settings, however, research has reported numerous barriers to their success (Foster-Fishman, Berkowitz, Lounsbury, Jacobson, &

Allen 2001) and limited empirical support for their effectiveness (Roussos & Fawcett 2000).

Although domestic violence fatality review teams have developed rapidly and widely, little is known about the nature of these teams or what they accomplish. Ultimately, it is not clear whether and how domestic violence fatality review teams actually contribute to a comprehensive response to intimate partner femicide. I therefore decided to employ qualitative methods to advance our understanding of collaborative settings by taking a detailed look at the nature of domestic violence fatality review teams and by identifying the critical tensions or issues they face in the course of their work. In the remainder of the introduction, I take a close look at the prevalence and nature of intimate partner femicide, the emergence of domestic violence fatality review teams as a collaborative response to this issue, the limitations of previous research evaluating the effectiveness of collaborative settings, and how the current study attempts to address some of these limitations.

Intimate Partner Femicide

Intimate partner femicide is a serious and pervasive problem worldwide (Krug et al., 2002). Crime statistics highlight the scope of the problem of intimate partner femicide. In the United States between 1992 and 2002, each year an average of 4,418 women were victims of culpable homicide, and of these women an average of 1,312 (30%) were killed by men who were their current or former intimate partners (Bureau of Justice Statistics, 2004). Similarly, in Canada between 1993 and 2003, each year an average of 187 women were victims of culpable homicide, and of these an average of 64 (34%) were victims of intimate partner femicide (Statistics Canada, 2003). Certain groups of women are particularly vulnerable targets of intimate partner femicide. Specifically, intimate partner femicide is the leading cause of death in the United States among young African American women between the ages of fifteen and forty-five (Campbell et al.,

2003). In some regions, whereas overall homicide rates are decreasing substantially, the rate of intimate partner femicide is relatively stable or even increasing (Adams, 2007; Campbell et al., 2003; Frye & Wilt, 2001). When declines in intimate partner femicide have been observed, this is often attributed to improvements in the system response, such as quicker arrival of emergency services (Websdale, 1999).

Sadly, crime statistics such as those reported here likely represent an undercounting of the actual number of incidents of intimate partner femicide, due to the lack of clear definitions (e.g., concerning what constitutes a current or former intimate relationship) and inconsistent procedures for recording and reporting these events (Pampel & Williams, 2000; Websdale, 1999). In addition, the statistics do not account for the number of additional individuals who are harmed in the context of intimate partner femicide. Specifically, it is not uncommon for children, new partners, family members, friends, and responding law enforcement officers to be injured or killed in the course of a femicide (Websdale, 1999). Previous research indicates that between 10% and 25% of intimate partner femicide cases also involve additional victims (Abrams, 2000; Watt et al., 2004). Furthermore, approximately 30% of perpetrators commit suicide immediately following the femicide, especially when there are multiple victims involved (Adams, 2007; Dawson & Gartner, 1998; Websdale, 1999). Due to increased awareness of the high prevalence and serious nature of this problem, substantial research has been conducted on intimate partner femicide over the past twenty five years that has significantly advanced our understanding of these tragic events.

Research on risk factors has identified general characteristics associated with the perpetrator, the victim, their relationship, and the community response that may contribute to the occurrence of intimate partner femicides. For example, perpetrators of intimate partner femicide

often have a history of experiencing child abuse, serious difficulties establishing and maintaining intimate relationships, proprietary attitudes, violent and non-violent criminality, mental health problems, and substance abuse (e.g., Belfrage & Rying, 2004; Campbell, Sharps, & Glass, 2001; Dobash, Dobash, Cavanagh, & Lewis, 2004; McFarlane et al., 1999). Victims of intimate partner femicide often have a history of experiencing intimate partner violence in previous relationships, stress-related physical and mental health problems, and substance abuse (e.g., Abrams et al., 2000; Sharps, Campbell, Campbell, Gary, & Webster, 2003). The relationship between the perpetrator and victim frequently includes a history of intimate partner violence, such as physical assault, threats, and stalking, as well as actual or attempted separation (e.g., Campbell et al., 2003; Dobash et al., 2004; McFarlane et al., 1999; Roehl, O'Sullivan, Webster, & Campbell, 2005; Wilson, Johnson, & Daly, 1995). Finally, the communities in which the perpetrator and victim live may be characterized by the presence of weak social support networks and serious limitations in the availability or delivery of criminal justice, health, and social services (Block, 2003; Dugan, Nagin, & Rosenfeld, 2003).

Discovery of common risk factors suggests that it may be possible to identify women who are at risk of being seriously harmed or killed by current or former partners and take preventive steps. In contrast to the traditional perception of intimate partner femicides as unpredictable crimes of passion, researchers and practitioners alike are now suggesting that they are preventable fatalities preceded by multiple opportunities for system intervention (Dawson, 2005; Watt & Allen, 2003). In fact, it is not uncommon for family members, friends, co-workers, neighbors, or agencies to be aware of or suspect serious problems in the victim-perpetrator relationship, and even to be concerned about the potential for femicide, prior to the killing (Abrams et al., Websdale, 2003). But lack of understanding about the risk factors for intimate

partner femicide; failure to report incidents of physical assault, threats of harm, or stalking; limited communication and collaboration between service providers; and problems in the system response to intimate partner violence occur frequently and decrease the chances for appropriate intervention (Watt et al., 2004). As a result of the immense personal, social, medical, and legal costs to society resulting from intimate partner femicide, it is critical to identify ways to increase understanding of these events and to develop strategies to prevent or reduce their occurrence (Frye & Wilt, 2001; Venis & Horton, 2002; Websdale et al., 1999).

Domestic Violence Fatality Review Teams

Over the last fifteen years, domestic violence fatality review teams have emerged in North America as an innovative means of understanding and preventing intimate partner femicide (Websdale, 2003). As previously mentioned, these teams developed during a period of increased popularity and widespread development of collaborative settings as a means of promoting systems change related a variety of social issues (Berkowitz, 2001). In general, systems change refers to sustainable efforts to address the root causes of an issue by changing policies, procedures, protocols, and practices that affect the issue (Kreger, Brindis, Manuel & Sassoubre, 2007). When applied to domestic violence fatality review teams, systems change refers to efforts to understand and prevent intimate partner femicide by making changes to policies, procedures, protocols, and practices of services and agencies involved in the response to intimate partner violence as well as changes to the ties between services and agencies. Due to the complex nature of intimate partner violence multiple systems may be involved a coordinated response to this issue such as the justice, health, and social services.

An important catalyst for the development of domestic violence fatality review teams occurred in 1991 (Websdale et al., 1999). Following the murder in California of Veena Charan

by her husband Joseph Charan, who subsequently killed himself, the state's Commission on the Status of Women reviewed the case and subsequently produced a report of its findings. The case was broadly publicized as a result of widespread breakdowns in the system response and the fact that the victim was murdered in front of her child's elementary school. The Charan Investigation, as it came to be known, identified a variety of problems in the system including lack of knowledge, training, and services related to diversity issues, failure to collect systematic or accurate data on domestic violence-related homicides, and gaps in communication and coordination between agencies involved. The process used and observations made by this investigation were critical for informing the development of subsequent domestic violence fatality review teams (Websdale, Moss, & Johnson, 2001; Websdale, Sheeran, & Johnson, 2001).

In 2006, when recruitment for the current study began, at least 28 states in the United States and 1 province in Canada had established at least one domestic violence fatality review team (Watt & Allen, 2008; Websdale, 2003). However, given there was often more than one team in each state or province, the total number of domestic violence fatality review teams far exceeded this number, amounting to approximately 75 teams in total. For instance, California had 22 county teams and Florida had 14 county teams at the time that this estimate of the prevalence of teams was made. The number of domestic violence fatality review teams operating in North America grew at a rapid pace up to 2006 and it appears very few teams disbanded after they were established over the years, which is likely a reflection of the perceived need and utility of these efforts. The proliferation of teams in the United States may have been stimulated in part by the passage in 1994 of the Violence Against Woman Act, which provided federal funding to efforts that addressed violence against women, and the establishment in 2002 of the National Domestic Violence Fatality Review Initiative (NDVFRI), a clearing house and resource center to

support the development of domestic violence fatality review teams.

Most generally, domestic violence fatality review teams involve a collaboration among people with an interest in intimate partner violence, many of whom are employed by government agencies (e.g., in the law enforcement, health care, social services, or education sectors), to identify and review cases of intimate partner femicide and to develop strategies to prevent or reduce future fatalities (Websdale et al., 1999). The process used by these teams to review cases is reminiscent of fatality, mortality, or accident review teams used routinely in fields such as aviation, aerospace, engineering, medicine, and nuclear energy to determine what caused critical incidents and how to prevent them in the future (Rex, Turnbull, Allen, Vande Voorde, & Luther, 2000). Typically, domestic violence fatality review teams analyze the events leading up to a series of cases of intimate partner femicides to determine what potential warning signs were present prior to the fatality and whether anyone could have responded differently to prevent its occurrence (Websdale, 1999). Following this review process, teams prepare a report that summarizes their activities, findings, and recommendations for systems change (Thompson, 2006). Recommendations made by teams are often directed at improving the response to intimate partner violence by promoting public and professional awareness, increasing coordination and communication across existing services, improving policies, procedures, protocols, and practices in the system response, and creating additional resources or services (Websdale, 1999). Based on the types of recommendations made by teams, they appear to be very similar to other collaborative settings in their attempt to accomplish system change by altering values, relationships, practices, procedures, policies, resources, and power structures (Foster-Fishman, Nowell, & Yang, 2007).

There are some reports that teams have been successful in promoting positive change and

possibly in decreasing the occurrence of intimate partner femicide (Thompson, 2006; Websdale, 2003). For example, the Washington State Domestic Violence Fatality Review (2004) reported increased public awareness regarding domestic violence homicides by disseminating their reports widely to community stakeholders and generating media attention through press releases. In addition, the State of New Hampshire Governor's Commission on Domestic and Sexual Violence Domestic Violence Fatality Review Committee (2002) witnessed better coordination between courts and crisis centers following the implementation of one of their recommendations. Improvements to practice were observed by the Maine Domestic Abuse Homicide Review Panel (2004) when one of their recommendations resulted in changes to law enforcement policies related to weapons removal in cases of domestic violence. Furthermore, the Ontario Domestic Violence Death Review Committee (2004) noted increased funding for domestic violence when the provincial government announced a sixty-six million dollar action plan to address a range of needs outlined in their report.

Aside from these anecdotal reports, however, there is a paucity of research conducted on these collaborative efforts and their implications for systems change. In fact, only one empirical study has been conducted which evaluated the impact of recommendations made by a single state wide domestic violence fatality review team for systems change within communities across the state. In contrast to the optimistic reports of some teams, this study found that very few communities had been successful in implementing recommendations made by the state wide domestic violence fatality review team to improve the local response to intimate partner violence (Starr, Hobart, & Fawcett, 2004). Even though stakeholders viewed the recommendations of the state wide domestic violence fatality review team as priorities in their communities very few were successful in making the changes suggested (Starr et al., 2004). Barriers to implementing

recommendations included lack of resources, resistance to change, competing demands, and lack of expertise (Starr et al., 2004). These findings suggest that, consistent with other collaborative settings, there may be various impediments and tremendous diversity regarding the capacity of domestic violence fatality review teams to affect systems change (Kreuter, Lenzin, & Young, 2000).

Although proponents of domestic violence fatality review teams have argued that the primary goal of these teams should be making systems change (e.g., Thompson, 2006), there is limited knowledge about if or how the work of teams ultimately translates to systems change or results in the prevention or reduction of future intimate partner femicides. There has been an absence of previous research examining what domestic violence fatality review teams are doing over and above the preparation of reports that are disseminated to the public. Therefore, at this point in time it is not clear the extent to which and how domestic violence fatality review teams advance a systems change agenda and whether they are positioned to do so. Furthermore it is unclear how the work of the team impacts on the prevalence of intimate partner femicides. In fact, some researchers have argued that it is premature and misleading to assert that domestic violence fatality review teams are responsible for changes in the systems response and decreases in the number of fatalities (Alvaraz, 2004).

Research on Collaborative Settings

There is a clear need for additional research on domestic violence fatality review teams and their implications for systems change. But it is unclear what the goals of this research should be or what methods should be used. To answer these questions, I turn next to a review of the more general literature on collaborative settings. As previously mentioned, collaborative settings, often referred to as coalitions, partnerships, councils, or teams, have become an extremely

popular means of promoting systems change over the last two decades. Although it is difficult to track the precise number of collaborative settings, it has been estimated that several thousand exist across North America (Berkowitz, 2001). Similar to domestic violence fatality review teams, these settings often involve bringing together diverse stakeholders to encourage communication and coordinated action in response to a wide variety of complex social issues, such as preventing substance abuse, stopping gun violence, or promoting affordable housing (Berkowitz, 2001). However, researchers and practitioners have suggested that not all collaborative settings are “created equal” and certain conditions need to be in place for effective collaboration to occur and for system change to take place (Goodman et al., 1998). Consequently, a great deal of research has been conducted on the facilitators and barriers to collaboration that has highlighted the complex, dynamic, and multilevel nature of this work. For instance, studies have emphasized the importance of the focus and clarity of objectives; the skills, knowledge, and motivation of members; the quality of relationships between members; the strength and focus of leadership; the formalization of processes and procedures; the ability to liaison with external stakeholders; and the targeted nature of strategies to promote systems change (e.g., Allen, 2005; Allen, 2006; Butterfoss, Goodman, & Wandersman, 1993; Foster-Fishman et al., 2001; Roussos & Fawcett, 2000).

Many stakeholders actively involved in collaborative settings have argued that these efforts can and do make a difference in addressing complex social issues (Allen 2006; Berkowitz et al., 2001; Butterfoss et al., 2001; Foster-Fishman et al., 2001; Kegler et al., 2001). Some studies have provided support for these claims, recognizing the potential role of collaborative settings in increasing knowledge, fostering relationships, promoting service coordination, and developing new or modified programs, policies, and practices (Allen, Watt, & Hess, 2008;

Roussos & Fawcett, 2000). Alternatively, other studies have revealed numerous barriers to their success and limited support for their effectiveness in system change pursuits (Kreuter et al., 2000; Roussos & Fawcett, 2000). For instance, collaborative settings have been criticized for failing to consistently demonstrate direct changes to the social issue they aim to address, such as drug or alcohol use (Roussos & Fawcett, 2000). The mixed findings regarding the effectiveness of collaborative settings is concerning given the amount of resources invested into these efforts and seriousness of issues targeted by these settings. In an attempt to make sense of these inconsistent findings, attention has been drawn to the numerous methodological obstacles of past research on the effectiveness of collaborative settings in promoting systems change (see Allen, Watt, & Hess, 2008; Berkowitz 2001; Roussos & Fawcett 2000; Yin & Kaftarian 1997), several of which will be highlighted below.

First, research has been criticized for paying limited attention to the specific nature of collaborative settings and failing to recognize the diversity of these efforts (Berkowitz, 2001). Some researchers have argued that it is necessary to obtain an in-depth understanding of collaborative settings before it can be determined what outcomes can be expected of them (Kegler et al., 2001). The absence of this type of information about collaborative settings may lead to assumptions being made about the nature of these settings that are not accurate reflections of what these settings aim to accomplish, how they are structured and operated, or what they are well positioned to achieve (Allen et al., 2008). For instance, if the primary goal of a collaborative setting is increasing understanding about a social issue as opposed to making systems changes related to a social issue, one could argue it would be misguided to evaluate the setting based on whether it has altered the system response. As a consequence of the potential mismatch between what these settings actually do in practice and what they are expected to accomplish, it has been

proposed that researchers may be neglecting to examine the intermediary processes by which collaborative settings may affect change and at times be “setting the bar too high” when evaluating the merit and worth of these efforts (Allen et al., 2008; Kegler et al., 2001). Therefore, a closer examination of the nature and diversity of these collaborative settings may improve our understanding of what types of outcomes we can reasonably expect which is essential for informing any evaluation of their ability to promote systems change.

Second, research has been limited by focusing primarily on providing descriptive accounts as opposed to explanatory accounts of collaborative settings. In other words, research has generally described what collaborative settings look like but failed to specifically explain why collaborative settings look this way (Cashman et al., 2001). In fact, researchers have highlighted that there is a dearth of empirical research regarding the formation and development of collaborative settings which may account for the wide range of structures and processes (Granner and Sharpe, 2004). Although research has contributed significantly to our understanding of numerous possible facilitators and barriers to collaboration and substantial diversity among collaborative settings with respect to their goals, structures, processes, and outcomes (e.g., Butterfoss, Goodman & Wandersman, 1993; Foster-Fishman et al., 2001; Roussos & Fawcett, 2000), it has contributed little to providing an explanation of why differences have occurred across collaborative settings. This is especially important given the nonlinear and evolutionary nature of collaborative settings, such as the variable and lengthy chain of events between forming a setting and achieving a desired outcome (Cashman et al., 2001; Kegler et al., 2001). Consequently, obtaining a better understanding of the processes underlying the structure and function of collaborative settings is critical for accounting for the variation in how they operate and what they accomplish.

Third, research has infrequently and inconsistently demonstrated that collaborative settings are associated with direct changes to the system response or clear improvements in the social issue they aim to address (Kreuter et al., 2000; Roussos & Fawcett, 2000). This may in part be due to the fact that research has largely focused on the extent to which collaborative settings have achieved distal outcomes, such as a reduction in a targeted health behavior, as opposed to proximal outcomes, such as improved coordination of services (Allen et al., 2008). Specifically, some researchers have suggested for collaborative settings to be determined effective they must demonstrate a change in the behavior or issue they aim to address (Yin & Kaftarian, 1997). Yet, an exclusive focus on long-term outcomes may fail to reveal the short term outcomes these settings are well positioned to achieve as they work towards addressing a larger social issue particularly because the issues these settings address require long-term investments of time, energy, and resources (Allen et al., 2008). But even when collaborative settings have been associated with successful outcomes, it is unclear why this happened and therefore how this could be replicated in other settings (Butterfoss et al., 2001). Neglecting to examine the connection between the nature of collaborative settings and the outcomes they achieve contributes to a lack of understanding of the diverse pathways by which they may promote systems change.

Fourth, previous research on collaborative settings has been criticized for narrowly relying on quantitative methods and several researchers have recommended expanding their approach to research by using qualitative methods to address the methodological obstacles highlighted above (Allen et al., 2008; Berkowitz, 2001; Cashman et al., 2001; Foster-Fishman et al., 2001). For instance, some researchers have suggested that evidence for the effectiveness of collaborative settings may be weak because researchers have not used the appropriate methods

when evaluating these settings (Berkowitz, 2001). Specifically, conventional evaluations relying on quantitative methods may be too dull to detect precise successes or failures (Berkowitz, 2001). Building on this argument, other researchers have noted that although qualitative methods have rarely been employed in the study of collaborative settings, the complex, varied, and dynamic nature of these settings make them natural candidates for qualitative research (Cashman et al., 2001). Specifically, researchers have advocated for employing qualitative methods as a single methodology or in combination with quantitative methods when studying collaborative settings (Granner & Sharpe, 2004). Therefore, qualitative methods have the potential of addressing the limitations of previous research highlighted above by providing an in depth understanding of collaborative settings, by explaining the diversity of these settings, and by exploring the connection between the nature of these settings and their ability to promote systems change.

Current Study

To summarize, despite the rapid and widespread development of domestic violence fatality review teams, there is limited knowledge about how these teams work, as well as whether and how this work ultimately translates to systems change or helps to prevent future intimate partner femicides. Therefore I decided to study domestic violence fatality review teams in greater depth, using methods designed to overcome the limitations identified in past research on collaborative settings. The current study had two goals. The first goal was to provide a detailed description of teams in terms of their goals, processes, structures, and outcomes. The second goal was to identify the major tensions or issues faced by teams as a way of revealing what implicit and explicit processes may shape the ultimate form that teams take. A more detailed discussion of these goals follows.

Description of teams

It is critical to obtain a thorough understanding of the specific nature of collaborative settings to obtain a realistic sense of what outcomes can be expected of them and to avoid making erroneous assumptions of what they are positioned to accomplish (Allen et al., 2008; Berkowitz, 2001; Kegler et al., 2001). Due to the rapid growth in the number of domestic violence fatality review teams and the relative absence of research in this area, little is known about the nature of these teams and what they accomplish. What is known is based primarily on the writings of individual committees themselves, as well as descriptions by others (e.g., Websdale, 2003). But none of these documents is comprehensive (e.g., surveys multiple domestic violence fatality review teams), systematic (e.g., collects standardized information about domestic violence fatality review teams), or detailed (e.g., provides an in depth description of domestic violence fatality review teams). The absence of comprehensive, systematic, and detailed information about domestic violence fatality review teams makes it difficult to explore the potentially heterogeneous nature of these collaborative settings and their efforts to promote systems change.

Although the vast majority of reports prepared by domestic violence fatality review team emphasize the similarities of these collaborative efforts (e.g., e.g., Delaware Fatality Incident Review Team, 2001; New Mexico Female Intimate Partner Violence Death Review Team, 1998), assertions by some professionals suggests that they may differ in important ways with respect to such things as their underlying philosophy, what they aim to accomplish, where they are established, who is included as members, how they review cases, and what recommendations they make (Websdale 2003; Websdale et al., 1999). These differences may have implications for the ability of domestic violence fatality review teams to promote systems change. For instance,

teams may have access to different amounts or types of information which could affect what types of recommendations are made by teams. Alternatively, teams may be established in different geographical regions which could influence whether recommendations are directed at a state or county level. Furthermore, teams may have access to varying amounts of funding which could impact on the time and resources members are able to invest in implementing recommendations. These examples are just a few of many possible differences between domestic violence fatality review teams that could have implications for systems change that have yet to be revealed. Therefore, obtaining an in-depth understanding of the nature of these teams is essential for informing any evaluation of the effectiveness in these efforts in promoting systems change. Furthermore, obtaining rich information about these collaborative settings may further our understanding of the implications of potentially diverse goals, structures, processes and outcomes of other collaborative settings.

Identification of tensions

As previously highlighted, past research on collaborative efforts has described what these settings look like but failed to explain why they look this way (Cashman et al., 2001). The establishment of domestic violence fatality review teams is likely the result of a series of conscious and unconscious decisions about what teams should be designed to accomplish and how they should operate to do so. During the course of their development teams may be forced to make choices between alternative courses of action that each have their relative costs or benefits. These dilemmas or tradeoffs are often referred to as *tensions* or *issues* in the research literature (Stake, 1995, 2006). Identification of tensions is commonly used as a means of understanding individuals, relationships, settings, and systems (Baxter & Montgomery, 1996; Stake, 2006). One of the primary strengths of tensions is that they inherently draw attention to

the complexity of a setting by focusing on concerns and problems (Stake, 1995). A great deal can be learned about a setting by observing how it struggles against constraints and copes with problems (Stake, 1995). Researchers argue that the nature of settings may become more transparent during these struggles (Stake, 1995) and that the resolution of these tensions may be essential to the change and growth of settings (Baxter, 1990).

The importance of issues or tensions for domestic violence fatality review teams was recognized at an annual conference where one of the primary topics of discussion was the implications of “thorny issues”, such as who should be included as a member on the team and what information should be shared among members (Johnson, 2005). These issues or tensions were considered important to address at this conference because they were perceived to have potential repercussions how teams were set up and what they accomplished. For instance, the issue of whether perpetrators of intimate partner violence should be included as members of teams was the source of heated discussion. Where teams fell on this issue appeared to have implications for their goals, structures, processes and outcomes, such as who would be willing to attend the meetings and what type of information would be shared. This debate highlighted that the dilemmas teams face and the choices they make may provide important explanatory accounts of the nature of these collaborative settings. Consequently, identifying the critical tensions faced by domestic violence fatality review teams and investigating differences in how teams navigate these tensions may increase understanding of potential diversity across teams with respect to how these teams operate and promote systems change. In addition, this type of analysis may further our understanding of similar processes underlying other collaborative settings which may account for potential variation across settings.

The current study examines the collaborative efforts of domestic violence fatality review

teams to better understand the nature of these teams and their efforts to promote systems change. Although this study focuses on domestic violence fatality review teams it has potential implications for all collaborative settings. There are several strengths of this study that build on previous research of collaborative settings. This study uses qualitative methods to obtain a more detailed and nuanced understanding of these settings than traditional quantitative methods have provided (Allen et al., 2008; Berkowitz, 2001; Cashman et al., 2001; Foster-Fishman et al., 2001). Qualitative methods are particularly well suited for obtaining in-depth information about everyday activities and revealing the assumptions and challenges underlying practices (Neuman, 2002). In this study qualitative methods were used to describe the goals, structures, processes and outcomes of domestic violence fatality review teams and to identify the critical tensions or issues navigated by these collaborative efforts. These methods will advance our understanding of collaborative settings by providing an in-depth understanding of potentially diverse and complex nature these settings, developing a potential explanatory account of these settings, and creating a foundation for future research examining the connection between the nature of these settings and their ability to promote systems change.

METHOD

Overview

The current study employs qualitative methods to examine the collaborative efforts of domestic violence fatality review teams to better understand the nature of these teams and the tensions or issues underlying their work. The study consisted of three phases. The first phase involves a review of relevant literature, discussion with experts in the field, and anecdotal experiences of team members. The second phase involves in-depth interviews with key informants and review of the most recent reports of 35 teams in the United States and Canada to gain a systematic understanding of their goals, structures, processes, outcomes and tensions. The sample includes at least one team from every state or province in which they were active at the time of the research was conducted, allowing for an examination of a wide variety of teams from different geographical regions. Data collection for the second phase of the research took place between June 2006 and October 2006. The third phase involved case studies of a subset of 3 domestic violence fatality review teams to obtain rich descriptive information about them and multiple perspectives regarding the tensions or issues underlying their work. These teams were selected for a variety of reasons including representing diverse approaches to conducting reviews, serving as strong exemplars of one or more tensions or issues, and covering different geographical regions, physical areas, and levels of urbanization. Data collection for the third phase of the research took place between September 2006 and December 2006.

Phase One

The first phase of the study involved a form of reconnaissance to heighten my understanding of these teams and to increase the possibility of successful recruitment to this study. As part of my involvement in a study investigating intimate partner femicides in British

Columbia in 2001, I conducted a review of various strategies used to understand and prevent intimate partner femicides (Watt et al., 2004). One of the strategies reviewed and which we recommended be established in the province was domestic violence fatality review teams. The few reports published by domestic violence fatality review teams and articles written about these collaborative efforts at that time provided me with a basis for beginning to explore the potential diversity of these teams and the tension or issues they faced. Partly as a consequence of the barriers we faced establishing a domestic violence fatality review team in the province and partly due to my growing knowledge of and experience with collaborative settings, I became very interested in learning more about the how these teams were established and what they accomplished.

By the time I proposed to conduct this study for my dissertation, I had become increasingly aware of some of ways in which violence fatality review teams varied as a consequence of reviewing several additional reports prepared by teams and articles that had been written about these settings. For instance, teams had a variety of goals such as identifying homicides resulting from intimate partner violence, examining risk factors and system failures contributing to the homicides, and changing the system response to intimate partner violence. In addition, teams had different structures for organizing their members including using a two-tiered or structure or a one-tiered structure. The knowledge I gained of the diversity across teams informed my thinking of the tensions or issues teams may face while conducting their work. Specifically, at this point in time I hypothesized that domestic violence fatality review teams faced potential tensions related to their underlying philosophy (e.g., no blame or shame versus accountability), their primary objectives (e.g., identification versus prevention), their information sharing guidelines (e.g., individual right to privacy versus public right to information) , and their

organizational structure (e.g., hierarchical versus horizontal). However, I was open to and expected that these tensions would change as I gained additional information about these settings.

My understanding of the potential diversity of teams and the tensions or issues they faced was further refined by my contact with experts in the field and attendance to relevant conferences. Specifically, in June 2005, I contacted Dr. Neil Websdale, a leading expert in the field of domestic violence fatality review teams, to inform him of my study and to discuss possible recruitment strategies. Dr. Websdale was the former director of the National Domestic Violence Fatality Review Initiative (NDVFRI), a clearinghouse and resource center for domestic violence fatality review teams. At the time of our conversation, Dr. Websdale was a member of the advisory board of the NDFVRI and was very active in providing training for both emerging and existing teams across the United States and Canada. Dr. Websdale was very supportive of the study and provided me with advice regarding how to obtain the most comprehensive list of active teams, how to approach the teams (e.g., letter, telephone, email), and how to structure my data collection (e.g., questionnaire, interview). Dr. Websdale said that, in his view, domestic violence fatality review teams were incredibly heterogeneous and experienced several common tensions or issues. In addition to the tensions or issues I had previously identified, Dr. Websdale reported observing teams struggle with the membership of the teams (e.g., grassroots versus professional), the method use to collect and analyze information (e.g., biography versus epidemiology), and the implications of the teams findings (e.g., surveillance versus social control). This conversation served to both clarify and expand the list tensions I had previously identified when reviewing relevant literature.

Following our discussion, Dr. Websdale invited me to attend the National Domestic

Violence Fatality Review Initiative Conference in August 2005. This was an annual conference hosted by the NDVFRI that provided a forum for domestic violence fatality review teams at all stages of their development to learn about the practices of other teams and to discuss relevant issues related to their work. As previously mentioned, this particular conference focused on reflecting on lessons learned by conducting domestic violence fatality review teams, discussing “thorny” issues that arose in the course of their work (e.g., bad victim blaming, female perpetrators, membership, and confidentiality), and exploring how the practice of violence risk assessment and management could contribute to understanding and preventing domestic violence fatalities. While attending the conference I was formally introduced to all of the key note speakers and a general announcement was made by the director of the NDVFRI about the research I planned to conduct in the future. I took comprehensive notes throughout this conference based on my observations of session and workshops and conversations with team members from various teams paying particular attention to tensions or issues. Attending the conference was particularly important for reinforcing the importance of tensions related to the membership (e.g., betterment versus empowerment) and information sharing (e.g., freedom of information versus individual right to privacy) of teams given that these were two of the primary “thorny issues” raised.

A final list of tensions was developed for the purpose of conducting the in depth interview in phase two of the study on the basis of all of the information gathered from the review of the literature, consultation with experts, and anecdotal experiences of members. These tensions were selected for framing the analysis due to the breadth of diverse struggles they were able to capture, the frequency with which they arose across different sources of information, and their association with goals, structures, processes and outcomes. Specifically, these tensions

included the extent to which teams emphasized (1) *no blame or shame* versus *accountability* as their underlying philosophy, (2) *freedom of information* versus *individual right to privacy* as their information sharing practices, (3) *betterment* versus *empowerment* as the means by which they are structured, (4) *biography* versus *epidemiology* as the method used to collect information, and (5) *understanding* versus *action* as the model used to promote systems change.

My review of reports prepared by teams and articles written about these collaborative settings, as well as my discussion with Dr. Websdale and attendance to the conference served to greatly increase my knowledge of the potential diversity of goals, structures, process, and outcomes of domestic violence fatality review teams. These experiences also helped to further my understanding of some of the critical tensions or issues teams grappled with while conducting this work. The advice I was given regarding how best to approach teams to invite their participation and the formal introductions and personal connections that were made at the conference also likely contributed to the success of my recruitment of teams to take part this study. Teams requested to be acknowledged as participants in this study to facilitate awareness of and communication among teams. Table 1 in Appendix A provides a list of participating domestic violence fatality review teams.

Phase Two

Sample/Participants

Domestic violence fatality review teams. The second phase of the study examined the collaborative efforts of 35 domestic violence fatality review teams in the United States and Canada. At least one team was recruited from each of 28 states in the United States and 1 province in Canada in which teams were operating at that time. When a state or province had more than 5 active teams, 2 to 3 teams were invited to take part in the study. All 35 teams that

were invited to take part in the second phase of the study agreed to participate. The “age” of participating domestic violence fatality review teams ranged between 5 months and 141 months (12 years, 9 months), with an average age of 54 months (4 years, 5 months).¹ The teams that participated in this study varied in size between 7 and 65 members, with an average of 24 members. For the vast majority of teams (86%) this estimate was based on the number of members listed in the most recent report prepared by each team. For the remaining teams that had not yet prepared a report (14%), this estimate was based on the interview with key informants. In general, key informants often reported a smaller number of active members during the interviews, with an average of 19 members. The discrepancy between the numbers of members indicated in the report and the interview was most likely due to the fact that key informants were either relying on their best estimate of the number of members in their team or had access to more recent information about changes to the membership of their team.

The organizations included on each team varied, however the vast majority of members fell within the following categories.² Within the criminal justice sector, 100% of teams included representatives from law enforcement, 91% from the prosecuting attorneys office, 77% from corrections, 49% from judiciary, 43% from legal aid, 43% from criminal justice based victim services, 34% from court services, 34% from batterer’s intervention programs, and 9% from criminal defense attorneys. An additional 34% of teams included representation from a variety of “other” criminal justice organizations (e.g., family court, child advocacy). Within the health sector, 80% of teams included representatives from health services, 71% from the coroners or medical examiners office, 63% from social services, 60% from family services, 57% from

¹ “Age” was calculated by subtracting the date the teams began reviewing cases from the date of the interview.

² Members were categorized based on the organization they were affiliated with as opposed to their position within the organization.

mental health services, and 23% from diversity focused services. An additional 23% of teams included representatives from a variety of “other” health organizations (e.g., Department of Community Affairs, Mayor’s Office to Combat Domestic Violence). Community based organizations included representatives from community based victim services (86%), domestic violence coordinating councils (66%), higher education and research institutions (43%), primary and secondary education (23%), private consultants (22%), religious organizations (11%), and politicians (9%). Very few teams included a community member (6%), such as a victim of domestic violence or a family member of a victim of intimate partner homicide, as a formal member of the team.

Key Informants. The second phase of the study explores the responses of 42 key informants and the contents of their team’s most recent reports. Because I was interested in obtaining an in depth understanding of the goals, structures, processes, outcomes, and tensions of domestic violence fatality review teams, I asked to speak with at least one member who was familiar with the history and day to day operations of the team. No limitations were placed on the number of members that took part in the interview, the position they held on the team, or their organizational affiliation. The number of key informants taking part in the interview ranged from one to three members, but in the vast majority of cases only one key informant from each team took part in the interview. Specifically, 37% of key informants included were chairs or co-chairs, 37% were coordinators, 14% were general members, 9% were staff members, and 3% were executive committee members. Member participation on the teams ranged between 5 months and 141 months (11 years, 9 months), with an average of 54 months (4 years, 5 months). The majority (67%) of key informants had been members since the inception of the team.

Key informants represented a wide range of organizations from the criminal justice, health, and community based organizations. Specifically, 23% of key informants were from the prosecuting attorneys office, 14% from domestic violence coordinating councils, 11% from health services, 11% from law enforcement, 11% from “other” health organizations (e.g., government office or division), 9% were private consultants, 6% from coroners or medical examiners offices, 6% from higher education and research institutions, 3% from legal aid, community victim services, and “other” criminal justice (e.g., family court) organizations respectively.

Procedures/Data Collection

Recruitment. For the purposes of this study I considered domestic violence fatality review teams that were active at the time of recruitment (e.g., having meetings and reviewing cases). A list of active teams was developed based on consultation with the National Domestic Violence Fatality Review Initiative. The National Domestic Violence Fatality Review Initiative maintains a list of teams with their contact information which is updated on an annual basis. Due to the ongoing emergence of new teams, this list was supplemented with discussions with experts in the field and a comprehensive internet search. As previously mentioned, at the time of compiling the list in April 2006, 28 states and 1 province had established at least one domestic violence fatality review teams – with approximately 75 teams in total (Websdale, 2003). Teams were purposively sampled in order to obtain a representative sample of the diverse goals, structures, processes, outcomes, and tensions across geographical regions. Specifically, at least 1 active team from every state and province was invited to take part in the study. However, when a state or province had more than 5 active teams, 2 to 3 teams were invited to take part in the study in order to obtain a sample of the potential diversity of teams within the state or province.

To begin the data collection process a recruitment letter was sent to the contact person for the team, informing them about the purpose of the study, describing what the team's participation would involve, and requesting their participation (see Appendix B for recruitment letter sent to the contact person). Within two weeks of sending the letter, a phone call was made to request the participation of the team and to answer any questions the contact person may have (see Appendix C for the telephone script for contact person). If the contact person indicated that the team would be willing to take part in the study, he/she was asked to identify the most appropriate person for the key informative interview (i.e., the person who was familiar with the history and day-to-day operations of the team). If the contact person was the most appropriate individual identified, an interview time was set for his/her key informant interview. If the contact person identified another team member as the most appropriate individual to take part in the key informant interview, the contact person was asked to provide the contact information for this individual. A second telephone call was then made to the individual identified by the contact person to request his/her participation and to set up an interview time if they were willing to participate (see Appendix D for the telephone script for key informant). A copy of the informed consent was either mailed or e-mailed to each key informant prior to the interview (based on their preference) and was read to them at the time of the interview (see Appendix E for copy of informed consent for the key informant for the second phase of the study). Key informants were specifically asked if they would like a copy of the transcribed interview and a final report summarizing the findings to be sent to them.

Key Informant Interview. Each key informant was called at the time agreed upon during recruitment to take part in an in-depth interview (see Appendix F for interview protocol for key informant). In-depth interviewing is well suited for this study because this method seeks to

obtain detailed information and understanding about everyday activities, to reveal the assumptions underlying practices, and to articulate multiple perspectives about an activity. In-depth interviews are semi-structured in nature to allow for additional questions to evolve within or between interviews (Johnson, 2002). In this study, the in-depth interviews lasted approximately two hours and consisted of two major sections.

The opening section of the interview was designed to address the first research question of the study by exploring the goals, structures, processes, and outcomes of each domestic violence fatality review team. The questions about the goals, structures, processes, and outcomes were informed by previous research on characteristics considered important when evaluating collaborative settings (e.g., Roussos & Fawcett, 2001; Foster-Fishman et al., 2001). Within this section, key informants were asked general questions regarding their involvement on the team and context in which the team was developed (e.g., facilitators and barriers). Following this, key informants were asked more specific questions about the primary goals and values of the team, how they were structured (e.g., location, leadership, membership, reporting), what their case review process involved (e.g., data collection, data analysis, and dissemination), and what their team had accomplished (e.g., improved relationships, increased knowledge, changes to policies and procedures).

The concluding section addressed the second research question directly by examining the critical tensions or issues underlying the work of each domestic violence fatality review team. As previously mentioned, five critical tensions or issues were identified based on consideration of the information that emerged during the first phase of the study through a review of reports and articles regarding domestic violence fatality review teams and collaborative efforts, consultation with experts in the field, and attendance to the National Domestic Violence Fatality Review

Initiative Conference. Specifically, key informants were asked about the extent to which their team emphasized (1) *no blame or shame* versus *accountability* as their underlying philosophy, (2) *freedom of information* versus *individual right to privacy* as their information sharing practices, (3) *betterment* versus *empowerment* as the means by which they are structured, (4) *biography* versus *epidemiology* as the method used to collect information, and (5) *understanding* versus *action* as the model used to promote systems change.

However, I recognized that this list was flexible and might change or evolve over the course of the study. Therefore, prior to asking questions about the tensions or issues that I had identified in advance, teams were invited to discuss any tensions they dealt with in order to increase the likelihood that additional tensions could emerge. In response to this question, half of teams (54%) identified tensions they faced in the course of the work. However, some of the tensions mentioned appeared to be challenges faced by teams rather than tensions they struggled with given that the issue could not be characterized as a dilemma or tradeoff. For instance, some teams reported difficulty carrying out their work due to lack of funding or struggling with the emotional impact of the review process. In addition, other tensions identified by teams appeared to be specific conflicts between members as opposed to more general tensions faced by the team. Specifically, teams reported a variety of disagreements due to existing politics between different agencies or as a function of working in a multi-disciplinary team. Furthermore, additional tensions described by teams appeared to be subcomponents of one of the broader tension already identified in the study. Specifically, debates about who is a member of the team and where the team is based were associated with the tension of *betterment* versus *empowerment*.

Document Review. Prior to conducting each key informant interview, the most recent report prepared by the team that was available at the time of recruitment of the key informant

was downloaded from the internet and reviewed. As previously mentioned, teams often make reports available to the public that describes their work, summarizes their findings, and outlines their recommendations for systems change (Thompson, 2006). These reports provide a wealth of information about the goals, structures, processes, and outcomes of the team that is particularly relevant for the first research question of this study. The primary purpose of systematically reviewing these reports was as a means of preparing myself for the in depth interviews by gaining an understanding of the team in advance and as a means of gaining additional information of the team that could be used to compare, contrast or supplement information provided by the key informant. The vast majority of domestic violence fatality review teams that took part in this study had published at least one report prior to the key informant interview (86%). The year of publication of the reports ranged from 2001 to 2006, with an average year 2004. Overall, reports were very comprehensive ranging from 4 to 130 pages, with an average of 44 pages per report.

Phase Three

Sample/Participants

Domestic Violence Fatality Review Teams. The third phase of the study involved case studies of a subset of 3 domestic violence fatality review teams from the second phase of the study. All 3 teams that were invited to take part in the third phase of the study agreed to participate. I will refer to these teams as *Team A*, *Team B*, and *Team C*. Although efforts were taken to protect the confidentiality of these domestic violence fatality review teams, each team was made aware that they might be identifiable due to characteristics associated with their team. For instance, the geographical location of their team might give away their identity due to the fact that there may have only been one team in the state or province in which they were located.

All three domestic violence fatality review teams agreed to take part in this study knowing this was a possibility.

Team A was a county team located in the Northeast region of the United States.³ This team was 102 months old (8 years, 6 months) and led by a group of core leaders. Although there were 46 official members on *Team A*, an average of 20 members attended meetings on a regular basis. The members consisted of a fairly balanced representation of organizations from the criminal justice, health, and community sectors. Specific organizations represented included law enforcement, prosecuting attorneys office, legal aid, criminal justice based victim services, “other” criminal justice organizations (e.g., family court), mental health services, health services, social service, family services, community based victim services, domestic violence coordinating council, diversity services, and a private consultant.

Team B was a state wide team located in the Western region of the United States that was 37 months old (3 years, 1 month) at the time of taking part in the study and coordinated by a single leader. There were 17 official members on this team, all of whom consistently attended meetings. The members of *Team B* represented slightly more organizations from the criminal justice sector than the health sector or community sector. Particular organizations represented included law enforcement, corrections, judiciary, prosecuting attorneys office, legal aid, batterers intervention programs, mental health services, health services, family services, community based victim services, a private consultant, and a politician.

Team C was a province wide team located in the Eastern region of Canada that was 41 months old (3 years, 5 months) and chaired by a single leader. There were 18 official members of this team, all of whom consistently attended meetings. In contrast to *Team B*, the members on

³ Official regions for the United States and Canada were used to describe the geographical location of the teams (e.g., as specified by the United States Census Bureau).

Team C represented slightly more organizations from the health sector than the criminal justice sector or community sector. The organizations represented by the members of the team included law enforcement, corrections, prosecuting attorneys office, coroners office, health services, domestic violence coordinating council, other coordinating council, diversity services, other health organizations (e.g., non-profit society), higher education and research institutions, and a private consultant.

Procedures/Data Collection

Recruitment. These 3 teams were purposely selected for the third phase of the study for a variety of reasons. First they appeared to represent diverse approaches to conducting domestic violence fatality reviews. For instance, *Team A* collected in depth information about a small number of cases, *Team B* collected general information about a large number of cases, and *Team C* used a combination of these approaches. Second, they appeared to serve as strong exemplars of one or more of the issues or tensions identified in the first and second phases of the research. Specifically, *Team A* appeared to most strongly emphasize *Individual Right to Privacy* and *Epidemiology*, *Team B* appeared to most strongly emphasize *No Blame or Shame* and *Biography*, and *Team C* appeared to most strongly emphasize *Betterment* and *Understanding*. Third, teams varied with respect to the geographical region in which they were located (e.g., Northeast, South, Midwest and West), and the physical area (e.g., state, county) and level of urbanization (e.g., urban, rural) covered by their reviews. The selection of these teams was based primarily on the information gathered in the second phase of the research, but was also influenced by knowledge gained of the nature of these teams and the personal connections made with these teams during the first phase of the study. This type of sampling strategy is consistent with case study methodology in which atypical cases as opposed to average cases are selected in order to provide

the richest possible information about tensions or issues (Stake, 1995).

To recruit the teams, a phone call was made to the key informant who had taken part in the semi-structured interviews to inform them about the purpose of the case study, describe what the teams participation would involve, and request their participation. The key informant was given the opportunity to discuss the study with the other members of the team prior to providing the teams consent to participate. When the key informant indicated that the team would be willing to take part in the case study, a letter was sent by mail or e-mail to provide the team with additional information about the study (See Appendix G for copy of information letter). Once the date for the case study was confirmed, a package of informed consent forms were mailed or e-mailed to the key informant for the members of the team to review and return prior to taking part in the case study. (See Appendix H for copy of informed consent for key informant and Appendix I for informed consent for members for the third phase of the study.) Key informants were sent a slightly different version of the informed consent forms from the other members of the team. All members were asked to indicate whether they were willing to participate in a brief interview and to be observed and audio-taped.

Case Study. The purpose of the 3 case studies was to obtain rich descriptive information about the process used by the team to promote systems change and to gather multiple perspectives about the tensions or issues that may account for how the team was set up and what it achieved. The strength of a case study is that it draws attention to the complexity of issues by highlighting multiple perspectives, instead of converging on a single perspective (Stake, 1995). Triangulation of different sources of information is used as a strategy for confirming a shared meaning of an observation and for illustrating how different people may interpret an observation in different ways (Stake, 1995). Therefore, multiple methods were used in these case studies,

including reviewing relevant documents, observing and documenting daily practices and procedures, and conducting interviews with several members of the team.

Document Review. Prior to conducting the site visit, documents were reviewed to gain additional information about the goals, structures, processes, and outcomes of each domestic violence fatality review team. The documents reviewed varied according to site and what written information was available. Whereas the most recent report prepared by each team was reviewed in the second phase of the study, all of the reports prepared by each team chosen for the case study were reviewed in the third phase of the study. By reading all of the reports prepared by each team it was possible to gain additional contextual information about the development of the teams and to observe how the goals, structures, processes, or outcomes of the teams may have changed over time. In addition, it was important to not rely solely on the most recent report prepared by the team as earlier reports tended to include copies of additional materials used by the teams such as confidentiality agreements, relevant legislation, and coding forms.

The published reports reviewed in this study consisted of 6 reports for *Team A* released in 2000, 2001, 2003, 2004, 2005, and 2006, 1 report for *Team B* released in 2005, and 3 reports for *Team C* released in 2002, 2004, and 2005. Beyond the prepared reports, each team was given discretion when determining what additional documents could be reviewed. Specifically, *Team A* provided a blank copy of a form used to help structure the process of making recommendations. *Team B* provided a copy of the state legislation, a news release regarding the formation of the team, and interview notes and file information for the upcoming case review. *Team C* did not provide any additional documents beyond their published reports.

Observations. Additional data was collected through observations of the daily practices and procedures of the 3 domestic violence fatality review teams. Specifically, a site visit was

arranged with each of the teams to observe one of their case review meetings and any additional meetings that occurred during the timeframe of the visit. The primary meeting of domestic violence fatality review teams is the case review meeting, where teams meet on a regular basis to collectively review cases of intimate partner femicide. This case review meeting typically involves some form of reviewing the case material, identifying risk factors or gaps in the system response, and developing recommendations for systems change. However, how teams approach this task and how much emphasis they place on each step may vary across teams. Although this is the primary meeting of the domestic violence fatality review teams, some teams hold other types of meetings for the purposes of planning, report writing, or implementing recommendations on a less regular basis.

For the purposes of this study, the case review meeting was observed for each of the 3 teams. When another type of meeting was scheduled during the time frame of the site visit, this meeting was also observed. Specifically, a risk assessment subcommittee meeting was observed during the site visit of *Team C*. Site visits occurred in the fall of 2006 and included a two to three-day visit at each site. While observing the teams, I took care not to interrupt daily routines by taking notes while sitting outside of the group and attempting not to participate in team discussions when possible. Team members appeared to be comfortable with my attendance to their meetings and their practices and procedures did not appear to be significantly influenced by my presence. This inference is based both on my own observations regarding the group dynamics and informal feedback I received from team members during interviews.

Interviews. I developed a semi-structured interview to be conducted with several members from each team (see Appendix J for interview protocol for members). Aside from some opening questions about the member's involvement on the team, the interview focused entirely

on discussing tensions and issues explored during the second phase of the study. There were several reasons for the modifications to the interview. First, the questions about the goals, structures, processes and outcomes of the team were removed from the interview because a great deal of information had already been collected about these areas between the interview with the key informant in the second phase of the interview and the review of all of the prepared reports. Second, the questions about tensions were maintained due to their potential importance for understanding the diversity of teams and their potential for systems change. Third, information about the tensions appeared to involve much more interpretation and subjectivity than information about the goals, structures, processes and outcomes of the teams. Therefore, the goal of the interview was to gain additional information and multiple perspectives about the tensions underlying each team's efforts to promote systems change. Members often had similar opinions about what side of each tension they believed their team actually emphasized, but sometimes had different opinions about what side of each tension they believed their team should emphasize. Although, the types tensions explored were consistent with those covered in the second phase of the research, minor revisions were made to the standard set of questions asked about each tension based on what had been learned during the second phase of the study. Specifically, a short introduction about the nature of the tensions was added, the description of the tensions was modified to better characterize the experiences of the teams, the number of questions asked about each tension was reduced, and the wording of each question was simplified.

Team members were intentionally selected to participate in interviews within each case study based on the extent to which they were likely to provide diverse perspective regarding the work of the team and the issues or tensions they faced. Evidence of potentially diverse perspectives was gathered through consideration of their professional affiliation, conversations

with the key informant, and observations of the review meeting. Members were given the option of taking part in the interview individually or collectively. Interviews lasted approximately one hour and were conducted with members of each team either during or following my site visit, based on the members preference. Interviews were conducted with 4 members from *Team A*, 3 members from *Team B*, and 5 members from *Team C*. While conducting the interviews, I paid particular attention to consistent or inconsistent ideas about the issues or tensions the team faced and how these contributed to their efforts to promote systems change. I also disclosed information about what I had learned from other teams about the tensions or issues in order to compare and contrast the member's perspective with other perspectives. This participatory style seemed to personalize the interview, foster engagement in the interview, and to elucidate the issues of interests.

Data Analysis

Goals, Structures, Processes, and Outcomes. The current study employed a qualitative approach to analyzing the data drawing from a variety of approaches. A combination of frequency analysis and content analysis were used to analyze the goals, structures, processes and outcomes of domestic violence fatality review teams. Frequency analysis was used to examine categories for goals, structures, processes and outcomes that required little interpretation and were defined in advance. For instance, frequency analysis was used to summarize what type of authority the teams were established under (e.g., legislative authority, statutory authority, executive orders, memorandum of understanding, interagency agreement), how often teams met to review cases (e.g., monthly, bi-monthly, quarterly, semi-annually, and irregularly), and what process teams used to analyze data (e.g., statistical programs, timelines, narratives). Frequency analysis involves the calculation of the frequency or proportion with which something occurs.

For this study, this process involved coding all of data from the transcripts based on the key informant interviews and from the document review of the most recent reports into the predefined categories and entering the data using SPSS data analysis program.

Content analysis was used to examine categories for goals, structures, processes and outcomes that required more interpretation and were not defined in advance. For example, content analysis was used to examine common themes with respect the primary goals of domestic violence fatality review teams as well as the types of recommendations made by teams. Content analysis refers to the process in which messages are systematically analyzed to uncover common themes (Berg, 1995, 2004). Applied to this study, this process involved reviewing all of the verbatim transcripts by the key informants and the most recent report prepared by teams and creating a set of themes that captured the range of categories for relevant goals, structures, processes, and outcomes. When the initial set of themes was too numerous or redundant, a second set of themes was created which more parsimoniously captured the data. For instance, the set of themes which captured the goals of the teams was reduced from six to three. Once the set of themes was finalized all of the transcripts were coded to examine whether each theme was present (yes or no) and to enter the verbatim into relevant theme using QSR's NVivo 8 qualitative software program (QSR, 2008).

Tensions or Issues. Components of case study analysis were used in this study to examine the tensions or issues experienced by domestic violence fatality review teams. The ultimate goal of case study analysis is to increase understanding of a setting or group of settings by illuminating tensions or issues (Stake, 1995; 2006). Although tensions or issues for framing the analysis are typically developed before data is collected, they are considered flexible and expected to change or evolve over the course of the study. The primary strength of case study

analysis is that it draws attention to the complexity of settings by highlighting multiple perspectives, instead of converging on a single perspective. Capturing divergent perspectives is accomplished through the collection of data from multiple sources of information (e.g., interviews, observations, document review). Ongoing triangulation of these different sources of information over the course of the study is used for confirming the shared meaning of an observation and for illustrating how different people may interpret an observation differently. Although important meanings can come from direct interpretation of a single observation, they typically come from aggregation across multiple observations. Analyses are commonly organized in a descriptive or narrative fashion to provide readers an opportunity for vicarious experience of the cases. For instance, vignettes are often used to summarize observations as a means of illustrating tensions and forming the basis of assertions. Within this study, 3 vignettes were used to capture observations of the case review meetings for each case study to provide a glimpse of the context of the meeting, the process used to review cases, and to means by which recommendations were developed. The case review meeting was chosen as the focus of the vignettes because they are the most common means by which teams attempt to promote systems change and the most accessible setting in which tensions were likely to be observed. These vignettes will be dispersed at the beginning, middle, and end of the results section to provide tangible illustrations of the work of teams.

As previously described, a set of five critical tensions or issues were developed and refined based on consideration of information that emerged during the first phase of this study. These tensions were selected for framing the analysis due to the breadth of diverse struggles they were able to capture, the frequency with which they arose across different sources of information, and their association with goals, structures, processes and outcomes. Although these

tensions were developed in advance they were open to changing or evolving over the course of the study based on the subsequent analysis of information that was collected from multiple sources including observation or team meetings, review of annual reports, and interviews with one or more members of the team. Triangulation of these different sources of information was used both to confirm and disconfirm the presence and relevance of these tensions or issues and to illuminate the complexity and implications of these struggles. A particular emphasis was placed on comparing and contrasting the verbatim transcripts across teams using QSR's NVivo 8 qualitative software program (QSR, 2008). Based on the considerable information confirming these tensions, the limited information disconfirming these tensions, and the lack of information supporting additional tensions, the five tensions identified a priori appeared to be critical tradeoffs teams make or dilemmas they face that may account for their goals, structures, processes and outcomes.

Due to the interpretive nature of qualitative methods and the fact that the author was the primary person conducting the analysis, several strategies were taken to increase the credibility of the qualitative analysis (e.g., Guba & Lincoln, 1994; Lincoln & Guba, 2000; Stake, 1995; 2006). First, during the first phase of the study, the identification of the goals, structures, processes, outcomes, and tensions were firmly grounded in reports prepared by teams, articles written about collaborative efforts, and discussions with experts and members in the field. Second, efforts were made while conducting interviews and case studies to foster flexibility with respect to the tensions that had been identified in advance by allowing for additional tensions to emerge from the data. Third, throughout the process of analysis, triangulation of different sources of information was used as means of confirming and disconfirming whether emerging themes and tensions were supported by multiple data sources. Fourth, member checks were

conducted with multiple domestic violence fatality review teams and experts in the field to obtain feedback about the extent to which the findings reflected their own impression and experiences. While there are many ways to increase the credibility of qualitative analysis, these strategies were tailored to the specific methods used in this study and helped to ensure that the presentation of findings provided a good representation of the data.

RESULTS

Team A Vignette

Florescent lighting illuminates the large board room with decorative pictures hanging from the white walls. A large national flag hangs from a pole standing at the front the room and is surrounded by several pots of imitation flowers. A long table runs down the length of the room that is surrounded by burgundy upholstered wood chairs, with additional chairs scattered around the edge of the room. Twenty two team members are seated around the table identified by name tags and representing a wide variety of agencies. Many arrive to the meeting late or leave the meeting early through two black doors with netted windows at either end of the room. A clock hangs prominently above one door near the front of the room. Various papers, folders, and binders belonging to the members are scattered around the table, including copies of a paper that has been distributed summarizing the neighborhoods in which women are at highest risk of domestic violence-related deaths. From her position at the head of the table, the coordinator sets the tone of the meeting by reinforcing how important it is to share what the data look like so that members can decide what they want to do personally. The team has just finished rapidly reviewing sixteen domestic violence-related cases within the span of one hour and fifty minutes by contributing information about the case from their respective agency files. The medical examiner and police officer share consistent information about the case about the cause and manner of death while other team members used their discretion when providing information related to the nature of past contacts with their agencies. One member of the team who is responsible for documenting information on a standard coding form frantically tries to keep up with the seamless stream of information shared by the members. The coordinator informs the team members that they have nine minutes remaining to review policy issues. Several members report seeing trends across the cases including victims who had a history of domestic violence, were young mothers, and experienced substance use problems. Others note the absence of contact with either domestic violence or substance use services and the gaps between different services in providing care. Some members argue for the need for education and training in the community and across different systems. The coordinator closes the meeting by handing out a flyer for a public discussion entitled, “Caught in the Crossfire: Children and Domestic Violence” and encourages members to participate.

Goals, Structures, Processes, and Outcomes

The following section describes the goals, structures, processes and outcomes of domestic violence fatality review teams. As described earlier, a detailed description of these collaborative settings is important for revealing how similar or different teams are with respect to

what they aim to accomplish, where they are established, who is included as members, how they review cases, and what recommendations they make. The potential diversity among domestic violence fatality review teams may have important implications for their ability to promote systems change. Therefore, it is critical to obtain a thorough understanding of the specific nature of these collaborative settings before it can be determine what outcomes can be expected of them.

Goals

Teams reported having a number of goals that could be grouped into three major themes, including increasing knowledge (89%), promoting systems change (86%), and fostering collaboration (34%). Specifically, activities related to increasing knowledge included conducting research, educating the public, and training professionals related to domestic violence fatalities. Activities related to promoting systems change included making recommendations for changes to legislation and public policy, improving the existing system response to domestic violence (e.g., implementing domestic violence screening in health care settings), and developing new services to address unmet needs. Activities related to fostering collaboration including developing trusting relationships, increasing coordination between services, and improving communication among services providers. Approximately half of teams (54%) reported that their ultimate goal was to prevent or reduce further domestic violence fatalities. However, a few teams asserted that actively facilitating prevention was outside of the scope of their team.

Structures

Authority. The vast majority of teams (77%) were established under legislative or statutory authority and executive orders. The primary purpose of formal authorization is to allow teams to have access to confidential information related to review of a death, prevent information

reviewed from being subject to subpoena or discovery, and provide immunity for each member of the team from civil or criminal liability. However, formal authorization may also mandate issues related to the goals (e.g., what the team should aim to achieve), structures (e.g., what organizations or agencies should be represented), processes (e.g., what types of cases should be reviewed), and outcomes of the teams (e.g., who the team should report to). The remaining teams (23%) were established under either a memorandum of understanding or interagency agreement which allows agencies to informally share with one another, but without any legal protections or authority. Most teams (86%) indicated they had a formal reporting structure in which they were responsible for reporting to a combination of criminal justice agencies, health services, government, and funding agencies.

Funding. Approximately half of teams (46%) received external funding for their efforts. Funding came from a variety of sources including federal funds such as the STOP Violence Against Women Formula Grants and the National Violent Death Reporting System; state funds such as State Health Departments and Coroners Offices; county funds such as County Boards, and private funds such as Private Health Foundations and American Express. The remaining teams (54%) did not receive any external funding and relied on either the volunteer efforts of members or the contributions of participating agencies (e.g., meeting space, office supplies, services of members, administrative support). Only 29% of teams reported that the funding they received was adequate to support the work of their team. Interestingly, almost half of the teams that reported receiving adequate funding were those that did not receive any external funding. With the exception of one state or provincial team, these were all county or regional teams who felt that the resources contributed by participating agencies were sufficient for their efforts.

Jurisdiction. The geographical area covered by teams varied in important ways across

states and provinces. Some teams were responsible for an entire state or province, while other teams were responsible for a single county or region within a state or province. Typically, areas that have state or provincial teams have only one team within the state or province and areas that have county or regional teams have more than one team within the state or province. In this study, 43% of the teams that participated were state or provincial teams and 57% were county or regional teams. Figure 1 in Appendix A provides a map of the distribution of state or provincial teams and county or regional teams in the United States. It is important to highlight that almost half of the states (43%) that had county or regional teams also had a state or provincial body overseeing their efforts. For instance, state or provincial bodies may have assisted with the establishment of teams, collection of standardized data from teams, provision of training and technical assistance to teams, and facilitation of the case review process for teams. However, there were significant differences in the type or amount of support the state body provided the county or regional teams and the degree of autonomy afforded to the county or regional teams.

Base. Teams were based at a wide variety of agencies and several teams reported being formal subcommittees of a larger agency or service. Approximately one third of teams were based at community organizations (34%), including domestic violence coordinating councils (22%), community based victim services (9%), and higher education institutions (3%). Approximately one third of teams (31%) were based within the health sector, including 11% at coroners or medical examiners offices, 11% at health services, and 9% at “other” health services. Approximately one third of teams were based within the criminal justice sector (29%). Most of these teams were based at a prosecuting attorneys office (20%) and the remaining teams were based at either law enforcement (6%) or batterer’s intervention programs (3%). A few teams (6%) reported having no permanent base but having routine spaces where meetings are held.

Interestingly, for 57% of teams there was a match between the base of the team and the organizational affiliation of at least one formal leader of the team, suggesting that where the team was based may have implications for which members hold positions of power on the team.

Leadership. Most teams (86%) had at least one formal leader. Forty-two percent of teams had a single leader, most frequently referred to as a chair, coordinator, or project director. Forty-four percent of teams had multiple leaders, which were either some combination of chairs, coordinators, and project directors, or a group of core leaders. The remaining teams had no formal leader (14%) but tended to have one or two members who adopted informal leadership roles or were responsible for a large portion of the work of the team. For those teams with formal leaders, 50% of teams had leaders from criminal justice organizations, 50% of teams had leaders from health services, and 10% of teams had leaders from community based organizations. The leadership structure was complicated by the fact that almost one quarter of teams (23%) also had an executive committee or advisory board which provided oversight or guidance to the teams. All of the executive committees and advisory boards appeared to play an important role for the team and to have substantial decision making power.

Membership. The vast majority of teams (94%) had tightly regulated membership in which only formal members of the team could attend the meetings with the exception of facilitators who were invited to help facilitate the case review process and service providers who were invited on a case by case basis. The remaining two teams had open membership in which anyone who wished to attend the meeting was welcome. What is perhaps most striking about the membership of the teams is that although all teams included members from the criminal justice agencies, health services, and community based organizations (100%), very few teams included community members (6%), such as victims of intimate partner violence or a family members of a

victims of intimate partner femicide, as a formal member of the team. The most important characteristics teams reported considering when selecting members included which agency the member was affiliated with, what position the member held in the agency, if the member had access to confidential information, or whether the member was considered an expert. Therefore, it is not surprising that teams were heavily weighted with professionals. Attempts were made by some teams to include community members in other ways such as inviting victims of intimate partner violence to share their experiences with the team or conducting interviews with family members of victims of intimate partner femicide.

Meetings. Almost all teams reported meeting on a regular basis (97%). The most common and routine meeting was the case review meeting where the primary focus was to review and discuss cases of intimate partner femicide as a group. However, the process that teams used to conduct the case review meetings varied across teams. This is well illustrated by the vignettes that are dispersed throughout the results section and offer a glimpse of these meetings. The diversity of the case review process will be discussed in greater detail below. Teams reported meeting to review cases monthly (49%), bi-monthly (28%), quarterly (17%), semi-annually (3%), and irregularly (3%). Case review meetings lasted an average of 3.9 hours but ranged between 1.5 and 16 hours held over 2 days. Over half of teams (54%) also reported having at least one formal subcommittee which met outside of the case review meeting. Some of these subcommittees were stable in nature and were formed to break down the work of the team. For instance, case screening subcommittees were responsible for selecting cases for the team to review, while report subcommittees were responsible for writing and publishing reports. Other subcommittees were temporary in nature and were formed to address specific gaps that were identified by the team, such as developing instruments for violence risk assessment and

management or improving the system response related to issues of diversity.

Processes

Case selection. Not surprisingly, all domestic violence fatality review teams review intimate partner femicides, the murder of a woman by her current or former partner. However teams differed with respect to the breadth of additional cases they reviewed. Some teams (43%) adopted a narrow definition for the cases they reviewed by focusing only on homicides, homicides-suicides, or near lethal violence between current or former intimate partners. Some of these teams also reviewed collateral deaths that occurred during the course of the violence. For instance, the vignettes for *Team A* and *Team C* are illustrative of teams that adopted a narrow definition. Other teams (57%) adopted a broad definition for the cases they reviewed by looking at any homicide of family or household members or domestic violence related deaths (e.g., suicides, sexually transmitted diseases, substance use, prostitution, homelessness). For instance, the vignette for *Team B* is illustrative of a team that adopted a broad definition. The differences between teams with respect to the types of cases reviewed appeared to be related to a variety of issues including concerns about confidentiality and liability, limited access to private information, scarce time or resources, and different definitions of what constitutes a domestic violence death. Regardless of the reason, these differences make it very difficult to make meaningful comparisons of findings related to the nature and prevalence of these events across teams and jurisdictions.

Data collection. The vast majority of teams reviewed closed cases (85%) which had been solved by police through death of the perpetrator, or had been prosecuted, sentenced and gone through the appeal process. However, a small minority of teams (15%) also reviewed open cases which were still in the process of being investigated by police or tried in court. Teams identified

cases for review using a wide variety and combination of sources. For instance, teams obtained lists of potential cases from the prosecuting attorney's office, law enforcement, medical examiners office, health services, and domestic violence coordinating councils at a county, state, or federal level. Teams also used less formal or reliable means of identifying cases such as by reviewing newspaper articles or soliciting referrals from members of the team or community. Half of teams (49%) reported attempting to review all cases identified each year, while the remaining teams reported reviewing a subset of cases identified each year based on the quality of information, diversity of issues, familiarity or interest to members, or impact on the community. Teams collected information about cases using a variety of different methods, including independent review of relevant files (67%), testimonial by members of the team (77%), and interview with service providers, family, or friends involved in the case (37%).

Data analysis. The majority of teams (69%) reported using a coding form to record and organize the information they collected. Coding forms varied in content and depth but typically included information about the perpetrator, victim, their relationship, and system contacts. The vignette for *Team A* provides an example how teams use a comprehensive coding form to collect record data. Some teams were encouraged to collect standardized data in the form of state or national coding forms. For instance, the National Violent Death Reporting System, a national monitoring system for violent deaths, provided funding to teams that were based in state health departments who were willing to use their national coding form and share the data that was collected. Teams used a variety of strategies to analyze the information collected. For instance, 54% of teams used statistical programs, 40% used timelines, and 34% used narratives. The vignette for *Team B* provides an example of how teams utilize timelines while the vignette for *Team C* provides an example of how teams utilize narratives to analyze data. Although the vast

majority of findings were reported in the form of frequency counts or descriptive statistics, teams found timelines and narratives helpful for combining the pieces of information collected into a whole and for understanding the context, process, and interactions of each case.

Outcomes

Developing recommendations. The vast majority of teams interviewed reported making recommendations (86%) and publishing them in a report that they made available to the public (80%). Overall, there was little disagreement between teams about whether they should make recommendations. Most of the teams who had not yet done so were in an earlier phase of their development and planning to do so in the future. However, one team argued against making recommendations because they felt it was not the role of the team or was not the most effective way to promote systems change. The process of making recommendations varies tremendously across teams as illustrated by the vignettes for the teams. Some teams, made recommendations tied to specific cases (25%), some made recommendations aggregated across specific cases (20%), and some made nonspecific recommendations (3%), while others made recommendations using a combination of these approaches (54%). The vignette for *Team C* provides an example of a team that makes recommendations tied to a specific case, while the vignettes for *Team A* and *Team B* provide examples of recommendations using a combination of approaches, including tied to specific cases and across specific cases. Debates arose between teams regarding how recommendations should be made. Specifically, proponents of case specific approach argued that recommendations should emerge from specific cases as a means of honoring the victim and maintaining the neutrality and credibility of the team. Proponents of an aggregated approach argue that recommendation should emerge from many cases in order to ensure that they represented common or systemic problems.

Implementing Recommendations. Consistent with the goals of the teams, 100% of teams made recommendations related to promoting systems change (e.g., healthcare providers should use standardized tools to assess risk for domestic violence), 89% of teams made recommendations related to increasing knowledge (e.g., child welfare and protection agencies should receive ongoing training about risk factors for domestic violence), and 71% of teams made recommendations related to fostering collaboration (e.g., the government should develop guidelines for enhancing coordination for cases involving domestic violence and child custody or access disputes). Beyond publishing the recommendations in the report made available to the public, teams varied greatly with the extent to which they were involved in implementing the recommendations. Although it is reasonable to assume that active involvement in implementation of recommendations would be an important step in achieving their goals of increasing knowledge, promoting systems change, and fostering collaboration, only half of teams were involved in implementation of recommendations. Specifically efforts teams made to assist in implementation of recommendations included, monitoring recommendations (51%), assisting in carrying out recommendations (46%), publishing actions taken by outside agencies (23%), and publishing an action plan for carrying out the recommendation (6%). Debates arose between teams regarding the extent to which they should be involved in implementing recommendations. Where they fell on this issue appeared to be related to what they viewed was the primary goal of the team.

Team B Vignette

The large conference room is warmly lit by sunshine pouring in from sliding glass doors at the back of the room and incandescent light falling from ceiling fans high above. The tables are draped in green and beige table cloths and arranged in two semicircles facing the front of the room. The metal chairs are cushioned by upholstery and the floor is covered by a burgundy carpet patterned with autumn colored pine cones and branches. Imitation trees are scattered around the room

and coffee, tea, and baked goods are set up in one corner of the room. The walls are littered with large pieces of flip chart paper covered in permanent marker providing a written timeline of events leading up to a domestic violence homicide which the nineteen team members have constructed over the last day and a half. The timeline was informed by reviews of information from agencies and interviews with family members and professionals involved in the case that were conducted over several months, as well as discussions with community members who are invited to review the timeline this morning. The community members are informed by the facilitator of the team that the goal of the review is to make recommendations for changes to policies and laws to prevent future domestic violence homicides. The community members and team members collaboratively and passionately brainstorm potential recommendations together such as “educating the community about domestic violence,” “developing mandatory reporting by physicians of domestic violence,” and “making stiffer sentences for assault of family members.” Many debates erupt about the comments made and the facilitator gently reminds the group not to judge the recommendations. After compiling twelve pages of notes the coordinator of the team asks the community members to leave the meeting and instructs the team members to break into small groups to develop four to five recommendations. The room is buzzing with discussion and laughter among the groups and the coordinator interrupts them to share their recommendations with each other. As each group takes turns to report their recommendations, the coordinator documents them on a flip chart. A final list of fifteen recommendations is compiled including “educating the faith community about domestic violence,” “implementing domestic violence screening for health professionals,” and “enforcing mandatory finger printing upon conviction of domestic violence.” The facilitator suggests that it may help to condense the list by voting on the most compelling recommendations. The coordinator wholeheartedly agrees.

Tensions or Issues

Reviewing the goals, structures and processes of domestic violence fatality review teams highlights differences across teams that may have implications for their ability to promote systems change. Identifying tensions or issues faced by teams and investigating differences in how teams navigate these tensions is critical for increasing understanding of the diversity across teams with respect to how these teams operate and position themselves to affect change. The following section reviews the five major tensions or issues that emerged in this study. As previously mentioned tension or issues refer to dilemmas teams face or tradeoffs teams make in the course of their work that each have their relative costs or benefits. Although these tensions

are characterized in dichotomous opposition to one another, in reality they may be more accurately occur along a dimension. For instance, both sides of the tension can be present at the same time and teams may emphasize each side of the tension to different degrees.

No Blame or Shame versus Accountability

The first tension that emerged in the study was *no blame or shame* versus *accountability*. This tension concerns the philosophy or values underlying the work of teams. Most teams initially adopted a *no blame or shame* philosophy that emphasized the importance of not placing blame on any single individual and agency for past behavior or future change. Risk and error were viewed as inevitable aspects of coordinated delivery of complex services and perpetrators were ultimately held responsible for the deaths of their victims (Websdale et al., 1999). This philosophy encouraged relationship building between team members and allowed members to feel more comfortable coming to the table to share information about their involvement in a case prior to a fatality (Websdale, 2003). This approach contrasts with the philosophy of *accountability* that underlies traditional strategies for reviewing domestic violence deaths (e.g., agency reviews, public inquests) which emphasized holding individuals or agencies accountable for past behaviour and future change (Watt, 2008). This philosophy encouraged the identification and correction of specific gaps or failures in the system response and placed little to no emphasis on relationship building.

“No blame or shame was important in terms of creating the right atmosphere for our discussions and encouraging people to come to the table. It was important for people to know that they were not going into this process to be attacked in the course of the meeting or knifed publicly as a result. You would never be able to have a trusting environment as a consequence (team 1).”

“We really do seriously want to look at these cases under a microscope. More importantly, we want to look at the agencies under a microscope and how they responded. And so the benefit is that it has helped us to make important system improvements. Not just changes but actually improvements. I think that the

downside is that nobody is running to tell me about every case that occurs because they know what it is going to lead to (team 2)."

Most teams (74%) reported experiencing tension between *no blame or shame* and *accountability*. Overall, 66% of teams reported emphasizing *no blame or shame*, 17% reported emphasizing *accountability*, and 17% reported emphasizing both (See Figure 2 in Appendix A). Although teams reported that glaring mistakes on the part of service providers rarely occurred, tension arose between these philosophies when teams were reviewing cases in which they observed a clear failure in the system response or desired to make more specific and targeted recommendations than a *no blame or shame* approach allowed. During these times, some teams reported feeling that it was important to hold individuals, agencies, or systems responsible for past behaviour and for future change and believed that their philosophy of *no blame or shame* prevented them from doing so. Although emphasizing a philosophy of *accountability* may have made stakeholders feel uncomfortable coming to the table and discussing past mistakes, some teams felt that holding others accountable was critical for making change.

"I have no problem calling a spade a spade. If there was something that was missed I think the importance of improving the system outweighs the no blame no shame philosophy. If you are sparing somebody from feeling embarrassed but you are not improving the situation for the next time then you haven't accomplished anything (team 10)."

Both philosophies appeared to have implications for promoting systems change. *No blame or shame* was perceived as particularly important for increasing participation of members, facilitating information sharing, and fostering relationships. Domestic violence fatality review teams argued that in the absence of the *no blame or shame* philosophy members would be unwilling to participate, the team would have insufficient information to reveal gaps in the system response, and the necessary relationship would not have been built to affect system change. Alternatively, *accountability* was viewed as critical for promoting difficult discussions

among members about failures in the system response, for making more targeted and specific recommendations for systems change, and for monitoring whether subsequent changes had been made. Teams argued that without *accountability* everyone may come to the table but no changes may be made outside of the team.

“It is not that we are not willing to call a system on the carpet for what might be in place there but we tend to be very careful about how we do that. You get more flies with honey than vinegar. Alienating a system from the activities of team because we have called them on the carpet and told them you are bad and you did this wrong, is not going to be effective. It is not that we are out to be everybody’s best friend but if we are going to truly effect change then we’ve got to be willing to open up a dialogue with them rather than just tell them they were wrong. (team 7).”

Several promising practices emerged as a result of the tension between *no blame or shame* and *accountability*. Teams that traditionally emphasized *no blame or shame* as their underlying philosophy have considered several strategies to hold individual and agencies *accountable* without harming carefully fostered relationships. For instance, if a team chose to make targeted or specific recommendations for system change, they may first inform the agency privately of the observed system failure or ask the agency for their input into the content of the recommendation prior to sharing it publicly.

“We may even ask someone who exposes a problem within their agency what their recommendation is for how we could improve that response within their agency. We are showing them even though their agency did not perform at one hundred percent we think they share in our concern that this be improved. And I think that helps an agency feel like they are not just being reviewed but actually part of the solution (team 2).”

Freedom of Information versus Individual Right to Privacy

Freedom of information versus *individual right to privacy* was the second tension that emerged in this study. This tension relates to the type or amount of information shared among members. *Freedom of information* refers to the practice of placing few restrictions on the type or

amount of information shared and often collecting or sharing private information. Alternatively, *individual right to privacy* refers to the practice of placing many restrictions on the type or amount of information shared and often collecting or sharing only public information. Teams tended to emphasize *freedom of information* among members inside of the team and *individual right to privacy* with the public outside of the team. The two sides of the tension interacted in that teams reported that they were able to share information freely with each other due to the confidentiality of their proceedings. Information sharing guidelines were structured in this way because the vast majority of teams had been established under legislative or statutory authority and executive orders. Formal authorization allowed the teams to have access to confidential information related to review of a death, prevented information reviewed from being subject to subpoena or discovery, and provided immunity for each member of the team from civil or criminal liability (Websdale, Sheeran, & Johnson, 2001).

“I think by sharing information freely we are actually able to pick up on patterns and trends that you would not get by just strictly sharing basic information. When everyone can come to the table and say whatever it is that they know about this case we can put the case together in a different way. If we do not have all of that information we are making a decision about what patterns and trends are and what we should share with the public with half the information (team 14).”

“The benefit of confidentiality is that we get the information that we want, which we would not if people were afraid of it ending up in the newspaper or on the television. If people did not believe that the information they shared was going to be treated confidentially, whether it was a mother talking about her daughter or a coroner talking about the autopsy, they would not give us the information (team 3).”

Most teams (77%) reported experiencing tension between *freedom of information* and *individual right to privacy*. Overall, 23% of teams reported emphasizing *freedom of information*, 46% reported emphasizing *individual right to privacy*, and 31% reported emphasizing both (See Figure 2 in Appendix A). Tension between *freedom of information* and *individual right to*

privacy emerged both inside and outside of teams when disagreements occurred among members regarding what type or amount of information should be shared. For instance, debates arose about information sharing inside of teams when the information sharing guidelines of a team conflicted with those of a single agency represented by a member. In these cases, instead of emphasizing *freedom of information*, a member emphasized the victim, perpetrator, or agency's *individual right to privacy* and limited the information shared with the team. Specifically, several teams reported that members from domestic violence shelters were not willing or able to share information because they had not obtained the victim's consent to do so and viewed this as a violation of the victim's right to privacy. However, the lack of information from shelters was often seen by other team members as a lost opportunity to evaluate potential gaps in the system response.

“The shelters perspective was that if you share information about a woman who died after being in the shelter that is the ultimate form of violating that women’s sovereignty. They just flat out refused to share information (team 27).”

Alternatively, debates arose about information sharing outside of domestic violence fatality review teams when considering what type or amount of information should be shared with the public. In these cases, instead of emphasizing the *individual right to privacy* of the teams proceedings, a member emphasized the importance of *freedom of information* with the public. For instance, many team members argued that sharing additional case specific information with the public would be important for honoring the victim and their family, helping to justify their recommendations, and promoting accountability of the system response. However, other team members argued that in the absence of confidentiality of their proceedings team members would be unwilling to come to the table to share this information.

“We struggle with the public dissemination of information and how specific it gets. Thus far, we have been very cautious about being sure that none of our

recommendations on general reading can be connected to one case. Because they generally come out of one case, it can mean that the recommendation gets watered down (team 6)."

Both *freedom of information* and *individual right to privacy* appeared to have the potential for impacting on the system response. The confidentiality of the proceedings of domestic violence fatality review teams was viewed as critical for bringing people to the table and for facilitating information sharing. In fact, several teams reported that members were unwilling to join the team until legislation had been established to ensure that the information reviewed could not be subject to subpoena or discovery. While, sharing information freely among team members was viewed as necessary for identifying the risk factors and system failures contributing to domestic violence deaths and for making recommendations for systems change. Most teams argued that the more information they had about a case, the better they were able to identify problems with and make change to the system response.

"We can really identify the issues that need to be addressed and help make significant improvements to the system by sharing the information honestly and openly within the group. Protecting and maintaining the confidentiality of the information allows us to continue to do that (team 2)."

The establishment of domestic violence fatality review teams under legislative or statutory authority and executive orders, interagency agreements, and confidentiality agreements are promising practices that emerged to allow teams to both share information and maintain the confidentiality of information shared. However, teams have been criticized for emphasizing confidentiality at the expense of information sharing. This debate raises questions about who is the rightful owner of this information and what are the implications of this ownership. Several teams have considered ways in which they could attempt to strike a balance between freedom of information and individual right to privacy. For instance, some teams have included sanitized case narratives in their reports to provide concrete and transparent support for their

recommendations.

“Our legislation states that we cannot disseminate any identifying information, only aggregate information. The team helped put together what is in that legislation and leaned more toward confidentiality. But now as the group has evolved we have moved toward honoring the victims who have lost their lives due to domestic violence. Yet we can never name the women, men, and children who have died because of our legislation (team 25).”

Betterment versus Empowerment

The third tension in this study, *betterment* versus *empowerment*, refers to the means by which teams have been structured. These terms were borrowed and modified from those identified in the community psychology literature to fit the unique structure of domestic violence fatality review teams (Himmelman, 2001). Teams that were structured based on a *betterment* model were often formed outside of a particular community at a state or provincial level where agency leaders or representatives shaped the development of the team. The members of the team were typically not directly involved in providing services to the perpetrators or victims prior the fatality and recommendations tended to be directed a state level. In contrast to the *betterment* model, teams that were based on the *empowerment* model were often formed within a particular community at a county or regional level, where community residents (e.g., local service providers, family members, victims) shape the development of the team. The members of the team were often directly involved in providing services to the perpetrators or victims prior the fatality and recommendations tended to be directed at a community level.

“It is hard to reflect on your work and your community with totally clear eyes and be willing to look at anything. You always want to think that you are working at the best agency or that your community is the most progressive. I think having someone evaluate the community from the outside is a great way to determine if you are on point, if you’re not on point, if you need to change... to have that clear view (team 5).”

“You may come up with some marvelous and wonderful ideas. And the community will say, ‘And who are you?’ ‘Well I live over in so and so and I’ve studied your

community and this is what you need to do to change it.' And everybody is going to laugh in your face. If you want to be taken seriously you are going to need to have people from the community in the process (team 16)."

Almost half of teams (40%) reported experiencing tension between *betterment* and *empowerment*. Overall, 74% of teams reported emphasizing *betterment*, 20% reported emphasizing *empowerment*, and 6% reported emphasizing both (See Figure 2 in Appendix A). However, it is important to recognize that because most of these teams are agency based they would fall on the *betterment* side of the continuum. Therefore, their perception of empowerment was not always consistent with what Himmelman (2001) described. One of the ways the tension between the *betterment* and *empowerment* model emerged was with respect to who is included as a member of a team. Many teams that have traditionally been based on a *betterment* model have debated about including community residents who were more directly involved in the cases reviewed, which would be more consistent with an *empowerment* model. For instance, teams have considered including victims and perpetrators of intimate partner violence, surviving family members of intimate partner violence femicides, advocates for victims of intimate partner violence, and local service providers as members of their team. Some teams reported that they would greatly benefit from the personal nature, rich detail, and sheer amount of information that could be provided by community residents. However, other teams argued against the inclusion of community residents due to concerns that this may decrease information sharing among members, increase the adversarial nature their interactions, threaten the confidential nature of their proceedings, increase their risk of liability, constitute a violation of their legislative or statutory authority, or result in potential harm to the community resident.

"It is really difficult for an agency to say we screwed up if the surviving family member is sitting there. We want to make the systems better and we're unlikely to do that if... I don't care what the person promises when they come in. For instance, if the mother of the deceased victim is there to give the victim

perspective and the law enforcement agency said, 'Well yeah, we actually did get a 911 call about a restraining order violation but we got backed up and didn't go check on it, and the next call we got was she was dead. So, yeah we should have responded and we didn't.' That is not going to happen if the mom's sitting there because she is going file a wrongful death suit right (team 4)?"

Another way that tension between *betterment* and *empowerment* model occurred was with respect to the formality and rigidity of the structures and processes that often accompanied the *betterment* model. The vast majority of teams (85%) that adopted a betterment model had been established under legislative or statutory authority and executive orders. As previously mentioned, this formal authorization tended to mandate issues related to the goals (e.g., what the team should aim to achieve), structures (e.g., what organizations or agencies should be represented), processes (e.g., what types of cases should be reviewed), and outcomes of the teams (e.g., who the team should report to). Several teams that had adopted a *betterment* model reported that members had expressed frustration about the bureaucratic or institutionalized nature of their teams. Some teams voiced concerns about restrictions placed on what they were able to communicate in their reports and share with the public. Other teams complained about the team's slowness in making systems change or the member's inability to advocate for systems change. As a consequence, many teams felt they would have benefited from the freedom and flexibility that an *empowerment* model could afford with respect to what they could say and do.

"Where a team is housed or rooted is one of the most major decisions any team can make. Being in the government literally governs, pun intended, almost every decision we make. There is a lot of bureaucracy and it is not always informed by the very folks that we're trying to help and assist. I would say that tension for us has actually been paramount over everything else. And if any team ever came to talk to me I would highly recommend you don't ever get situated in government (team 25)."

Domestic violence fatality review teams reported that both *betterment* and *empowerment* impacted systems change in important ways. First, teams stated that these models had an

influence on what types of recommendations were made. For instance, recommendations based on the *betterment* model tended to be directed at “top down” system level changes (e.g., changes to public policies) whereas recommendations based on the *empowerment* model tended to be directed at “bottom up” grass roots level changes (e.g., changes to daily practices). Second, domestic violence fatality review teams reported that these models had repercussions for where recommendations were directed. As consequence of the membership of the team and where it is based, improvements to policies, procedures, and practices tended to be directed at a state or provincial level for the *betterment* model and the county or regional level for the *empowerment* model. Third, teams indicated these models appeared to have different implications with respect to implementing recommendations. Recommendations made from the *betterment* model appeared to benefit from the power, influence, and credibility of agency leaders or representatives in implementing state level changes, whereas recommendations made from the *empowerment* model appeared to benefit from the knowledge, experience, and relationships of community residents in implementing county or regional level changes.

“The benefit of the betterment model is that you have players who can affect change within a system who are looking at the information and who are knowledgeable and passionate about wanting to make that kind of change. You have the right set of characters who might be able to influence that process from the inside. Especially if you choose them like we do where we get people who have the clout necessary to make systemic change internally. The downside of the betterment model is that it is not stimulating as much of the grassroots changes as I would like to see. It has not stimulated as much of the prevention and early intervention efforts that might address some of the prevailing norms in the community that may be perpetuate a climate that allows for the kind of violence that we see happen occur. I would love to see us struggle with that more (team 26).”

Several teams voiced concerns that systems changes directed at one level (e.g., state) had little to no impact on system changes occurring at the other level (e.g., community) and argued for a combination of approaches that could maximize the strengths of both models. Although the

structure of most teams continues to be heavily influenced by the *betterment* model, several promising practices have occurred when teams have attempted to incorporate elements of an *empowerment* model by including community residents in a variety of innovative ways. For instance, some teams have invited victims of domestic violence, advocates for victims of domestic violence, and local service providers to be members of their team, interviewed surviving family and friends about their experiences and perspectives, conducted focus groups with community residents related to specific issues that arise, and involved local service providers in developing and implementing recommendations.

“We talk with family and friends and they have so much information for us that we would never know from public records about the victim’s experience. Maybe she called the shelter and the shelter was full. Maybe the police said that if they had to come out again that they were going to arrest her and put her kids in care. A lot of information about the messages that the system was sending to the victim and the perpetrator about their willingness to intervene, we learn from friends and family (team 15).”

Biography versus Epidemiology

The fourth tension in this study was *biography* versus *epidemiology*. This tension concerns the method teams use to collect and analyze information. Teams that used a *biographical* approach collected detailed information about a small number of cases, sometimes referred to as a case specific or systems approach (Websdale et al., 1999). The primary goal of this approach was to obtain an in depth understanding of the dynamics of each case. For instance, one team using this approach spent up to several months collecting and reviewing information about a single death. The *biographical* approach to collecting and analyzing cases was illustrated in the vignettes for *Team B* and *Team C*. In contrast to this approach, teams that used an *epidemiological* approach collected general information about a large number of cases, sometimes referred to wide-angle or investigative model (Websdale et al., 1999). The primary

goal of this approach was to obtain an understanding of trends across cases. For example, one team using this approach spent as few as four minutes collecting and reviewing information related to hundreds of deaths. The *epidemiological* approach to collecting and analyzing cases was illustrated in the vignette for *Team A*. Teams selection of one approach over the other appeared to be influenced by a variety of issues including the type of resources devoted to the team (e.g., time and money), the amount of information available to the team (e.g., private or public), and the underlying values associated with each method by the team (e.g., the importance of honoring the victim versus the importance of maintaining research integrity).

“Because domestic violence is such a complex issue, we really need to gather a lot of information and take an in depth look to get at the complexities and the uniqueness of each case. It gives you the opportunity to really identify gaps in the system response. If you do not dig deep into a specific case the likelihood that you are going to be able to identify these things is pretty slim (team 8).”

“If we just did the in depth reviews you would be missing what you can learn from trends. This is really important because a lot can be learned from trends and numbers. They give a voice to how prevalent the issue is and how generalizable your findings are. How would you decide what cases to look at and what could you say about the cases you did not review (team 8)?”

A somewhat less apparent tension, only approximately one third of teams (34%) reported experiencing tension between biography and epidemiology. As previously mentioned many teams (34%) used a combination of approaches to collecting and analyzing their data. However, 78% of teams reported emphasizing biography, 11% reported emphasizing epidemiology, and 11% reported emphasizing both (See Figure 2 in Appendix A). Tension arose within teams about biography and epidemiology when teams initially selected a method to analyze cases and over the course of reviewing cases when the costs of the approach they were using began to outweigh the benefits. The primary way this tension emerged was with respect to debates about what type of information was necessary and sufficient to understand the cases reviewed and to form the

basis for recommendations. Proponents of the biographical approach reported that in depth information about individual cases was essential for revealing complex dynamics and processes within each case and identifying the gaps or failures in the system response. They stated that if they did not use the biographical approach they would risk missing critical information about the system response and would have difficulty making well informed recommendations for systems change. In contrast, proponents of the epidemiological approach argued that general information about a large number of cases was necessary for understanding common patterns across cases and problems within the system. They warned against the dangers of basing any decisions about system change on a single case which may not be representative of other cases and asserted that recommendations for systems change should be based on trends observed across cases.

“We worry about making recommendations based on six to ten cases. While those are very well researched cases, how much can we speak to the twenty or thirty cases we have not investigated? How much of the patterns that we have seen in these cases are indicative of other cases? If we can gather more data it will help substantiate some of the policy recommendations we are trying to make (team 26).”

Domestic violence fatality review teams argued that both *biography* and *epidemiological* had implications for systems change. First, teams argued for the persuasiveness of each of these approaches in illustrating problems and encouraging change in the system response to intimate partner violence. Some teams argued that the power of the individual story offered by the *biographical* approach was often what was needed to emotionally impact people and motivate them to make change. Other teams argued that the magnitude of the problem illustrated by the *epidemiological* approach made it difficult for people to dismiss their findings and was necessary to logically convince people that changes needed to be made. Second, domestic violence fatality review teams reported that these approaches had different implications for where changes occurred within the system response. Some teams reported that the *biographical* approach was

particularly important for making local informal changes to the daily practices of members of the team. For instance, one team discussed how a police officer changed the type of information collected during investigations of domestic violence homicides due to the *biographical* approach. Alternatively, other teams reported that the *epidemiological* approach was particularly important for making broader formal changes to policies and procedures at a state or provincial level. For example, one team indicated that state wide incorporation of a domestic violence protocol had been made into the training for all police officers as a consequence of the *epidemiology* approach.

“A lot of times I have found that real changes are made in policies and procedures based on the impact of a single case. Something comes up and it just moves everyone. They hear the facts of it, they hear the history behind it, they hear the fallout from the death, and people are just really moved, and then political will is there to make changes. But we found that we were losing some persuasiveness in terms of policy change and we realized that there is value in the epidemiology as well. I think in order to get buy in, you need a combination of the two things, a powerful story and the numbers to back it up (team 4).”

Many domestic violence fatality review teams that have debated about the costs and benefits of *biographical* and *epidemiological* approaches to collecting and analyzing information have resolved this tension by adopting a mixed methods approach. For instance, teams have collected general information about all cases that they review and in depth information about a subset of cases. In addition, teams have conducted an in depth review of all cases per year and use the number of cases they want to review as a guide to determine the extent to which they can delve into each case. As a consequence of using a mixed methods approach teams are able to capitalize on the benefits of both approaches with respect to identifying system failures, examining trends across cases, and making recommendations for system change.

“This is an issue we dealt with very early on. Both approaches have strengths and weaknesses so we tried to balance them. One of the driving forces of the epidemiology approach is you get complete enumeration. But we also understand

that one of limitations of a bean counting approach is that you lack the richness of depth. We figured out how much time we could spend on a case to maximize both issues. We were able to get all of the cases and get most of the details of the cases (team 27)."

Understanding versus Action

The final tension that emerged in this study was *understanding* versus *action* which relates to models domestic violence fatality review teams used to promote systems change. Some teams approached systems change by emphasizing *understanding*. They tended to view themselves as independent fact finding bodies whose responsibility it was to educate others about changes that needed to be made to policies, procedures, and practices. They typically made recommendations for systems change but were not involved in monitoring or implementing those recommendations. In contrast, other teams approached systems change by emphasizing *action*. These teams saw themselves as an important part of the system response and believed it was their responsibility to implement changes to policies, procedures, protocols, and practices. In addition to making recommendations for systems change they were often involved in monitoring or implementing those recommendations.

"Our goal as a team is to collect information and to promote understanding in the community. We hope that somebody in the community can interpret our findings in a way that might be preventative at some time in the future. We want to achieve or foster some kind of action but we do not want to be the ones doing that activity. Without the community picking up some of these things and running with them then it makes our work seem futile (team 19)."

"One of the members stood up one day and said, 'I am just not the same person I was when I came in here three years ago. I am doing things differently in the way I work on a daily basis with these battering couples. I am just plain doing things differently and that is the biggest value to me.' We threw that around the room everybody started saying the same thing. Everybody can say what somebody else ought to be doing, but the bottom line is what are you going to do (team 16)?"

Over half of teams (54%) reported experiencing tension between *understanding* and *action*. Overall, 37% of teams reported emphasizing *understanding*, 20% reported emphasizing

action, and 43% reported emphasizing both (See Figure 2 in Appendix A). The first way that tension between *understanding* and *action* arose was with respect to what role teams should play in promoting systems change. Most teams agreed that they should increase awareness of problems in the system response as a means of stimulating systems change. However, they disagreed about the extent to which they should be actively involved in monitoring or implementing those system changes themselves. Teams emphasizing *understanding* argued it was up to people outside the team to make systems change. They were reluctant to become involved in monitoring or implementing recommendations because they believed they did not have sufficient resources, expertise, and power, and worried that agencies would become more defensive or resistant to change. Teams emphasizing *action* argued it was up to members inside the team to make systems change. They believed that the sole purpose of developing understanding was to make systems changes to prevent future fatalities and without the involvement of the team in monitoring or implementing recommendations this was unlikely to happen.

“We have had some questions about what we want to do with this information now that we are done reviewing cases. We have had some discussion about monitoring recommendation. A couple of the people said, ‘We’ve got these great relationships, we’ve got this great team, I don’t want it to go to waste. What do you mean, we are not going to monitor, what are we going to do then?’ And the majority of us said, ‘Maybe we have accomplished what we said we were going to do and that is okay. We can keep meeting and keep talking about this but we don’t have to officially be monitoring or pointing fingers (team 23).’”

For domestic violence fatality review teams that emphasized both *understanding* and *action* as models for promoting systems change, the second way that tension emerged concerned the amount of time that was devoted to each model. Most teams agreed that an understanding of the cases should serve as a basis for any action taken. However, debates occurred within teams when members became frustrated about the amount of time taken on gaining understanding

before any action could be taken. For instance, teams ranged from collecting and analyzing information for months to years before making recommendations for systems change. Some members emphasized the importance of gaining an in depth understanding of the cases before making recommendations to avoid any unintended negative consequences to the systems response. Other members expressed frustration about the time and resources devoted to increasing understanding before making recommendations after the team had observed recurring problems in the system response and not taking any action to prevent those problems.

“There was a collective frustration that came up at the last meeting. Several people went down this line of thinking. We have reviewed these cases for months, years, approaching a decade. There was this almost, I don’t want to say resignation, but sort of questioning about all the redundancy with regards to understanding. People wanted to move ahead with implementation as our primary method of intervention. That tension comes up and is one that I personally struggle with (team 27).”

Domestic violence fatality review teams reported that the models of *understanding* and *action* promoted systems change in different ways. Teams that emphasized *understanding* argued that increasing awareness and knowledge of risk factors contributing to these fatalities and gaps in the systems response was a critical foundation for forming the basis for systems change. They reported that a comprehensive understanding of the cases provided convincing evidence for of the nature and gravity of the problem, assisted with the development of well supported recommendations, and maintained the credibility and neutrality of the team. All of these factors were thought to increase the likelihood recommendations would be implemented by others. Teams that emphasized *action* agreed that *understanding* was an important place to start but argued that it was an equally important place not to end. They urged teams to become more actively involved in monitoring and implementing recommendations in order for systems change to occur. They believed this was critical for developing more realistic and collaborative

recommendations, for identifying who was responsible or accountable for implementing recommendations, and for directly facilitating the promotion of systems change. In fact, many of these teams had originally emphasized *understanding* as their primary means of promoting systems change, but shifted their emphasis to *action* when they examined whether their recommendations were being implemented by others and observed that very few changes are being made to the system response.

“Understanding was essential in the beginning. You can’t get to action unless people understand why. We obtained a higher level of understanding within the team and we were able to convey that more coherently externally. So it was very important, but not as important as action. Because we have all been on lots and lots of committees where we understand all kinds of things, but that has a finite reach. We may all understand in the room but that does not mean it changes any of the system’s problems. So we put a heavy emphasis on that fact that we did not want this report to sit. Even if we took three recommendations and began to work on them at least that was a place to start (team 32).”

The increased recognition of the limitations of solely relying on increasing understanding as a means of promoting systems change led many domestic violence fatality review teams to make changes to their practices to increase the likelihood their recommendations would be put into action. For example, in addition to continuing to build on their understanding of the risk factors contributing to these fatalities and the problems with the system response, teams have followed up with agencies to monitor whether recommendations were implemented, to assist them with implementation of the recommendations, and to document improvements made to the agencies practices and policies in subsequent reports. Not only will these strategies lead to potential improvements in the system response but they will increase the ability of domestic violence review team’s ability to evaluate whether these changes are occurring.

“I think before we started doing this work most of the teams made recommendations that went in the report and sat there. Well what happens to them and what is the purpose of developing them? How are people going to know that they are even there and the reason for them if you do not take it a step

further? Because you can make all the recommendations in the world and if they are not looked at by the people who have the ability to change the policies and procedures, then you are just creating something to put on my shelf (team 28)."

Team C Vignette

The mission statement, "We speak for the dead to protect the living" is posted prominently in the reception area of the concrete building. The boardroom is brightly lit by panels of fluorescent lights and a gently buzz from the lights fills the room. A long table runs down the center of the narrow room standing on a floral grey and purple carpet and surrounded by plush burgundy chairs. Several tables lining one corner of the room are dressed with linens and cutlery for food service. Fifteen team members are seated around the table serving as experts and representing various professions. The chair of the team is seated at the head of the table. The team has spent the last hour and half systematically reviewing a domestic violence homicide case that had been prepared in advance by one of the members of the team. For each case review meeting a different member is responsible for reviewing coroners files and preparing a document that summarizes events preceding the homicide, identifies risk factors present, outlines potential areas of intervention, characterizes systems involvement, and drafts potential recommendations tied to the case being reviewed. The team has completed reviewing the case and in the midst of discussing potential recommendations. One recommendation states, "It is recommended that the psychiatric association receive continuing education regarding domestic violence and lethality factors. Psychiatrists should conduct a risk assessment with clients who present with depression and feelings of aggression following an intimate relationship breakup." A member argues that the recommendation should go beyond education about assessment to education about management and what psychiatrists should do in a high risk case. Another member counters that she thinks psychiatrists understand what they need to do but do not want to get involved. Yet another member repeatedly asks the team to whom the recommendation should be directed and encourages them to think about how they are framing the recommendation. She warns against telling psychiatrists "You must do this," which another member likens to telling judges what to do. The chair of the team interrupts the lively discussion and informs members they have reached the two-hour mark. He sternly reminds them that he would like them to get each case review down to sixty minutes.

DISCUSSION

Overview

The findings of this study provided rich descriptive information about domestic violence fatality review teams, a novel form of collaborative setting intended to increase understanding of and to contribute to the prevention of intimate partner femicide. There were two primary findings. First, the domestic violence fatality review teams studied were remarkably diverse with respect to goals, structures, processes, and outcomes. Second, despite this heterogeneity, domestic violence fatality review teams were strikingly consistent with respect to the identified critical tensions or issues they faced. While not every team consciously identified experiencing each tension, they could all be located somewhere along the continuum of the tension. The following describes the results of the study in greater detail with a particular emphasis on the meaning and implications of these findings for the promotion of systems change. In light of the methodological strengths and limitations of this study, the potential use of these findings for informing future theory and research about collaborative settings and facilitating improvements to practice and policy in this area will be discussed.

Findings

Evidence of Diversity

This study revealed the incredible diversity of the goals, structures, processes and outcomes of domestic violence fatality review teams. Although the observed heterogeneity of teams supports the assertions by some professionals (e.g., Websdale, 2003; Websdale et al., 1999), it has tended to be overlooked or downplayed in reports prepared by teams that discuss these collaborative settings as if they are a single type or category (e.g., Delaware Fatality Incident Review Team, 2001; New Mexico Female Intimate Partner Violence Death Review

Team, 1998). First, teams had several major goals, including increasing knowledge (e.g., conducting research, educations, and training), promoting systems change (e.g., changing policies, practices, and procedures), and fostering collaboration (e.g., fostering relationships, coordination, and communication), which they emphasized to different degrees. Second, the structure of teams varied with respect to under what authority they were established (e.g., legislative authority, interagency agreement), whether they received funding, what geographical area they covered (e.g., state, county), where they were based (e.g., health sector, criminal justice sector), who was included as leaders or members, and the frequency, duration, and nature of their meetings. Third, teams used diverse processes to review cases reflected by the type of cases selected, the sources of information collected, and the method used for analyzing information. Fourth, the outcomes of teams differed with respect to how recommendations were developed, what recommendations were made, and whether teams were involved in implementing recommendations. Given the shared focus of domestic violence fatality review teams in involving a collaboration of stakeholders to identify and review cases of intimate partner femicide and to develop strategies to prevent or reduce future fatalities, the extent of the heterogeneity in every respect of their goals, structure, process and outcomes is both unexpected and remarkable.

The diverse nature of domestic violence fatality review teams begs the question as to what may be accounting for these differences. First, the diversity may reflect an absence of shared assumptions about what these teams should aim to accomplish, how they should be structured and operated, or what they should be well positioned to achieve (Websdale et al., 1999; Wolff, 2001). Although most teams shared a goal of wanting to promote systems change, it is possible they had very different assumptions about how to obtain systems change and a lack

of consistent information from one site to another regarding “best practices” related to conducting a domestic violence fatality review. For instance, some teams aimed to achieve systems change by promoting understanding whereas others aimed to achieve systems change by promoting action. These differences may have major implications for the goals, structure, process, and outcomes of the teams and the extent to which they are ultimately positioned to affect change. Researchers and practitioners alike have long recognized the importance of having clear and consistent goals, objectives, and action plans as well as shared understanding about the target problem and systems change for effective collaboration (Foster-Fishman et al., 2001; Kegler et al., 2001; Wolff, 2001). This recommendation implies that there is often a great deal of diversity with respect to views of best practice

Second, the diversity may reflect how sensitive these teams are to the contexts in which they arise and how important it is to ensure a good fit between the team and the community (Allen et al., 2008; Morrissey et al., 2007; Nation et al., 2003; Websdale, 2003). Thus, the emergent diversity among teams may reflect their unique negotiation of local realities. For instance, whether domestic violence fatality review teams were established and how they were established appeared to depend on the occurrence of a high-profile intimate partner femicide, the community support for the importance of intimate partner violence, the presence of a powerful stakeholder to champion the issue, the political will to develop an intervention to reduce or prevent future fatalities, and the resources to support the establishment of a domestic violence fatality review team. This is consistent with the practical wisdom and research studies that emphasize how crucial community readiness is for effectively implementing a prevention program (e.g., Goodman et al., 1998; Stith et al., 2008). Furthermore, the community context in which collaborative settings are embedded is viewed as having a critical impact on collaborative

settings and affecting these efforts at multiple points over time (Allen, 2009; Allen et al., 2008; Roussos & Fawcett, 2000). For instance, some researchers suggest that collaborative settings are not necessarily empowered to implement systems change on their own and may rely on engaging stakeholders outside of the team to obtain their goals of increasing awareness, improving relationships, and making systems change (Allen et al., 2008, Yin & Kaftarian, 1997). Therefore, it would not be surprising if contextual factors played an important role in shaping the structures and processes teams develop and fostering or constraining the goals and outcomes of the teams.

Third, the diversity may reflect different stages in the development of domestic violence fatality review teams (Cashman et al., 2001; Kegler et al., 2001). Although the dynamic nature of these settings was not directly examined, key informants indicated that the goals, structures, processes, outcomes of their teams had changed over time. For instance, key informants described changes to the authority under which they were established, where they were based, who was included as leaders or members, and how they reviewed cases. All of these changes would have major implications for how domestic violence fatality review teams operated at different points in time. The dynamic nature of domestic violence fatality review teams is consistent with the recognition in the collaboration literature of the long chain of events between forming a collaborative setting and achieving targeted outcomes (Kegler et al., 2001). Therefore, it is possible that the observed diversity reflected the existence of a few types or categories of teams at various stages of evolution or development, rather than numerous types or even the absence of meaningful types. Unfortunately, due to the cross sectional design of the current study, it is impossible to evaluate this possibility at this point in time.

In addition to considering what may be accounting for the diverse nature of domestic violence fatality review teams, it is important to consider what the implications of the diversity

might be. The findings are suggestive of two possibilities with respect to their potential effectiveness. The first possibility is that teams are equally effective. This possibility can be characterized as a Dodo bird verdict in which, “everybody has won and all must have prizes” (Carroll, 1865, Luborsky et al., 2002; Rosenzweig, 1936). Such a verdict rests on the assumption there is no single best model for establishing a collaborative setting to prevent intimate partner femicide. This could be true if one accepts world view that is strongly contextual and highly optimistic. That is, if one believes the communities in which teams are established are so different and so influential and team members are so highly perceptive and intelligent that each team naturally will develop its own unique yet optimally effective model. Although the context in which teams are embedded is likely to play an important role in the effectiveness of teams, it seems unlikely that domestic violence fatality review teams always do the right thing or are equally effective. This is consistent with research on other collaborative settings which indicates that these settings are not uniformly effective in meeting their goals (Allen, 2006; Goodman et al., 2006).

Therefore, the second possibility is that teams are differentially effective. But, if the diversity of teams implies differentially effectiveness, then why do teams not adopt a small number of models, or even a single model reflecting consensual views of best practice? It seems implausible that most or all the teams deliberately adopted models they knew were not optimal. Leaving this possibility aside, then the diversity of teams likely reflects a lack of evidence about the effectiveness of domestic violence fatality review teams or a lack of consensus regarding the meaningfulness of any evidence about the effectiveness of teams. In either case there must be a near complete lack of evidence or consensus of evidence, otherwise it is likely that one or more distinct models would exist. This is consistent with the limited research on the effectiveness of

domestic violence fatality review teams. Furthermore, the diversity of teams also likely reflects a lack of evidence about, or lack of consensus regarding the meaningfulness of evidence about, collaborative settings more generally. Otherwise, it seems logical that teams would have developed a smaller number of models drawn from the more general literature on collaborative settings. Although there is a great deal of information about the facilitators and barriers to collaboration (e.g., Butterfoss et al., 1993; Foster-Fishman et al., 2001; Roussos & Fawcett, 2000), there are no explicit guidelines about how to form a collaborative setting and no consistent expectations of what these settings are expected to accomplish.

Evidence of Tensions

This study also revealed that domestic violence fatality review teams were strikingly consistent with respect to the identified critical tensions or issues they faced. Exploring tensions revealed a set of dynamic processes actively navigated by teams that explained a great deal about the conscious and unconscious decisions made during the course of their work that may help to account for the heterogeneity of these settings. Specifically, the current study calls attention to five critical tensions that were identified during the first phase of the study and were confirmed and elaborated upon during the data collection portion of the study as important tradeoffs teams made or dilemmas they faced in the course of their work. Specifically, the tensions teams grappled with included the extent to which they emphasized *no blame or shame* versus *accountability* as their underlying philosophy, *freedom of information* versus *individual right to privacy* as their information sharing practices, *betterment* versus *empowerment* as the means by which they were structured, *biography* versus *epidemiology* as the method used to collect information, and *understanding* versus *action* as the model used to promote systems change. These five tensions were deemed critical tradeoffs teams made or dilemmas they faced based on

the considerable information confirming these tensions, the limited information disconfirming these tensions, and the lack of information supporting additional tensions. In light of the incredible diversity of domestic violence fatality review teams it is striking that they grapple with shared tensions or issues. This suggests that teams are dealing with similar constraints and problems but resolving them in very different ways.

The diverse teams and shared tensions suggest that where teams fell on these tensions may have had important implications for the specific goals, structures, processes and outcomes of these collaborative settings. Future research could interrogate more directly how the ways they navigate tensions implicitly or explicitly is related to what they aim to accomplish, how they are structured, what process they use, and which outcomes they pursue. For instance, a preliminary look at the intersection between teams stated tensions and goals suggests that whether teams emphasized *no blame or shame* or *accountability* as their underlying philosophy appeared to have implications for the primary goals of their team. Teams emphasizing *no blame or shame* tended to identify increasing knowledge as their primary goal while teams emphasizing *accountability* tended to emphasize promoting systems change as their primary goal. In addition, whether teams emphasized *betterment* or *empowerment* appeared to be associated with the geographical area covered by the team. Teams emphasizing *betterment* tended to be based at a state or provincial level while team emphasizing *empowerment* tended to be based a county or regional level. Perhaps most obviously, whether teams emphasized a *biography* or *epidemiology* appeared to implications for the sources of information collected and the method used for reviewing cases. Teams emphasizing *biography* tended to collect detailed information about a small number of cases while teams emphasizing *epidemiology* tended to collect general information about a large number of cases. Finally, not surprisingly, whether teams emphasized

action or *understanding* appeared to be related to the extent to which they were involved in implementing recommendations. Teams emphasizing *action* were far more likely to be involved in recommendations than teams emphasizing *understanding*. Therefore, by identifying critical tensions navigated by domestic violence fatality review teams, this study built on previous descriptive account of what collaborative settings looked like by providing a potential explanatory account of why they looked this way. This also suggests that it may be important to explore the development of teams with attention to decisions that may precipitate chosen goals, structures, processes, and outcomes.

The diverse ways in which domestic violence fatality review teams navigate shared tensions raises the question of what could be accounting for these differences. First, how tensions are navigated may reflect the charismatic authority of the leadership guiding the team. Many teams reported that where they fell on these tensions was a consequence of decisions that one or more leaders had made. In this way, leaders may have imprinted their personal experience, attitudes, and values on the team and strongly influenced how teams resolved these tensions. Effective leadership is considered a critical factor contributing to the success of collaborative settings, although there is some debate about what constitutes an effective leader (Allen, 2005; Butterfoss et al., 1996; Foster-Fishman et al., 2001; Roussos & Fawcett, 2000; Stith et al., 2006; Wandersman et al., 1997). Collaborative leaders have been distinguished from traditional leaders in their emphasis on shared power, decision making, and responsibilities, their flexible and inclusive nature, and their emphasis on process as well as outcomes (Wolff, 2001). The leadership style of domestic violence fatality review teams appeared to fall somewhere between collaborative and traditional leaders, with state or provincial team tending to emphasize traditional leaders and county or regional teams tending to emphasize collaborative leaders. Both

leadership styles may have important implications for the navigation of these tensions.

Second, how tensions are navigated may reflect the formal authority under which domestic violence fatality review teams are established. Findings show that the vast majority of teams were established under legislative or statutory authority and executive orders. Although the primary purpose of formal authorization was to allow teams to have access to confidential information and to provide them with protections related to their proceeding (Websdale et al., 2001), one of the consequences of this authorization is that it often mandated issues related to the goals, structures, processes, and outcomes of the teams which would have direct implications for how teams navigated these tensions. For instance, where formal authorization directed teams to be based and who to include as members appeared to affect whether teams emphasized *betterment* or *empowerment* as the means by which they were structured. Importantly, being established under formal authorization is one of the primary ways domestic violence fatality review teams differ from other collaborative settings. Although other collaborative settings often form partnerships with government organizations (Kurland & Zeder, 2001), they are rarely established under formal authorization. Therefore, the nature of other collaborative settings and how they navigate critical tensions may not be constrained in the same way.

Third, how tensions are navigated may reflect perceptions about the success or failure of the domestic violence fatality review team. Many teams reported shifting their emphasis on given tensions as a consequence of evaluations of their efforts. For instance, some teams moved their emphasis from *understanding* to *action* as means of promoting systems change when they realized that their recommendations were not being implemented by others and observed that very few changes are being made to the system response. In addition, other teams moved from emphasizing *biography* to *epidemiology* as the method used to collect information with

increasing recognition of the strength of illustrating the magnitude of the problem to convince others to make change to the systems response. Although very few domestic violence fatality review teams underwent a formal evaluation of their efforts, most appeared to be going through an informal and continuous process of self reflection. The self reflective and dynamic nature of collaborative settings is reflected in previous case studies of these efforts (e.g., Fodayemi, 2001; Hathway, 2001) and supported by researchers in the field (e.g., Cashman et al., 2001; Kegler et al., 2001). Therefore, it would not be surprising if the teams' own perceptions of their effectiveness played an important role in their navigation of critical tensions.

Fourth, how tensions are navigated may reflect chosen theories of systems change. Given that systems change is one of the primary goals of domestic violence fatality review teams it would be expect that theories of systems change would serve as a framework for guiding the choices they made. For instance, a few theories of systems change have been developed in recent years that would be well suited for applying to collaborative settings (e.g., Christens, Hanlin, & Speer; Foster-Fishman, Nowell, & Yang, 2007; Tseng & Seidman, 2007). Yet, theories of systems change were virtually absent from discussions with domestic violence fatality review teams. This did not appear to be something that was considered during the establishment of teams and did not appear to play a significant role in their navigation of tensions. Consequently, there did not appear to be a conscious process of articulating a theory of change where the efforts of teams were linked to desired outcomes. This is consistent with assertions that have been made about other systems change efforts in the human service and community change fields. Specifically, these efforts have been criticized for ignoring the dynamics and properties of the system they are attempting to change and failing to appreciate the complexity of the change process (Foster-Fishman, 2007).

Promoting Systems Change

Both the diverse nature of these settings and their navigation of tensions appeared to reflect how teams attempted to promote systems change. Although teams did not use an explicit theory of systems change as a framework for establishing, operating, and evaluating their teams, they did appear to use implicit models for promoting systems change. First, the tension of *understanding* versus *action* directly highlighted two very different models of promoting systems change. Teams that emphasized *understanding* appeared to prioritize increasing awareness and knowledge as means of encouraging others to implement systems change. These teams appeared to believe that by educating others about risk factors and system gaps this would lead them to make changes to the system response. Alternatively, teams that emphasized *action* appeared to prioritize becoming actively involved in implementing recommendations for systems change to occur. These teams appeared to believe that teams needed to become actively involved in implementing recommendations for systems change to occur. Many teams argued that *understanding* was a necessary place to start but that *action* was a necessary place to end. This is consistent with findings in the collaboration literature that increasing understanding is unlikely to translate into changes to the system response without additional action (Foster-Fishman & Behrens, 2007).

Second, the tensions of *betterment* versus *empowerment* indirectly highlighted two additional models of promoting systems change. Teams that emphasized *betterment* appeared to prioritize power-based approaches in which systems change occurs through the transformation or redistribution of power (Wolff, 2001). Alternatively, teams that emphasized *empowerment* appeared to emphasize relationship-based approaches in which systems change occurs through building strong, caring, and respectful relationships (Wolff, 2001). These models appeared to

have major implications for the level of the system at which change efforts were directed. Teams emphasizing *betterment* were more likely to direct changes at public policies at a state or provincial level while teams emphasizing *empowerment* were more likely to direct changes at daily practices at a community or regional level. Which approach is most effective may be highly dependent on the context in which the team occurs. For instance, power-based approaches may be better suited to a state or provincial team while relationship-based approaches may be better suited for a county or regional team. Although researchers have asserted that these approaches are not incompatible (Wolff, 2001), in this study conflict frequently arose around this tensions and both sides of the tension were rarely equally emphasized. This highlights the inherent paradox in collaborative setting between building relationships and redistributing power (Chavis, 2001).

Although a fundamental assumption about domestic violence fatality review teams is that they are established to develop strategies to prevent or reduce future fatalities by changing the system response to intimate partner violence, this study revealed that teams were pursuing different proximal goals to different degrees across settings. Surprisingly, promoting systems change was just one of several goals that teams emphasized and the extent to which teams pursued this goal varied across teams. In fact, some teams reported that promoting systems change was not one of their primary goals and was inconsistent with the philosophy of their team. This raises the questions of whether promoting systems change should be an explicit and required goal when these setting are initially established and whether other locally grown priorities such as increasing knowledge and fostering collaboration are sufficient. However, if the assumption is that these fatalities can be reduced or prevented by making improvements to the system response, it is unlikely that educating the public about intimate partner violence and

improving the relationships between responding service providers will result in corresponding systems change and a decline in fatalities (Butterfoss et al., 2001). This illustrates a tension long recognized by those developing and emphasizing coordinated approaches in the response to intimate partner violence – that collaboration between stakeholders should not be an end unto itself (Pence, 1999). Additional efforts are often required to implement new knowledge into action or to generalize improved relationships into sustained system transformation (Butterfoss et al., 2001; Foster-Fishman & Behrens, 2007; Klein & Sorra, 1996). Even when the system has been successfully changed this does not always lead to the prevention or reduction of intimate partner violence (Visser, Harrell, Newmark, & Yahner, 2008). The questions remains as to whether and how teams should be charged with a mandate of pursuing specific change strategies and if their organic unfolding process reflecting local priorities, realities, and resources is worthwhile.

Perhaps more surprising than the finding that not all domestic violence fatality review teams identified promoting systems change as one of their primary goals is the finding that theories of systems change was not considered during the establishment of teams or the navigation of tensions. Given that making changes to the system response is one of the primary ways in which teams aim to reduce and prevent future fatalities, it would be expected that the concept of systems change would be central in determining what goals, structures, processes, and outcomes should be established and how tension or issues should be navigated. As previously mentioned, teams did not discuss using theories of systems change to guide decisions they made during their course of their development. Although the concept of systems change was an implicit idea serving as a background for their development it was not an explicit theory serving as a framework for their development. At the time the study was conducted, teams had been

primarily preoccupied with the substantial task of establishing their settings and were just beginning to consider the implications of their goals, structures, and processes for promoting systems change. A theory of systems change could have provided domestic violence fatality review teams a framework for establishing, operating, and evaluating the teams and provided a conscious decision-making process to encourage a match between desired outcomes, and the specific strategies that would encourage those outcomes. Indeed, this problem is not specific to domestic violence fatality review teams and could be applied to any collaborative setting (Foster-Fishman et al., 2007). This may reflect that the process in which local teams become divorced from the initial thrust advocating for the formation of teams. They may become so preoccupied with the pragmatics of team development that they lose sight of the broad understanding of teams as an explicit approach to systems change, or other long term goals.

By revealing the diverse nature of the goals, structures, processes, and outcomes of these collaborative efforts and identifying the shared tensions or issues they navigated, this study provided a foundation for examining the connection between the nature of domestic violence fatality review teams and the outcomes they are positioned to achieve. Although this study did not allow for the examination of *whether* domestic violence fatality review teams achieved system change, it did allow for the exploration of the issues surrounding *how* domestic violence fatality review teams are positioned to promote systems change as well as how they are not positioned to promote systems change. It could be argued that understanding *how* domestic violence fatality review teams are positioned to promote systems change is equally important to understanding *whether* domestic violence fatality review teams actually achieve systems change. Without an understanding the conditions under which domestic violence fatality review teams promote systems change it would not be possible to explain why certain teams achieve certain

outcomes while others do not (Butterfoss et al., 2001). However, additional efforts are needed to gain a greater understanding of both *whether* and *how* domestic violence fatality review teams promote systems change. For instance, this study raises additional questions as to whether certain strategies are more effective than others in promoting systems change, what specific mechanisms are responsible for achieving systems change, and how contextual factors facilitate or impede the use of different strategies. All of these possibilities for future research will be discussed in more detail in the implications section.

Limitations

While the current study builds on previous research by using qualitative methods to increase understanding of the nature of collaborative settings and their efforts to promote systems change, there are several limitations that are important to recognize. First, this study relied heavily on the self report of few members from each domestic violence fatality review team about their goals, structures, processes, and outcomes and the critical tensions or issues they faced in the course of their work. Gaining the perspective of additional members from each team may have provided multiple and diverse perspectives about the nature of these teams and the tensions they navigated. However, the perspectives of additional members may have been less accurate and comprehensive given their potential lack of familiarity with the history and day-to-day operations of the team. In fact, for one team that was included in the study it quickly became apparent that the member who agreed to be interviewed was not familiar with the history and day-to-day operations of the team and was unable to answer many of the interview questions. As a consequence additional members who had been involved since the inception of the team and who were responsible for overseeing the team were contacted and interviewed. This limitation was considered prior to conducting this study and it was thought to affect the validity

and generalizability of certain aspects of the study more than others. Specifically, questions about the goals, structures, processes and outcomes were considered reasonably concrete in comparison to questions about tensions or issues. As a consequence, when conducting the interviews in the second phase of the study only the most recent published report was used to supplement this information, but when conducting the case studies in the third phase of the study additional efforts were made to review all reports published by the team and to gain multiple perspectives about the tensions navigated.

Second, this study did not allow for the examination of whether domestic violence fatality review teams achieved system change. Given the amount of resources invested into these efforts and the seriousness of the issue targeted by these teams this is a critical question to attempt to answer. As previously mentioned, it would have been premature to conduct an evaluation of the effectiveness of these settings in obtaining direct changes to the system response or clear improvements in the social issue they aimed to address due to the limited knowledge about the nature of these teams and the lack of information about the outcomes they achieved (Alvaraz, 2004). For instance, prior to conducting this study it was unclear what domestic violence fatality review teams identified as their primary goals, how they worked towards obtaining their goals, and what they defined as effectiveness in reaching their goals. Therefore, any effort to measure outcomes may have risked imposing assumptions about these settings that were not accurate reflections of what these settings aimed to accomplish, how they are structured and operated, or what they are well positioned to achieve (Allen et al., 2008). In addition, while conducting this study it became clear that very few teams were collecting information about the impact of their efforts or the outcomes they achieved. Specifically, only one half of teams monitored whether their recommendations were being implemented and only

one quarter of teams made this information publicly available through their published reports. Furthermore, few domestic violence fatality review teams were monitoring or sharing information about outcomes in a systematic or consistent way. All of these issues make it difficult to measure the effectiveness of their efforts and draw attention to the need for teams to conduct ongoing evaluations of their impact (Kellam & Langevin, 2003; Rhatigan, Moore, & Street, 2005).

Third, this study only collected information about nature of domestic violence fatality review teams and the tensions they faced at a single point in time. As previously mentioned, gaining an understanding of the formation and development of these collaborative settings would be especially important given the nonlinear and evolutionary nature of collaborative settings, such as the variable and lengthy chain of events between forming a setting and achieving a desired outcome (Cashman et al., 2001; Kegler et al., 2001). This became increasingly apparent over the course of conducting interviews during the second phase of the study. As expected, teams described what they were currently doing with respect to their goals, structures, processes, outcomes, and tensions. What was unexpected was that teams also described what they had been doing in the past and what they hoped to do in the future. Many domestic violence fatality review teams appeared to be going through an ongoing process of self evaluation and changing rapidly over time. Teams that look similar currently may have developed very differently in the past and may no longer look similar in the future as they proceed to take different developmental paths. Therefore, the cross sectional nature of this study may have only caught domestic violence fatality review teams at one stage of their development. Consequently, any efforts to develop a descriptive typology of their efforts would need to be based on an understanding of their dynamic nature as they change over time as opposed to their static characteristics at a single

point in time.

Fourth, the author of this study was the primary person involved in determining the goals, structures, processes, outcomes, and tensions to investigate, conducting the interviews and case studies, and coding and analyzing the information collected. This may raise concern that the findings are simply a consequence of an idiosyncratic interpretation of the data or an unconscious effort to confirm preconceived hypotheses. Although it could be argued that all studies should be expected to be influenced by the social location and subjective perspective of the author (e.g., Olesen, 2003), as previously mentioned, several steps were taken in this study to increase the extent to which the findings reflected the experiences of the domestic violence fatality review teams.

First, phase one of the study was critical for ensuring that the identified goals, structures, processes, outcomes, and tensions were embedded within a thorough review of reports prepared by teams and articles written about collaborative efforts, discussion with experts in the field about their perception of the nature of these teams and tensions they experienced, and anecdotal experiences of team members drawn from observations of sessions and workshops at a national conference. The process of identifying tensions in advance and grounding them in a firm understanding of the case based on multiple sources of information is consistent with case study methodology as a means of guiding subsequent inquiry and analysis (1995).

Second, efforts were made while conducting interviews and case studies to allow for flexibility with respect to the tensions that had been identified in advance by asking teams about the extent to which they had experienced these tensions and inviting them to discuss any additional tensions they had encountered. Although no additional salient tensions arose during the course of the interviews, it is possible that the identification of tensions in the first phase of

the research may have precluded the emergence of additional tensions. Therefore, while the tensions identified in advance were confirmed to be shared by many teams, there may have been additional tensions that were not identified during the course of the study.

Third, throughout the process of analysis, triangulation of different sources of information was used to both confirm and disconfirm the presence and relevance of emerging themes and tensions. Specifically, information from review of documents, observation of meetings, and interviews with members were used to support and challenge the presence of emerging themes and tensions. Comparing responses from interviews with members within and between teams was particularly important for providing multiple perspectives about tensions or issues navigated by teams in order to draw out the inherent complexity of domestic violence fatality review teams.

Finally, advantage was taken of several opportunities which arose to share the results of the study with domestic violence fatality review teams and experts in the field to obtain their feedback about the extent to which the findings reflected their own impressions and experiences. Specifically, the results were shared with seven of twenty nine teams that took part in the study at a regional conference in the United States and a national conference in Canada. This process was extremely important for obtaining feedback about the extent to which the findings reflected their own impression and experiences. Although all of these processes provided support for the credibility of the findings, this research could certainly be strengthened by having a second rater code the goals, structures, processes, and outcomes of the teams as well of the tensions or issues they faced.

Implications

Implications for Theory and Research

Theory. In light of the methodological strengths and limitations of this study, findings can be used to inform future theory and research about collaborative settings. The rich information this study provided about the nature of these settings and the tensions underlying their efforts could be used to inform the development of explicit theories about how collaborative settings promote systems change. Any explicit theory that is developed to explain how collaborative efforts promote systems change would need to go beyond describing the nature of collaborative settings to explaining the impact they have on the system response. Therefore, this would require an in depth understanding of *both* the nature of collaborative settings, which is the focus of the current study, and the targeted system that they are attempting to change, which should be the focus of future research. Currently, there is a paucity of frameworks available to assist researchers and practitioners in understanding, designing, and assessing interventions to promote systems change (Foster-Fishman et al., 2007). Researchers have argued that it is important to obtain an understanding of the various parts within a system response and the interdependencies among these system parts when developing frameworks for promoting systems change (Foster-Fishman et al., 2007). Specifically, one framework that has been developed has proposed that in order to understand systems change interventions it is critical to establish system boundaries by defining the problem and the system, to identify fundamental parts of the system, to assess the interaction between the system parts, and to locate strategic levers for facilitating systems change (Foster-Fishman et al., 2007). Therefore, the in-depth knowledge this study provides about the nature of collaborative settings and the tensions or issues underlying their efforts would provide a foundation that future theory development could build upon by obtaining a complimentary understanding of the dynamic, complex, and interdependent system collaborative settings endeavor to change as outlined above.

Research. Future research could build on the findings of this study by examining whether domestic violence fatality review teams are achieving system change and the conditions under which (e.g., team structures, community features) they are most successful. During the course of this study, teams raised some very important questions including, “*What are we accomplishing?*”, “*Is it worth the time, energy and resources?*”, and “*How do we compare to other prevention efforts?*” Many teams reported that it was critical to address these questions to prove to themselves that it was worth the effort that they were devoting to these teams and to demonstrate to funding agencies to continue to provide the resources necessary to support their work. This will become an increasingly important task within the context of recent studies that have found that changes to the coordinated community response have not resulted in the reduction of intimate partner violence (Visser et al., 2008). Future research could evaluate the effectiveness of these collaborative settings in a number of ways. First, the findings of the current study could be used to examine the association of the nature of the goals, structures, processes of teams and the tensions underlining their work with the efforts they identified using to promote systems change such as developing, monitoring, and implementing recommendations. Second, rather than emphasizing only distal outcomes to assess council effectiveness, additional studies could investigate the extent to which domestic violence fatality review teams achieve proximal outcomes they reported aiming to achieve including increasing knowledge (e.g., as illustrated by better understanding of risk factors for and the system response to intimate partner violence in the community), promoting systems change (e.g., as illustrated by shifts in policy, protocol, and practice in the system response to intimate partner violence), and fostering collaboration (e.g., as illustrated by improved relationships, coordination, and communication among service providers), given their potential for directly or indirectly

influencing distal outcomes. Third, future research could expand on the findings of this study by exploring the ultimate question as to whether and the work of domestic violence fatality review teams actually translates in the prevention or reduction of intimate partner femicides both on their own and in comparison to other prevention efforts (Stith et al., 2006). All of these efforts would go a long way in moving from anecdotal to empirical evidence and bridging the gap between research and practice when evaluating the effectiveness of collaborative settings.

In addition to increasing understanding of whether domestic violence fatality review teams are achieving systems change, additional studies should continue to build on our understanding of how these collaborative settings are promoting system change. As previously mentioned, during the course of this study teams emphasized the evolutionary nature of their work by describing what they had been doing in the past, what they were doing currently, and what they hoped to do in the future. Many teams reported the changes they had made to their goals, structure, processes, and outcomes over time were a consequence of reflecting both on the work of their own team and other teams. The dynamic nature of these settings calls for an increased use of longitudinal methods to examine how these teams change over time, why these teams change over time, and what the implications of the changes they make are for their effectiveness in promoting systems change (Allen et al., 2008). Given that the changes domestic violence fatality review teams make to the nature of their setting appears to be in part a reflection of their own self evaluation of whether they are achieving their goals, there is a great deal that can be learned from this decision making process. Examining the evolutionary nature of teams could expand on the current study by allowing for the evaluation of both teams that are currently active and successful and those that are not longer active and failed to succeed. Including teams within the full range of stages of their development would help to illuminate

which characteristics of these settings may be critical barriers or facilitators that contribute to the success or failure of teams over time.

Future research would also benefit from expanding on our understanding of the broader community context in which these teams emerge, develop and persist (Allen et al., 2008; Roussos & Fawcett, 2000). In this study, key informants described how the community context had a major impact on their collaborative process at multiple points in time. For instance, many teams reported how it often took a local tragedy in their community to motivate stakeholders to consider forming a team. In addition, several teams stated that external funding was critical for providing ongoing support for their team to continue. Furthermore, teams reported that whether recommendations were implemented often depended on the presence of local champions, powerful stakeholders, or public interest outside of the team. This is consistent with previous research suggesting that collaborative efforts are not necessarily empowered to implement systems change on their own and are often dependent on the community context to help facilitate recommended changes (Allen, 2009; Allen, Javdani, Lehrner, & Walden, 2009; Kegler et al., 2001; Yin & Kaftarian, 1997). Given the importance of the broader community context in which collaborative settings occur, future research should continue to examine the unique goals, structures, processes and outcomes of teams with special consideration to the contextual factors that may influence their nature and outcomes. In addition, research should more closely examine how closely linked navigation of tensions is to the local realities and constraints faced by the teams and whether different contexts require different strategic approaches. In fact, any examination of how teams changed over time would be limited if it were restricted to examining characteristics inside the team as opposed to considering characteristics outside the team, as well as their potential interaction. Case study research is very well suited for obtaining an in depth

understanding of the broader community context in which these teams emerge, develop and persist.

Implications for Practice and Policy

Improving practices of teams. By drawing attention to the diverse nature of domestic violence fatality review teams, this study highlighted common strategies teams could benefit from using to improve their practices. Although many teams reported sharing a goal of reviewing cases of intimate partner femicide to develop strategies to prevent or reduce future fatalities, this study revealed that the process teams used to review cases varied dramatically across settings. The vignettes provided vivid examples of the diversity of the case review meeting and highlighted the need for a more consistent and systematic processes for reviewing cases across settings. For instance, the mortality reviews conducted in the fields of aviation, aerospace, engineering, medicine and nuclear fuels, on which domestic violence fatality review teams were based, routinely make use of well established procedures for reviewing tragedies (Rex et al., 2000). Specifically, an analytic tool referred to as “root cause analysis” is frequently utilized to perform comprehensive system-based reviews of tragic events or critical incidents within these fields. This tool includes strategies for the identification of the root and contributory factors, determination of risk reduction strategies, and development of action plans along with measurement strategies to evaluate the effectiveness of the plans (Hoffman, Beard, Greenall, U, & White, 2006). This framework shows a great deal of promise for systematically identifying problems and analyzing critical incidents to generate system improvements (Bagian et al., 2001). Given the complimentary goals of root cause analysis in determining “*what happened*”, “*why it happened*”, and “*what can be done to reduce the likelihood of a recurrence*” domestic violence fatality review teams could greatly benefit from adopting this tool to guide their review process

(Hoffman et al., 2006).

Facilitating communication between teams. In addition to improving the practices of domestic violence fatality review teams, the finding of this study could be used to help facilitate communication between teams. The importance of establishing a forum for domestic violence fatality review teams to learn from one another was emphasized by the establishment of the National Domestic Violence Review Initiative which posted information about teams (e.g., annual reports, research articles, review tools) on their website and hosted an annual conference for teams to attend. This research could build upon existing knowledge of domestic violence fatality review teams by providing the first comprehensive, systematic, and detailed study of the nature of the teams and the tensions they face. In this way, teams could learn about how they are similar and different to other teams, about the challenging issues other teams have faced, and the about the promising practices other teams have initiated. This information may encourage teams to continue to reflect on their own work and to make improvements to their own practices. As previously mentioned, an opportunity arose to share preliminary results of this study with domestic violence fatality review teams at a Regional Domestic Violence Fatality Review Conference in Princeton, New Jersey in 2006 and at a National Conference on the Prevention of Domestic Homicides in London, Ontario in 2009. The participants of the conference were surprised by the diversity of the goals, structures, and processes of teams and resonated with the shared tensions or issues. Given the extensive barriers faced by domestic violence fatality review teams (e.g., funding, liability, confidentiality), it is critical to continue to facilitate communication and understanding among members about the diverse ways of approaching this work and the potential implications of the choices they make. As a consequence, a technical report summarizing the findings of this study will be made available to domestic violence fatality

review teams who participated in this study.

Promoting establishment of teams. Beyond improving practices and facilitating communication of existing domestic violence fatality review teams, the finding of this study could be used to promote the establishment of additional teams. As previously mentioned, one of the most important questions that this research highlighted may not be *whether* domestic violence fatality review teams should be established but *how* domestic violence fatality review teams should be established. Because not all domestic violence fatality review teams are created equal, it is critical for stakeholders who plan to establish a team to ensure that the structures and processes they put in place are consistent with the goals of their team and the outcomes they hope to achieve. Therefore, stakeholders planning to establish a team would benefit greatly from learning about the diverse options they have for establishing a team, the tensions or issues they are likely to encounter in the course of their work, and the potential implications of how they resolve these dilemmas for promoting systems change. Efforts have already been taken to make the preliminary findings of this research available to stakeholders who were interested in establishing a domestic violence fatality review team. Specifically, a “think tank” was recently hosted in 2008 by the Ontario Domestic Violence Fatality Review Team to encourage other provinces in Canada to consider establishing a team of their own. A paper that was written on the basis of preliminary findings from this study focusing on the critical issues and promising practices of domestic violence fatality review teams was used to structure the discussion of this meeting. The hope is that the findings of this research can continue to be used to promote the establishment of additional teams that have been developed in light of the outcomes they hope to accomplish. For instance, a position paper could be written recommending several options for the establishment of domestic violence fatality review teams and summarizing the potential

strengths and limitations of each which could be presented to any professional stakeholders or community members interested in establishing a team.

Conclusions

Domestic violence fatality review teams have emerged in North America over the last fifteen years as a promising means of understanding and preventing intimate partner femicide. However, similar to other collaborative efforts there is limited knowledge about the nature of these settings or what they accomplish. The findings of this study provided rich descriptive information to increase understanding of the nature of collaborative settings and their efforts to promote systems change. First, this study illustrated that domestic violence fatality review teams have diverse goals, structures, processes, and outcomes, something which has been largely overlooked by previous articles where they are typically discussed in uniform terms. Second, this study identified shared critical tensions or issues underlying the efforts of domestic violence fatality review teams, which provided a potential explanatory account of the diversity of these settings. Importantly, both the diverse nature of these settings and their navigation of these tensions or issues appeared to have implications for how these teams promote systems change and how well-positioned they were to achieve this end. This study provided support for the use of qualitative methods to address several limitations of previous research of collaborative settings, including paying limited attention to the specific nature and potential diversity of collaborative settings and focusing primarily on providing descriptive as opposed to explanatory accounts of collaborative settings. Understanding the diversity of collaborative settings and the processes underlying their efforts is critical for informing future theory and research about collaborative settings and to facilitate improvements to practice and policy in this area.

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APPENDIX A: Tables and Figures

Table 1

Participating Domestic Violence Fatality Review Teams

State	Domestic Violence Fatality Review Team
California	Los Angeles County Domestic Violence Death Review Team Santa Clara County Domestic Violence Death Review Committee
Colorado	Denver Metro Domestic Violence Fatality Review Committee
Connecticut	Connecticut Domestic Violence Fatality Review Committee
Delaware	Delaware Fatality Incident Review Team
Florida	Broward County Fatality Review Team Palm Beach County Fatality Review Team Pinellas County Fatality Review Team
Georgia	Georgia Domestic Violence Fatality Review Project
Hawaii	Hawaii's Fatality Review Team
Iowa	Iowa Domestic Abuse Death Review Team
Kansas	Governor's Domestic Violence Fatality Review Board
Kentucky	Louisville Metro Domestic Violence Fatality Review Committee
Maine	Maine Domestic Abuse Homicide Review Panel
Maryland	Calvert County Domestic Violence Fatality Review Team
Michigan	Macomb County Domestic Violence Fatality Review Team
Minnesota	Hennepin County Domestic Violence Fatality Review Project
Montana	Montana Domestic Violence Fatality Review Commission
New Hampshire	New Hampshire Domestic Violence Fatality Review Committee

Table 1 (continued)

Participating Domestic Violence Fatality Review Teams

State	Domestic Violence Fatality Review Team
New Jersey	New Jersey Domestic Violence Fatality and Near Fatality Review Board
New Mexico	New Mexico Intimate Partner Violence Death Review Team
New York	Kings County Domestic Violence Fatality Review Team New York City Domestic Violence Fatality Review Team
Ohio	Domestic Violence Fatality Review Committee of Cuyahoga County
Oklahoma	Oklahoma Domestic Violence Fatality Review Board
Ontario	Ontario Domestic Violence Death Review Committee
Pennsylvania	Philadelphia Women's Death Review Team
Tennessee	Knox County Domestic Violence Fatality Review Panel
Utah	Utah Domestic Violence Fatality Review Committee
Vermont	State of Vermont Domestic Violence Fatality Review Commission
Virginia	Chesterfield County Intimate Partner & Family Violence Fatality Review Team Colonial Area Family and Intimate Partner Violence Fatality Review Team Henrico County Family Violence Fatality Review Team
Washington	Washington State Domestic Violence Fatality Review
West Virginia	West Virginia Domestic Violence Fatality Review Team

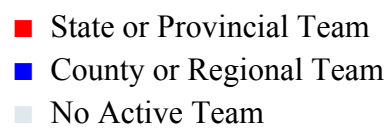
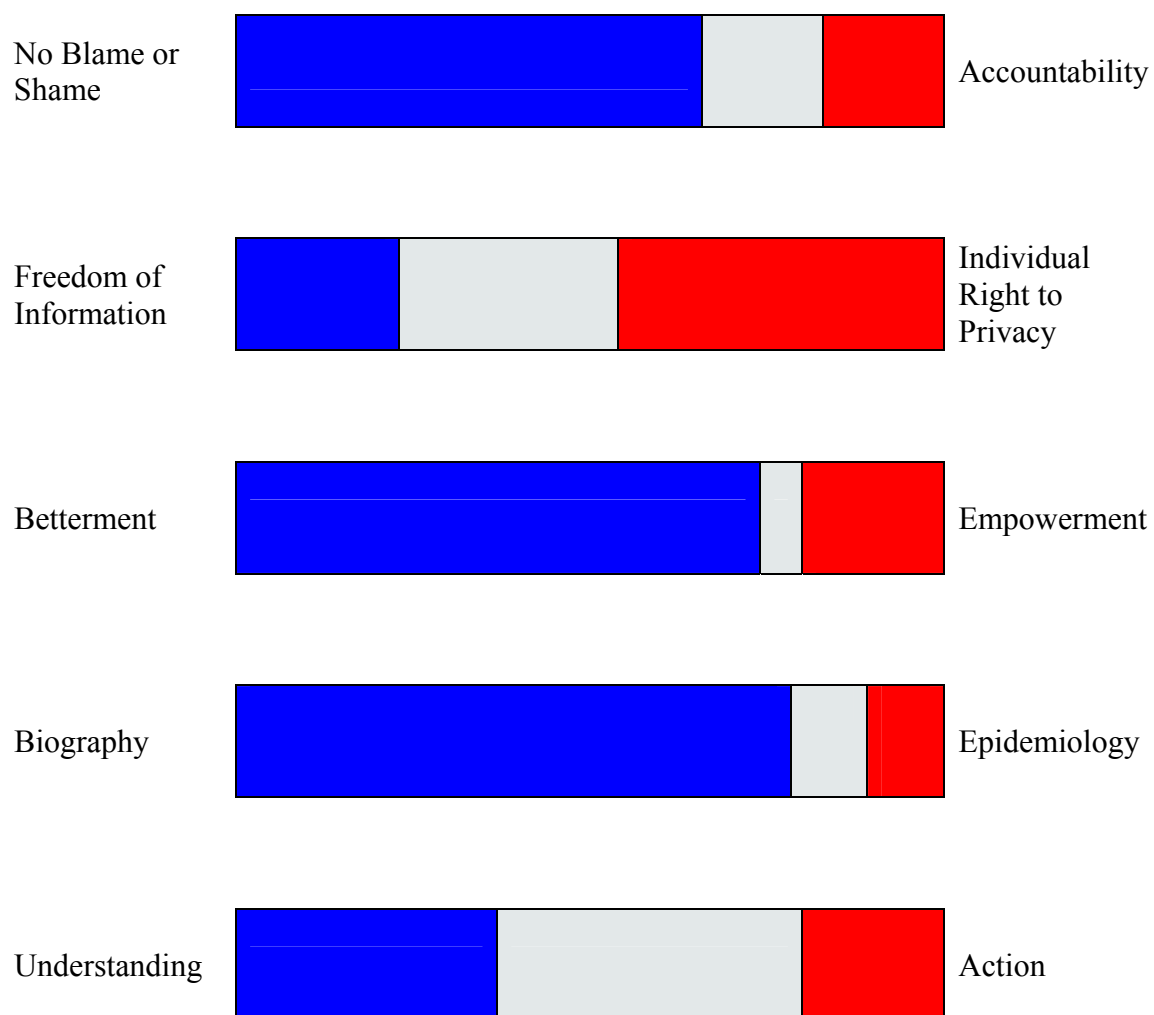


Figure 2: Domestic Violence Fatality Review Teams Navigation of Tensions



APPENDIX B: Recruitment Letter

[ADDRESS]

Dear [NAME],

We are writing to ask for your help with an important project about domestic violence fatality review teams. We know that you are the [POSITION] of a local effort in [COUNTY/STATE]. We are interested in talking with people from across the United States and Canada regarding their domestic violence fatality review teams and were hoping that we could talk with someone about the work occurring in [STATE].

As you know, over the past fifteen years there has been a rapid growth in the number of domestic violence fatality review teams. Anecdotal evidence suggests that teams can have a positive effect in addressing the complex issues that arise when responding to violence against women. However, the benefit of conducting fatality reviews has yet to be evaluated on a systematic or broad scale. To address this gap, we will be conducting a study of domestic violence fatality review teams that aims to provide a better understanding of the challenges they face and accomplishments they achieve. Our hope is that this study will support the development and coordination of fatality review efforts across North America. The National Domestic Violence Fatality Review Initiative Conference in the summer of 2005 punctuated the importance of sharing information across communities. We believe this study can be an important part of such a process.

We hope that you or someone from the [DVFRT] will be willing to participate in this study. We would like to conduct a phone interview with the member of the team who is most familiar with the history and day-to-day operations of your domestic violence fatality review. This member may be you or it may be someone else on the team. Interviews should take between one and two hours. Your participation is completely voluntary.

We also want to assure you that only the investigators of this study will have access to completed interviews. All results will be confidential and your responses will remain anonymous in any report of research findings from these interviews. Upon project completion, a final report will be available to you summarizing the findings across domestic violence fatality review teams in the United States and Canada.

The participation of the [DVFRT] is extremely valuable to us. We will be contacting you by phone within the next month to invite you to participate in the study and to answer any questions you may have. If you have any questions about your participation in this project you can collect call Kelly Watt at (604) 697-0016 (kwatt@uiuc.edu) or Dr. Nicole Allen at (217) 333-6739 (allenne@uiuc.edu).

Sincerely,

Kelly A. Watt, M.A.

University of Illinois at Urbana-Champaign

Nicole E. Allen, Ph.D.

University of Illinois at Urbana-Champaign

APPENDIX C: Telephone Script for Contact Person

Hello, may I please speak to _____ (the Contact Person of the domestic violence fatality review team)?

[IF FIRST CONTACT PERSON IS AVAILABLE]

Hello, my name is Kelly Watt and I am conducting a study on domestic violence fatality review teams with Nicole Allen of the Department of Psychology at the University of Illinois at Urbana-Champaign. We sent you a letter inviting you to participate in the study in [MONTH, YEAR]. Would it be possible for me to take some time to talk to you about the study?

[IF YES]

As you know, over the past fifteen years there has been a rapid growth in the number of domestic violence fatality review teams. Anecdotal evidence suggests that teams can have a positive effect in addressing the complex issues that arise when responding to violence against women. However, the benefit of conducting fatality reviews has yet to be evaluated on a systematic or broad scale. To address this gap, we will be conducting a study of domestic violence fatality review teams that aims to provide a better understanding of the challenges they face and accomplishments they achieve. Our hope is that this study will support the development and coordination of fatality review efforts across North America.

As part of this study, I would like to conduct a phone interview with the member of the [DVFRT] who is most familiar with the history and day-to-day operations of your domestic violence fatality review team. This member may be you or it may be someone else on the team. Who do you consider is most familiar with the history and day-to-day operations of your team?

Key Informant Name: _____

A) [IF ALREADY SPEAKING WITH KEY INFORMANT - CONTINUE]

Interviews should take approximately two hours. To be sure that I am accurately recording your responses, with your permission, I will be taping the interview. Participation is voluntary and your responses will be anonymous. The benefit of this study is that information gathered may increase understanding of domestic violence fatality review teams and be used to assist with their development and coordination. Upon completion of the project, a final report will be available to you summarizing the findings across fatality reviews. Do you have any questions about the study?

Would you be willing to take part in an interview regarding your experiences in the review process?

[IF YES]

When would be a good date and time for me to call you to conduct the interview?

Date and Time: _____

What phone number should I reach you at?

Phone Number: _____

Prior to the interview I will mail you a copy of a consent form for you to keep for your records. I will also read the consent form to you at the time of the interview. What address would you like me to send the consent form to?

Address/Email: _____

B) [IF KEY INFORMANT IS SOMEONE ELSE]

What is the best way for me to contact (Key Informant)?

Phone Number: _____

What is the best time for me to contact (Key Informant)?

Time: _____

APPENDIX D: Telephone Script for Key Informant

Hello, may I please speak to _____ (the Key Informant identified by the Contact Person)?

[IF KEY INFORMANT IS AVAILABLE]

Hello, my name is Kelly Watt and I am conducting a study on domestic violence fatality review teams with Nicole Allen of the Department of Psychology at the University of Illinois at Urbana-Champaign. We sent you a letter inviting you to participate in the study in [MONTH/DATE]. Would it be possible for me to take some time to talk to you about the study?

[IF YES]

As you know, over the past fifteen years there has been a rapid growth in the number of domestic violence fatality review teams. Anecdotal evidence suggests that teams can have a positive effect in addressing the complex issues that arise when responding to violence against women. However, the benefit of conducting fatality reviews has yet to be evaluated on a systematic or broad scale. To address this gap, we will be conducting a study of domestic violence fatality review teams that aims to provide a better understanding of the challenges they face and accomplishments they achieve. Our hope is that this study will support the development and coordination of fatality review efforts across North America.

As part of this study, I would like to conduct a phone interview with the member of the [DVRT] who is most familiar with the history and day-to-day operations of your domestic violence fatality review. [Contact Person] has identified you as this person.

Interviews should take approximately two hours. To be sure that I am accurately recording your responses, with your permission, I will be taping the interview. Participation is voluntary and your responses will be anonymous. The benefit of this study is that information gathered may increase understanding of domestic violence fatality review teams and be used to assist with their development and coordination. Upon completion of the project, a final report will be available to you summarizing the findings across fatality reviews. Do you have any questions about the study?

Would you be willing to take part in an interview regarding your experiences in the review process?

[IF YES]

When would be a good date and time for me to call you to conduct the interview?

Date and Time: _____

What phone number should I reach you at?

Phone Number: _____

Prior to the interview I will mail you a copy of a consent form for you to keep for your records. I will also read the consent form to you at the time of the interview. What address would you like me to send the consent form to?

Address/E-mail: _____

APPENDIX E: Key Informant Informed Consent for Phase Two

[ADDRESS]

Dear [NAME],

Thank you for agreeing to participate in the study of domestic violence fatality review teams being conducted by Kelly Watt and Nicole Allen of the Department of Psychology at the University of Illinois at Urbana-Champaign. As you are aware, over the past fifteen years there has been a rapid growth in the number of domestic violence fatality review teams. Anecdotal evidence suggests that teams can have a positive effect in addressing the complex issues that arise when responding to violence against women. However, the benefit of conducting fatality reviews has yet to be evaluated on a systematic or broad scale. To address this gap, we will be conducting a study of domestic violence fatality review teams that aims to provide a better understanding of the challenges they face and accomplishments they achieve. Our hope is that this study will support the development and coordination of fatality review efforts across North America.

As a member of the [DVFRT], you have agreed to take part in an interview regarding your experiences participating in the review process. By completing the interview you indicate voluntary participation in the study. Interviews should approximately two hours. To be sure that I am accurately recording your responses, with your permission, I will be taping the interview. You have the right to review the audiotape and/or transcript of our interview if you choose and to make a request to make partial or complete edits or additions to the information you provide.

Participation is strictly voluntary. You may refuse to participate or withdraw participation at any time. If you agree to be interviewed, you do not have to answer any questions you do not want to answer. Your responses will be anonymous. You will not be identified by name and any potentially identifying information will not be collected or will be deleted. The data will be stored in a filing cabinet in a locked office with only a participant identification number on it. Only the investigator working on this project will have access to the information collected.

There are no significant risks associated with these procedures. The benefit of this study is that information gathered may increase understanding of domestic violence fatality review teams and be used to assist with their development and coordination. Upon project completion, a final report will be available to you summarizing the findings across fatality reviews.

Your participation is extremely valuable to us. We greatly appreciate your time and look forward to speaking with you on [DATE/TIME]. A second copy of this consent form has been provided for your records. If you have any questions about your participation in this project you can collect call Kelly Watt at (604) 697-0016 (kwatt@uiuc.edu) or Dr. Nicole Allen at (217) 333-6739 (allenne@uiuc.edu). If you have questions about your rights as a research participant you can collect call the Institutional Review Board Office (IRB) at (217) 333-2670.

By completing this interview, you acknowledge that you are participating in this study of your own free will and that you may refuse to participate or stop participating at any time without penalty.

APPENDIX F: Interview Protocol for Key Informant

Over the past fifteen years, domestic violence fatality review teams have emerged as a popular and promising means of preventing intimate partner femicides. I am interested in hearing about *your* team's experiences. I will be asking you a number of questions today. I am going to start off by asking you some basic questions about the context, goals, structures, processes and outcomes of your team. Then I am going to move to more in depth questions about tensions or issues that your team may face in the work that you do.

Do you have any questions before we begin?

Key Informant

1. How long have you been involved in the team?
2. What led to your involvement in the team?
3. What is your professional affiliation?

Context

4. When was your team established (month/year)?
5. How would you describe the social or political climate prior to setting up the team? What types of things facilitated or were barriers to the establishment of the team?
6. What outside stakeholders do you feel are supportive of the efforts of the team? What outside stakeholders do you feel are unsupportive of your efforts?
7. Has the team been established under state legislation, an executive order, or some other mechanism (specify legislation, executive order, interagency agreement)? Why was it established this way?
8. What steps have you taken to try to define or ensure confidentiality (e.g., confidentiality or immunity legislation, confidentiality agreement, shredding information)?
9. What type of funding does the team receive? How long have you been receiving this funding?
10. What type of technical assistance or support does the team receive? Do you feel that this technical assistance is adequate?

Goals

11. What are the primary goals of the team?
12. How would you describe the philosophy or values of your team?

Structure

13. Where is your team based or housed?
14. What geographical area does the team cover (e.g., state, city, county)? What is the level of urbanization of this area (e.g., urban, rural, suburban, mixed)?
15. How often does the team meet? How long are your meetings?
16. What is the organizational structure of the team? (e.g., chairs, co-chairs, subcommittees, single or two tiered)?
17. How many members do you currently have on your team? Is your membership stable or dynamic?
18. What are the professional affiliations of the members of your team?
19. How is it decided who will become a member of the team (e.g., mandated by law or regulation)? What types of qualities or characteristics are considered important for membership?
20. Does your team involve non-members to participate in the process (e.g., on a case by case basis, as part of the review process)?
21. Has your team considered including any additional people to participate in the process (e.g., victims or perpetrators of IPV, family members of victims or perpetrators of IPF, members of religious communities)? If so, what role do you think they should play?
22. Who does your team report to or share information with (e.g., findings, accomplishments recommendations)? How does your team share this information (e.g., annual reports, presentations, newsletters)? What does this information consist of?

Processes

23. I want to make sure I understand the process that your team uses to review cases. I'll be asking you some specific questions about this but before I do this, could you describe the steps in the process that your team uses to review cases?
24. What types of cases does the team review? (e.g., intimate partner femicides, intimate partner homicides, domestic violence related deaths, near lethal violence/open vs. closed cases) Why does the team review these types of deaths and not others?
25. Approximately how many cases does the team review per year? What proportion is this of the total homicides that could have been reviewed that year?
26. How does the team select and gain access to these cases?
27. What types of information does the team collect? (e.g., information about the event, perpetrator, victim, relationship, family, community/system response). Why do you think the team collects this type of information and not others?
28. What types of data sources does the team use to collect information? (e.g., coroners report, autopsy report, police files, newspaper articles, medical records, mental health records, social service reports, dv shelter, interviews with family members or service providers) Why do you think the team uses these sources of information and not others?
29. How does the team organize or analyze the information that it collects? (e.g., coding forms, narrative, timelines, statistics)
30. What types of recommendations does the team make? What process does your team use to make recommendations?
31. How has the team been involved in implementing recommendations?

Outcomes

32. What do you feel that your team has accomplished? (e.g., improved relationships, increased knowledge, changes to policies and procedures)

Tensions

We have completed the first portion of the interview. I feel I have a good sense of how your team was established and currently operates. Next I am going to ask you some questions about issues or tensions that your team may face. By issues or tension, I mean tradeoffs that teams have to make or dilemmas that teams have to face. From what I understand about domestic violence fatality review teams, they often have to make a choice between alternative courses of action that each may have their relative costs and benefits. For instance, one of the tensions I am going to ask you about is how your team handles freedom of information on one hand and individual right to privacy on the other. I believe that gaining a better understanding of these issues or tensions will help to illuminate the complexity of these teams and will help to explain their diverse goals, structures, processes, and outcomes.

33. What are some of the critical issues or tensions that your team deals with?

Tension #1: No Shame or Blame vs. Accountability

34. Tell me about your team's orientation to *no shame or blame*. By no shame or blame I mean building strong, caring, trusting, and respectful relationship, blaming perpetrators instead of agencies for the IPF, and focusing on future changes. How important does your team feel that promoting no shame or blame is for the work that you do? What are some of the costs and benefits of promoting no shame or blame? How has your team promoted no shame or blame?
35. Tell me about your team's orientation to *accountability*. By accountability I mean building honest and candid relationships, identifying gaps or failures in the system response, focusing on responsibility for past mistakes. How important does your team feel that promoting accountability is for the work that you do? What are some of the costs and benefits of promoting accountability? How has your team promoted accountability?
36. Between these two, which orientation is more dominant in your setting, accountability or no shame or blame? Is your orientation to (no shame or blame/accountability) a conscious choice?
37. In what ways, if at all, does your orientation to accountability compete with your orientation to no shame or blame? Could you give some examples of when this tension has come up? How has your team handled/resolved this tension?

Tension #2: Freedom of Information vs. Individual Right to Privacy

38. Tell me about your team's orientation to freedom of information. By freedom of information I mean sharing information freely, collecting private information, and disseminating findings publicly or openly. How important does your team feel that freedom of information is for the work that you do? What are some of the costs and benefits of freedom of information? How has your team handled freedom of information?
39. Tell me about your team's orientation to individual right to privacy. By individual right to privacy I mean restricting information sharing, collecting only public information, and disseminating findings in a limited way. How important does your team feel that individual right to privacy is for the work that you do? What are some of the costs and benefits of confidentiality? How has your team handled individual right to privacy?
40. Between these two, which orientation is more dominant in your setting, freedom of information or individual right to privacy? Is your orientation to freedom of information/individual right to privacy a conscious choice?
41. In what ways, if at all, does your orientation to freedom of information compete with your orientation to individual right to privacy? Could you give some examples of when this tension has come up? How has your team handled/resolved this tension?

Tension #3: Betterment vs. Empowerment

42. Tell me about your team's orientation to *betterment*. By betterment I mean forming a team within an institution or agency outside of a particular community; where agency leaders or representatives shape the goals, structure, and process of the team; with a norm of collaboration and relationship building; improving program delivery and services, and advocating for policy or systems change. How important does your team feel that betterment is for the work that you do? What are some of the costs and benefits of betterment? How has your team promoted betterment?
43. Tell me about your team's orientation to *empowerment*. By empowerment I mean forming a team within a particular community; where the community residents (e.g., advocates, family members, victims) shape the goals, structure and process of the team, and increasing the ownership and power of those primarily affected by the team's activities. How important does your team feel that empowerment is for the work that you do? What are some of the costs and benefits of empowerment? How has your team promoted empowerment?
44. Between these two, which orientation is more dominant in your setting, betterment or empowerment? Is your orientation to (betterment/empowerment) a conscious choice?
45. In what ways, if at all, does your orientation to betterment compete or conflict with your orientation to empowerment? Could you give some examples of when this tension has come up? How has your team handled/resolved this tension?

Tension #4: Biography vs. Epidemiology

46. Tell me about your team's orientation to biography. By biography I mean collecting in depth information about a small number of cases, sometimes referred to as a case specific or systems approach. How important does your team feel that taking a biographical approach to collecting information is for the work that you do? What are some of the costs and benefits of the biographical approach? How has your team taken a biographical approach? (e.g., case review process)
47. Tell me about your team's orientation to epidemiology. By epidemiology I mean while collecting broad information for a large number of deaths, sometimes referred to as a wide angle approach or investigative model. How important does your team feel taking an epidemiological approach to collecting information is for the work that you do? What are some of the costs and benefits of an epidemiological approach? How has your team taken an epidemiological approach? (e.g., case review process)
48. Between these two, which orientation is more dominant in your setting, biography or epidemiology? Is your orientation to (biography/epidemiology) a conscious choice?
49. In what ways, if at all, does your orientation to biography compete with your orientation to epidemiology? Could you give some examples of when this tension has come up? How has your team handled/resolved this tension?

Tension #5: Understanding vs. Action

50. Tell me about your team's orientation to *understanding*. By understanding I mean increasing knowledge about factors associated with IPF, your local system response to IPV, and the roles of different agencies or members. How important does your team feel that promoting understanding is for the work that you do? What are some of the costs and benefits of promoting understanding? How has your team promoted understanding?

51. Tell me about your team's orientation to *action*. By action I mean recommending or changes to policies, procedures, or practices in your community. How important does your team feel that promoting action is for the work that you do? What are some of the costs and benefits of promoting action? How has your team promoted action?
52. Between these two, which orientation is more dominant in your setting, action or understanding? Is your orientation to (understanding/action) a conscious choice?
53. In what ways, if at all, does your orientation to action compete or conflict with your orientation to understanding? Could you give some examples of when this tension has come up? How has your team handled/resolved this tension?
54. Are there any additional critical issues or tensions that your team deals with?

Closing questions

55. What are the next steps of the team?
56. Is there anything you would like to share with me that we have not yet discussed?
57. Is there anything that you would like to ask me?

Thank you so much for participating in the interview. Your participation is extremely important for the study and I greatly appreciate your time.

APPENDIX G: Information Letter

[ADDRESS]

Dear [KEY INFORMANT],

Thank you for agreeing to participate in the study of domestic violence fatality review teams being conducted by Kelly Watt and Nicole Allen of the Department of Psychology at the University of Illinois at Urbana-Champaign. I am writing to provide you with additional information about the study. You are welcome to share this letter with other members of your team.

As you know, over the past fifteen years there has been a rapid growth in the number of domestic violence fatality review teams. Anecdotal evidence suggests that teams can have a positive effect in addressing the complex issues that arise when responding to violence against women. However, the benefit of conducting fatality reviews has yet to be evaluated on a systematic or broad scale. To address this gap, we will be conducting a study of domestic violence fatality review teams that aims to provide a better understanding of the diverse challenges they face and accomplishments they achieve. Our hope is that this study will support the development and coordination of fatality review efforts across North America.

The first part of the study involves conducting interviews with a member of domestic violence fatality review teams across North America. The goal of the first part of the study is to gain a general or broad understanding of the different approaches to establishing and operating domestic violence fatality review teams. The recruitment strategy for first part of the study is to conduct at least one interview with a member of a team in every state and province that they are currently active. The interview focuses on the context, goals, structures, processes, outcomes, and tensions of the team. As you are aware, we have already started the first part of the research and anticipate completing interviews by the end of August. We have received a wonderful response from the teams that have been approached to take part in the study.

The second part of the study involves conducting case studies with three to five teams across North America. The goal of the second study is to increase understanding of a case, like the [DVFRT], by gaining indepth information about the case and illuminating issues or tensions that help to inform the goals, structures, processes, and outcomes of the team. The strength of a case study is that it often draws attention to the complexity of issues by highlighting multiple perspectives, instead of converging on a single perspective. Teams were selected because they appeared to represent diverse approaches to conducting domestic violence fatality reviews based on the interviews that were conducted in the first part of the study. The case study involves multiple methods, including conducting interviews with some of the members of the team, observing and documenting daily practices and procedures, and reviewing relevant documents. Interviews will take approximately one hour and will focus on member's experiences participating in the review process and the tensions or issues that the team may face. Daily practices and procedures that may be observed include meetings, workshops, or the review process. Care will be taken not to interrupt daily routines while observing and taking notes.

Documents that may be reviewed include annual reports, confidentiality agreements, legislation, coding forms, and meeting minutes.

It is important to note that case studies will be tailored to the individual settings of the teams involved in the second part of research. Decisions will be made about which members to interview, what daily practices to observe, and what documents to review in collaboration with the primary informant of the team. A copy of the interview schedule will be sent to the primary informant for their review prior to conducting interviews with the members of the team. Documents that will be written on the basis of the second part of the study will be sent to participating teams for their review and feedback from the teams will be welcome.

Participation in the second part of the study is strictly voluntary. Any member of the team may refuse to participate or withdraw participation at any time. If members agree to be interviewed, they do not have to answer any questions that they do not want to answer. Members' responses will be anonymous. Individuals participating in this study will not be identified by name and any potentially identifying information will not be collected or will be deleted. Although efforts will be taken to remove any information that could reveal the identity of the team, because of the in depth nature of the case study, there may be a possibility that those familiar with the unique goals, structures, processes, or outcomes of the team may be able to recognize it. The data will be stored in a filing cabinet in a locked office with only a participant identification number on it. Only the investigator working on this project will have access to the information collected.

There are no significant risks associated with these procedures. The benefit of this study is that information gathered may increase understanding of domestic violence fatality review teams and be used to assist with their development and coordination. Upon project completion, a final report will be available to you summarizing the findings across fatality reviews.

Your participation is extremely valuable to us. We greatly appreciate your time and look forward to speaking with you further about the second part of the study. As discussed, we hope to conduct the case study [DATE]. Once we confirm a date for the case study, consent forms will be sent to the team.

If you have any questions about your participation in this project you can collect call Kelly Watt at (604) 697-0016 (kwatt@uiuc.edu) or Dr. Nicole Allen at (217) 333-6739 (allenne@uiuc.edu).

Sincerely,

Kelly A. Watt, M.A.
University of Illinois at Urbana-Champaign

Nicole E. Allen, Ph.D.
University of Illinois at Urbana-Champaign

APPENDIX H: Key Informant Informed Consent for Phase Three

Thank you for agreeing to participate in the study of domestic violence fatality review teams being conducted by Kelly Watt and Nicole Allen of the Department of Psychology at the University of Illinois at Urbana-Champaign. As you know, over the past fifteen years there has been a rapid growth in the number of domestic violence fatality review teams. Anecdotal evidence suggests that teams can have a positive effect in addressing the complex issues that arise when responding to violence against women. However, the benefit of conducting fatality reviews has yet to be evaluated on a systematic or broad scale. To address this gap, we will be conducting a study of domestic violence fatality review teams that aims to provide a better understanding of the diverse challenges they face and accomplishments they achieve. Our hope is that this study will support the development and coordination of fatality review efforts across North America.

As the Primary Contact of the [DVFRT], you have agreed to allow Kelly Watt to conduct interviews with members of your team, observe daily practices and procedures, and review relevant documents. Interviews will take approximately one hour and will focus on member's experiences participating in the review process and the tensions or issues that the team may face. Daily practices and procedures that may be observed include meetings, workshops, or the review process. While observing, Kelly Watt will take notes and take care not to interrupt daily routines. Documents that Kelly Watt may review include annual reports, confidentiality agreements, legislation, coding forms, and meeting minutes.

Participation is strictly voluntary. You may refuse to participate or withdraw participation at any time. If you agree to be interviewed, you do not have to answer any questions you do not want to answer. Your responses will be anonymous. Individuals participating in this study will not be identified by name and any potentially identifying information will not be collected or will be deleted. The data will be stored in a filing cabinet in a locked office with only a participant identification number on it. Only the investigator working on this project will have access to the information collected.

There are no significant risks associated with these procedures. The benefit of this study is that information gathered may increase understanding of domestic violence fatality review teams and be used to assist with their development and coordination. Upon project completion, a final report will be available to you summarizing the findings across fatality reviews.

Your participation is extremely valuable to us. We greatly appreciate your time and look forward to visiting your team between [DATES]. To confirm your participation, please sign one copy of this consent form and return it to Kelly Watt. Please keep the second copy of the consent form for your own records. If you have any questions about your participation in this project you can collect call Kelly Watt at (604) 697-0016 (kwatt@uiuc.edu) or Dr. Nicole Allen at (217) 333-6739 (allenne@uiuc.edu). If you have questions about your rights as a research participant you can collect call the Institutional Review Board Office (IRB) at (217) 333-2670.

-
- ☐ I am willing to participate in a brief interview.
 - ☐ I am willing to be observed and audiotaped.

☐ I am willing to permit you to review relevant documents.

I acknowledge that I am participating in this study of my own free will. I may refuse to participate or stop participating at any time without penalty.

Participant Name

Participant Signature

Date

APPENDIX I: Member Informed Consent for Phase Three

Kelly Watt and Nicole Allen of the Department of Psychology at the University of Illinois at Urbana-Champaign are conducting a study of domestic violence fatality review teams. As you know, over the past fifteen years there has been a rapid growth in the number of domestic violence fatality review teams. Anecdotal evidence suggests that teams can have a positive effect in addressing the complex issues that arise when responding to violence against women. However, the benefit of conducting fatality reviews has yet to be evaluated on a systematic or broad scale. To address this gap, we will be conducting a study of domestic violence fatality review teams that aims to provide a better understanding of the diverse challenges they face and accomplishments they achieve. Our hope is that this study will support the development and coordination of fatality review efforts across North America.

To gather this information, over a period of one week, Kelly Watt will observe daily activities of the [DVFRT] and conduct interviews with some members of the team. While observing, Kelly Watt will take notes and take care not to interrupt daily routines. Interviews will take approximately one hour and will focus on about the member's experiences participating in the review process and the tensions or issues that the team may face. Kelly Watt has also obtained permission to review relevant documents (e.g., annual reports, confidentiality agreements, legislation, coding forms, meeting minutes).

If you are willing to participate in this study, Kelly Watt may observe your daily activities and may also ask you to answer some questions about your experiences. Participation is strictly voluntary. You may refuse to participate or withdraw participation at any time. If you agree to be interviewed, you do not have to answer any questions you do not want to answer. Your responses will be anonymous. Individuals participating in this study will not be identified by name and any potentially identifying information will not be collected or will be deleted. The data will be stored in a filing cabinet in a locked office with only a participant identification number on it. Only the investigator working on this project will have access to the information collected.

There are no significant risks associated with these procedures. The benefit of this study is that information gathered may increase understanding of domestic violence fatality review teams and be used to assist with their development and coordination. Upon project completion, a final report will be available to you summarizing the findings across fatality reviews.

Your participation is extremely valuable to us. We greatly appreciate your time and look forward to visiting your team between [DATES]. If you would like to participate, please sign one copy of this consent form and return it to Kelly Watt. Please keep the second copy of the consent form for your own records. If you have any questions about your participation in this project you can collect call Kelly Watt at (604) 697-0016 (kwatt@uiuc.edu) or Dr. Nicole Allen at (217) 333-6739 (allenne@uiuc.edu). If you have questions about your rights as a research participant you can collect call the Institutional Review Board Office (IRB) at (217) 333-2670.

-
- ☐ I am willing to participate in a brief interview.
 - ☐ I am willing to be observed and audiotaped.

I acknowledge that I am participating in this study of my own free will. I may refuse to participate or stop participating at any time without penalty.

Participant Name

Participant Signature

Date

APPENDIX J: Interview Protocol for Members

Over the past fifteen years, domestic violence fatality review teams have emerged as a popular and promising means of preventing domestic violence related homicides. I am interested in hearing about *your* team's experiences. At this point in my study I have conducted interviews with at least one team from every state or province they currently exist. I have also conducted an in depth interview with one of the members of your team and reviewed your annual reports.

I will be asking you a number of questions today. I am going to start off by asking you some basic questions about your involvement in the team. Following this, I am going to move to more in depth questions about issues or tensions that your team may face in the work that you do. By issues or tension, I mean tradeoffs that teams have to make or dilemmas that teams have to face. From what I have come to understand about DVFRT, they often have to make a choice between alternative courses of action that each may have their relative costs and benefits. I believe that gaining a better understanding of these issues or tensions will help to illuminate the complexity of these teams and will help to explain their diverse goals, structures, processes, and outcomes.

Do you have any questions before we begin?

Member

1. What is your job?
2. What is your position/role on the team?
3. What are your particular responsibilities on the team?
4. How long have you been involved in the team?
5. What led to your involvement in the team?

Goals

6. What are the primary goals of the team?

Tensions

Tension #1: Understanding vs. Action

One of the most common goals across teams is the prevention of future domestic violence related homicides. However, how they approach prevention differs from team to team.

Understanding: Some teams approach prevention through *understanding*. They review cases, identify risk factors, highlight gaps in the system response, and make recommendations. They see their role as an independent fact finding body and believe it is the responsibility to educate others about changes that need to be made to policies, procedures, and practices.

Action: Some teams approach prevention through *action*. They monitor whether recommendations have been implemented and they are involved in the implementation of recommendations. They see their role as part of the system response and believe it is their responsibility to implementing changes to policies, procedures, and practices.

7. What approach does your team emphasize? (understanding/action)
8. How does your team's emphasis on (understanding/action) facilitate the team's goals?
9. What do you think are some of the costs and benefits of this approach?
10. In what ways has the team's emphasis on understanding come into conflict with their emphasis on action? (examples/resolution)
11. Do you agree with the approach the team takes?

Tension #2: No Shame or Blame vs. Accountability

Teams have also identified different core values or philosophies guiding their work.

No Shame or Blame: Some teams emphasize the value of *no shame or blame*. They believe it is important not hold any one individual or agency responsible for past behaviour or for future change. They feel that adopting a value of *no blame or shame* may make people feel more comfortable to come to the table and that it is critical for making change.

Accountability: Some teams emphasize the value of *accountability*. They believe it is important to hold individuals or agencies responsible for past behaviour and for future change. They feel that adopting a value of *accountability* may make people feel uncomfortable to come to the table but that it is critical for making change.

12. What approach does your team emphasize? (no shame or blame/accountability)
13. How does your team's emphasis on (no shame or blame/accountability) facilitate the team's goals?
14. What do you think are some of the costs and benefits of this approach?
15. In what ways has the team's emphasis on no blame or shame come into conflict with their emphasis on accountability? (examples/resolution)
16. Do you agree with the approach the team takes?

Tension #3: Betterment vs. Empowerment

Teams have chosen different ways of structuring their team.

Betterment: Some teams have been formed at a state level, where agency leaders and representatives shape the team. The members of the team were often not involved in providing services to the perpetrators or victims prior the fatality. The aim of the team is to make improvements to programs, services, systems and policies at a state level.

Empowerment: Some teams have been formed at a county or regional level, where community residents (e.g., advocates, family members, victims) shape the team. The members of the team were often involved in providing services to the perpetrators or victims prior the fatality. The aim of the team is to make improvements to programs, services, systems and policies at a county or regional level.

17. What approach does your team emphasize? (betterment/empowerment)
18. How does your team's emphasis on (betterment/empowerment) facilitate the team's goals?
19. What do you think are some of the costs and benefits of this approach?
20. In what ways has the team's emphasis on betterment come into conflict with their emphasis on empowerment? (examples/resolution)
21. Do you agree with the approach the team takes?

Tension #4: Biography vs. Epidemiology

Teams have chosen different ways to collect and analyze information.

Biography. Some teams collect in depth information about a small number of cases, sometimes referred to as a case specific or systems approach. The goal of this approach is often to obtain an in depth understanding of the dynamics of a single case.

Epidemiology. Some teams collect broad information for a large number of deaths, sometimes referred to as a wide angle approach or investigative model. The goal of this approach is often to obtain a general understanding of the trends across cases.

22. What approach does your team emphasize? (biography/epidemiology)
23. How does your team's emphasis on (biography/epidemiology) facilitate the team's goals?
24. What do you think are some of the costs and benefits of this approach?
25. In what ways has the team's emphasis on biography come into conflict with their emphasis on epidemiology? (examples/resolution)
26. Do you agree with the approach the team takes?

Tension #5: Freedom of Information vs. Individual Right to Privacy

In general teams tend to emphasize information sharing within the team and confidentiality outside of the team. However, teams differ to the extent to which they emphasize each inside the team and outside the team.

INSIDE

Freedom of Information: Some teams emphasize freedom of information within the team. They collect private information and place no restriction on the amount or type of information shared.

Individual Right to Privacy: Some teams emphasize individual right to privacy within the team. They collect public information and place restrictions on the amount or type of information shared.

27. What approach does your team emphasize? (freedom of information vs. individual right to privacy)
28. How does your team's emphasis on (freedom of information vs. individual right to privacy) facilitate the team's goals?
29. What do you think are some of the costs and benefits of this approach?
30. In what ways has the team's emphasis on freedom of information come into conflict with their emphasis on individual right to privacy? (examples/resolution)
31. Do you agree with the approach the team takes?

Tension #5: Freedom of Information vs. Individual Right to Privacy (continued)

OUTSIDE

Freedom of Information: Some teams emphasize freedom of information outside the team. They may inform people outside the team which cases they are reviewing (e.g., family members and service providers) or include information in the report that may identify the case reviewed (e.g., names of victims, case scenarios).

Individual Right to Privacy: Some teams emphasize individual right to privacy outside the team. They do not inform people outside the team which cases they are reviewing (e.g., family members and service providers) or include information in the report that may identify the case reviewed (e.g., names of victims, case scenarios).

32. What approach does your team emphasize? (freedom of information vs. individual right to privacy)
33. How does your team's emphasis on (freedom of information vs. individual right to privacy) facilitate the team's goals?
34. What do you think are some of the costs and benefits of this approach?
35. In what ways has the team's emphasis on freedom of information come into conflict with their emphasis on individual right to privacy? (examples/resolution)
36. Do you agree with the approach the team takes?
37. Are there any additional critical issues or tensions that your team deals with?

Outcomes

In general, one of the primary goals of DVFRT is to facilitate or promote social change that helps to prevent domestic violence related fatalities.

38. What are the biggest obstacles that your team encounters in trying to facilitate or promote social change? (What are the biggest problems you face?)
39. What are the things that your team does that are most effective in trying to facilitate or promote social change? (What do you do best?)
40. What do you feel that your team has accomplished? (e.g., improved relationships, increased knowledge, changes to policies and procedures)

Closing questions

41. Is there anything you would like to share with me that we have not yet discussed?
42. Is there anything that you would like to ask me?

Thank you so much for participating in the interview. Your participation is extremely important for the study and I greatly appreciate your time.