GEORGIA COMMISSION ON FAMILY VIOLENCE | GEORGIA COALITION AGAINST DOMESTIC VIOLENCE

2012 GEORGIA DOMESTIC VIOLENCE FATALITY REVIEW ANNUAL REPORT

TABLE OF CONTENTS

CHARTS

NARRATIVE

24-HOUR STATEWIDE CRISIS LINE: 1-800-33-HAVEN (1-800-334-2836)

Regarding Gender Language in this Report

According to the Bureau of Justice, women account for 85% of the victims of intimate partner violence and men account for approximately 15% (Bureau of Justice Special Report, Intimate Partner Violence, 1993-2010, November 2012). The majority of domestic violence homicides in Georgia tracked by the Project involve men killing women in heterosexual relationships. We acknowledge that men are battered by female partners and sometimes men are killed by female partners. It is also important to acknowledge that domestic violence exists in same-sex relationships at the same rates or higher as in heterosexual relationships, and lives are also lost. The language we use in this report reflects these realities. However, it should not be construed to suggest that all victims are female and all perpetrators are male.

EXECUTIVE SUMMARY

Welcome. The goal of the 2012 Georgia Domestic Violence Fatality Review Project Annual Report is to discuss gaps in the community's response to domestic violence and put forth recommendations for change in services, resources, policies, practices, information, collaboration, and training. The data and stories shared in the Report are drawn from nine years of fatality reviews in Georgia and reflect the lived realities of victims of domestic violence. Here, you will learn the valuable role you play in making your community a safer place.

Each of us has the power to do something differently. Whether you are reading this report as someone who regularly works with victims and perpetrators of domestic violence or someone with a friend who is being abused or being abusive, there is much you can do. Each section of this report offers recommendations to help you create change in your community.

The time to learn from domestic violence-related deaths and make necessary changes is now. Georgia's unfortunate distinction is to be ranked 10th nationally for the rate at which men kill women in single-victim homicides, and most of these are domestic violence-related murders ("When Men Murder Women: An Analysis of 2010 Homicide Data." Violence Policy Center, September 2012). Georgia has ranked among the top 20 states in this category for all 13 years the study has been conducted and among the top 10 for seven of those years. In the chart on page 6, you can see the magnitude of the problem: We have recorded the domestic violence-related deaths of over 1,200 Georgians in the 10 years we have been collecting this information. These deaths were captured using a media-monitoring service and by collecting information from local domestic violence programs. This number includes primary victims, secondary victims and alleged perpetrators. We believe this reflects a significant portion of the deaths that can be attributed to domestic violence. However, we acknowledge the limitations of collecting data in this way and believe the actual number of deaths may be higher.

This year's report focuses on the complexity of domestic violence and the importance of taking a holistic approach to victim services. Some domestic violence cases do escalate to homicide with no prior involvement with the criminal justice system or social service agencies; however, the chart on page 8 reveals that victims and perpetrators of domestic violence more often interact with a variety of systems and agencies in the years leading up to the homicide. Unfortunately, the systems in place to respond to victims and perpetrators usually provide a single-focus response and do not address the complex nature of this problem. Issues that frequently co-occur with or compound domestic violence go unresolved, leading to missed opportunities to address the life experiences of domestic violence victims and the barriers they face.

We encourage communities and service providers to develop partnerships and work to provide victims of domestic violence with comprehensive

EXECUTIVE SUMMARY

support that addresses all of the challenges they face in achieving safety.

We begin the 2012 Annual Report with Kate's story, a powerful narrative written by a survivor chronicling her survival of a near-fatal attack by her husband. Kate provides readers with a complete picture of their relationship: the early warning signs of power and control issues, how she navigated her husband's controlling tactics, the steps she took to stay alive despite his horrifying acts of abuse, and the day she knew she had to escape or be killed.

In Kate's story, we highlight an issue that commonly occurs with domestic violence but is rarely talked about: pet abuse. Many people consider pets to be members of their family. The family pet may become a target of abuse as a way to control other victims in the home. As we explore this topic, we include recommendations for several service providers and provide information on a valuable resource in Georgia: Ahimsa House.

Economic abuse severely limits victims' mobility and options, whether they choose to stay in the relationship or leave. Our fatality reviews have revealed just how important economic security is for the safety of domestic violence victims. We include Maria's story to highlight the importance of financial security for victims seeking to end their relationship with their abuser—especially for those who are mothers—and the impact awarding child support in a Temporary Protective Order can have on a victim.

This year we explore two issues we have seen co-occur with domestic violence: substance abuse and mental health. When these problems occur in the life of someone who is also experiencing domestic violence, they complicate a victim's ability to reach out for help and impede service providers from offering effective help. We present several ways that we have seen these issues interwoven in the lives of victims, the increased barriers victims face, and how systems and service providers should respond differently to better support victims. In Mable's story, readers learn how a domestic violence-related injury affected her mental health, which eventually led her to abuse alcohol. Gina's story specifically highlights how her drug use influenced her decisions and impacted her ability to achieve safety.

In response to the added complications of substance abuse, mental health, sexual abuse and trauma which victims of domestic violence experience, we provide information on a recommended response to working with survivors: Trauma-Informed Care. This approach is not only beneficial to victims and survivors, it also addresses the vicarious trauma that inevitably affects service providers who work closely with people experiencing trauma.

Sexual abuse is a tool used by abusers that can have a lasting traumatic impact on victims. However, the silence surrounding this issue prevents many victims and service providers from engaging in discussion. We encourage advocates and community members to

break down the stigma, silence and shame surrounding sexual abuse by spreading awareness that sexual abuse is a tactic of power and control, by responding to sexual abuse with a trauma-informed approach, and by believing all disclosures of sexual abuse.

As promised last year, we have taken a further look into women's use of violence. We offer readers a summary of our early findings after reviewing several cases involving women who have killed their male partners and interviewing women in the Georgia State Prison System. Surprisingly, we found that the lives of the women who have killed their male partners do not look much different from the lives of women who have been killed by their male partners. Our early findings are coupled with early recommendations for a variety of systems.

Finally, conducting fatality reviews yields two kinds of recommendations: those that are specific to a local community and those that can be applied on a statewide level. In response to the Project's recommendations, we offer our implementation initiatives for these important systems: law enforcement, the faith community and the workplace. These resources are available for any community interested in utilizing these tools.

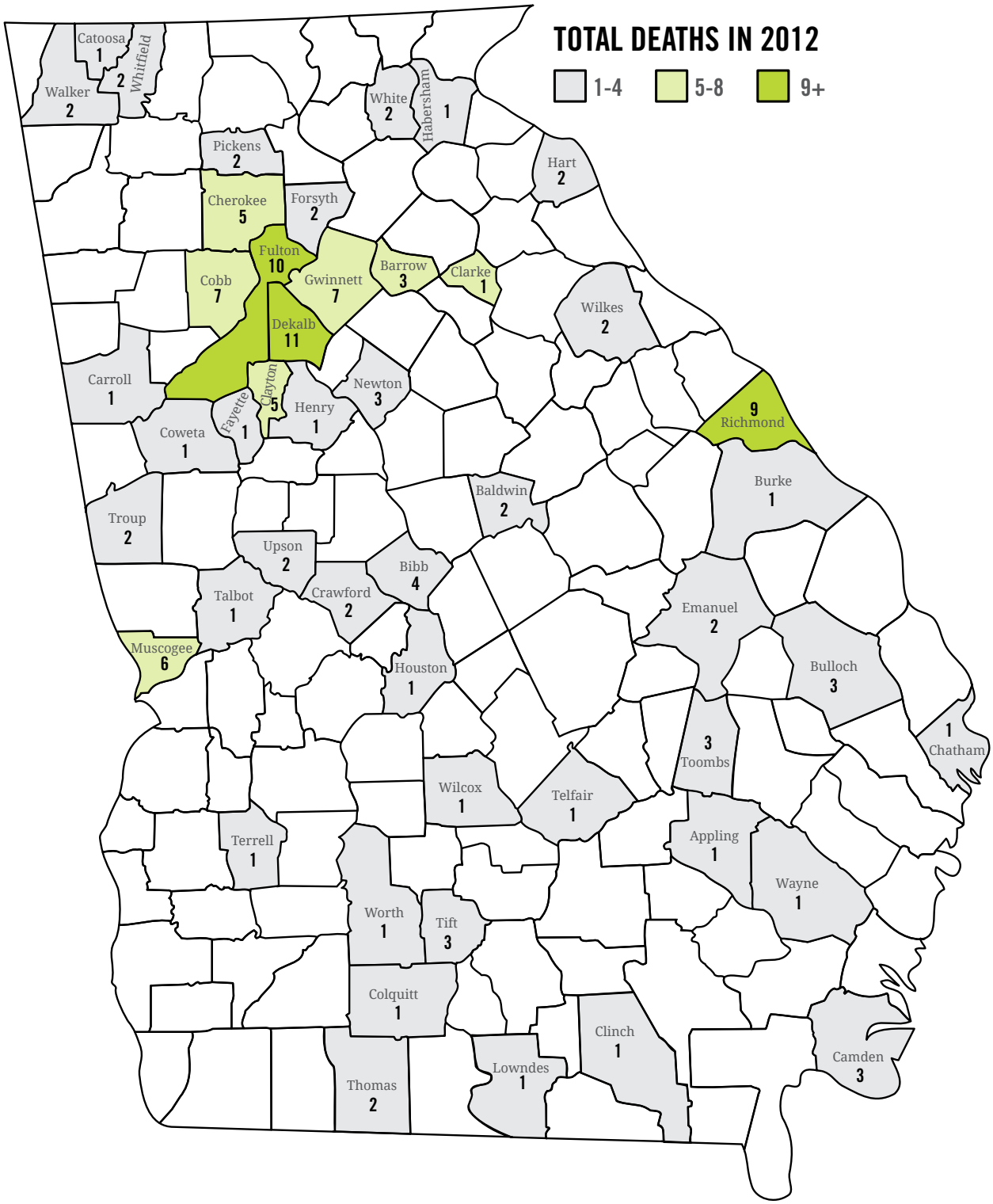
GEORGIA IS RANKED

10TH IN THE NATION FOR

THE RATE AT WHICH MEN KILL WOMEN, IN SINGLE-VICTIM HOMICIDES, MOST OF WHICH ARE

DOMESTIC VIOLENCE-RELATED MURDERS.

1 DOMESTIC VIOLENCE DEATHS IN GEORGIA BY COUNTY 2012



KEY POINTS (CHARTS 1&2)

The chart above and the chart on page 6 include only Georgia counties in which a domestic violence homicide is known to have occurred in the years listed. Statistics have been compiled by GCADV and GCFV from media monitoring services and from domestic violence programs statewide. This count represents all the domestic violence-related deaths known to us at the time of this report, including intimate partner victims and related persons such as new partners, children, and other family members. Statistics also include alleged perpetrator deaths, most of whom committed suicide after killing or attempting to kill the victim(s). Deaths of alleged perpetrators are included to show the full scope of loss of life due to domestic violence.

2 DOMESTIC VIOLENCE DEATHS IN GEORGIA BY COUNTY 2003-2012

How many died from domestic violence in each Georgia county by year?

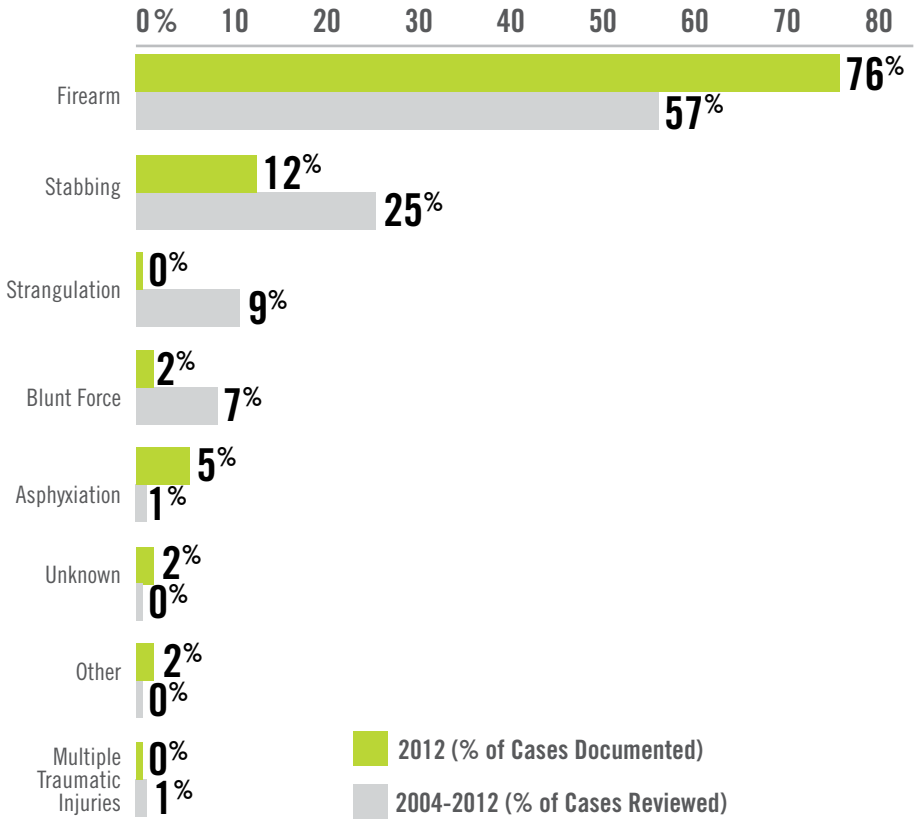
COUNTY	TOTAL ANNUAL DEATHS				
	'12	'11	'10	'09	'03-'08
Appling	1	2			4
Baldwin	2		2	2	7
Barrow	3	1			3
Bartow					7
Ben Hill			1		5
Berrien					1
Bibb	4	2		7	19
Bleckley					3
Brantley					2
Brooks			1		0
Bryan		2	2		0
Bulloch	3	1		2	1
Burke	1	2			6
Butts		2	2		3
Calhoun					4
Camden	3				3
Carroll	1			3	5
Catoosa	1			1	1
Chatham	1	2	2	4	25
Chattooga				1	0
Cherokee	5	3		4	13
Clarke	1		1	10	10
Clay			2	2	0
Clayton	5	3	2	1	39
Clinch	1				0
Cobb	7	4	5	7	37
Coffee		1			2
Colquitt	1		5		7
Columbia		1			4
Cook					3
Coweta	1		2	1	6
Crawford	2		1		0
Crisp			1		4
Dawson		2			1
Decatur				3	1
DeKalb	11	7	5	9	53
Dodge				1	1
Dooly					1
Dougherty		4	3	1	7
Douglas					4
Early			3		0
Echols			1		0
Effingham			4		1
Elbert				1	2

COUNTY	TOTAL ANNUAL DEATHS				
	'12	'11	'10	'09	'03-'08
Emanuel	2	1	2		0
Evans		1			0
Fannin					5
Fayette	1				8
Floyd		1	2	2	8
Forsyth	2		1		9
Franklin				1	1
Fulton	10	11	12	11	49
Gilmer		1			1
Glascock					1
Glynn					6
Gordon			1	2	6
Grady			2		2
Gwinnett	7	6	13	12	55
Habersham	1	2	2		1
Hall		2	1		7
Hancock					1
Haralson		1			4
Harris				2	3
Hart	2				0
Henry	1	3	1		12
Houston	1	2	4		11
Jackson		3	3	2	10
Jeff Davis					1
Jefferson					4
Jenkins					2
Jones		2			0
Lamar		1			3
Lanier			1		0
Laurens					8
Lee		1			3
Liberty			1		10
Lincoln			2		0
Lowndes	1	3	1	5	10
Lumpkin					1
Macon		2			2
Madison					2
McDuffie		1	1		5
Meriwether		1			1
Monroe		3		2	1
Montgomery					1
Murray		2		1	0
Muscogee	6	5	3	1	26
Newton	3		5		13

COUNTY	TOTAL ANNUAL DEATHS				
	'12	'11	'10	'09	'03-'08
Oconee					1
Oglethorpe			1	1	1
Paulding				2	3
Peach			3		2
Pickens	2				2
Pierce					1
Pike			2	3	0
Polk		1			5
Pulaski		1		1	0
Rabun			1		0
Randolph		2	1		0
Richmond	9	2	5	4	21
Rockdale				2	8
Schley					1
Screven					1
Seminole		3			1
Spalding		2	3		4
Talbot	1				0
Tattnall				2	3
Telfair	1			2	6
Terrell	1				0
Thomas	2		2		3
Tift	3				7
Toombs	3				0
Towns					2
Troup	2	2		2	3
Twiggs					1
Union				2	2
Upson	2				3
Walker	2		1		3
Walton		2	2	1	3
Ware					2
Warren					1
Washington					4
Wayne	1				9
Webster					1
Wheeler					2
White	2				5
Whitfield	2		4		6
Wilcox	1				0
Wilkes	2				0
Worth	1		3		3
Undisclosed			1		3
Total By Year	**128**	**109**	**132**	**123**	**711**
TOTAL DEATHS OVERALL					**1,203**

3 CAUSE OF DEATH 2004-2012

How were the victims killed?



KEY POINTS (CHART 3)
Firearms continue to be the leading cause of death for victims in cases we track and review, greater than all other methods combined. This finding indicates the urgent need to use all legal means possible to remove firearms from the hands of perpetrators.

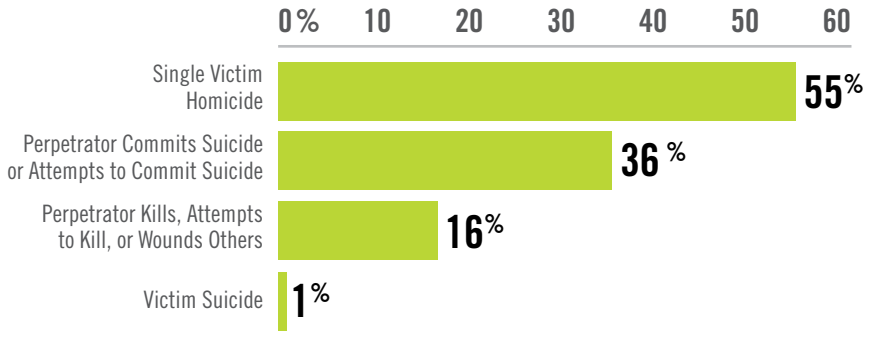
KEY POINTS (CHART 4)
In 36% of the cases reviewed, the perpetrator attempted or completed suicide at the homicide scene or soon thereafter, in addition to killing or attempting to kill one or more persons. This finding indicates a significant correlation between domestic violence perpetrators' suicidal thoughts or threats and their danger to others.

A perpetrator's threat of suicide is one of the strongest indicators for imminent lethal violence. The Project promotes training of first responders, advocates, attorneys, parole officers, court personnel, social services, and health care personnel to increase vigilance and recognition of this extreme risk factor.

In 16% of the cases reviewed, the perpetrator killed, attempted to kill, or injured someone other than the primary victim. Perpetrators do not limit their violence to their intimate partner. Often, other people close to the primary victim are targeted either because they are with the primary victim at the time of the attack or because the perpetrator intends to cause additional anguish to the primary victim by harming her friends or loved ones.

4 TYPES OF INCIDENTS IN REVIEWED CASES 2004-2012

Was it a single homicide, a suicide, or were others killed or hurt?



5 AGENCIES AND SERVICES KNOWN TO BE INVOLVED WITH VICTIMS OR PERPETRATORS IN THE FIVE YEARS PRIOR TO THE FATALITIES 2004-2011

Which agencies and services interacted with victims and/or perpetrators?

	AGENCY / SERVICE / PROGRAM	VICTIMS		PERPETRATORS	
		#	% total cases	#	% total cases
JUSTICE SYSTEM AGENCIES	Law enforcement	68	77%	72	82%
	Prosecutor	32	36%	45	51%
	Superior court	27	31%	33	38%
	Magistrate court	26	30%	33	38%
	Civil court, including juvenile court	21	24%	20	23%
	State court	20	23%	18	20%
	Protection order advocacy program	15	17%	1	1%
	Court-based legal advocacy	13	15%	2	2%
	Probation	7	8%	31	35%
	Municipal court	5	6%	9	10%
	Legal aid	4	5%	0	0%
	Parole	1	1%	9	10%
SOCIAL SERVICE AGENCIES	Child protective services (DFCS)	9	10%	10	11%
	Child care services	4	5%	2	2%
	TANF or Food Stamps	4	5%	2	2%
	Medicaid	4	5%	1	1%
	WIC	3	3%	0	0%
	Homeless shelter	2	2%	1	1%
	PeachCare	1	1%	0	0%
HEALTH CARE AGENCIES	Hospital care	19	22%	17	19%
	Private physician	17	19%	14	16%
	Emergency medical care	16	18%	8	9%
	Emergency medical service (EMS)	13	15%	7	8%
	Mental health provider	9	10%	21	24%
	Substance abuse program	2	2%	5	6%
FAMILY VIOLENCE AGENCIES	Community-based advocacy	16	18%	4	5%
	Domestic violence program or safe house	14	16%	0	0%
	Family violence intervention program (FVIP)	2	2%	10	11%
	Sexual assault program	1	1%	1	1%
MISCELLANEOUS AGENCIES	Religious community, church, or temple	26	30%	18	20%
	Immigrant resettlement	2	2%	1	1%
	English as a Second Language (ESOL) program	1	1%	0	0%
	Anger management	1	1%	5	6%

KEY POINTS (CHART 5)

Law enforcement had the most contact with both victims and perpetrators prior to the homicide. Continued law enforcement training on the dynamics of domestic violence and how and where to refer domestic violence victims for services is needed. See section on Roll Call trainings (page 45) for information on strategies for change.

Only 16% of domestic violence homicide victims were in contact with a domestic violence program or safehouse in the five years prior to their death. Domestic violence programs need to take proactive steps to ensure their full range of services are known, accessible, culturally relevant, and inviting to victims.

A significant number of perpetrators and victims interacted with a religious community, church, temple, or mosque in the five years prior to the homicide.

Faith communities have great potential for offering resources, referrals, and safety to congregants. See section on Safe Space Curriculum (page 47) for more information on strategies for change.

KATE'S STORY

Since 2006, the Project has reviewed six cases where victims of domestic violence survived a near-fatal attack at the hands of their intimate partner. Reviewing these cases provides communities with the opportunity to learn ways to better serve victims by hearing first-hand from survivors. This process is valuable because it documents what survivors have endured and honors their courage to share what has happened to them. Listening to and learning from survivors' personal stories has a powerful impact on our teams, our communities, the Project coordinators, and, as many have said, the survivors as well.

This year, we worked with a survivor by the name of Kate*. Kate endured horrific abuse at the hands of her husband and, unlike most of the women whose cases we review, survived to tell her story. She has come to be a strong advocate for victims of domestic violence in Georgia and is dedicated to helping victims in any way she can. Usually, the Project Coordinators write the near-fatality stories that appear in the Annual Reports from the information collected during the case review and interviews with the survivor. While the survivors always review and approve the stories we publish, this year, Kate wrote, edited and approved what you are about to read. Her story is one of bravery and endurance, and showcases the resilience of a mother, a sister, a daughter, and a friend.

IN THE BEGINNING

John* and I were married for over 20 years; we dated for five years before getting married. We knew many of the same people during college but did not become friends until after graduation. A few months later, we went on our first date. During our third year of dating, John left the state for job training and I stayed behind to continue working in my career field. We saw each other about once a month and our relationship remained solid. I was in love with John and we made plans to marry after he finished training.

Everything was good between us at first. He was loving, devoted, extremely smart and focused on succeeding in his career. However, looking back, I can see he had a controlling side. I did not view this as a huge red flag at the time as I attributed this behavior to his Type-A personality; most of the time, John seemed kind and generous to friends, family, and strangers. As our relationship developed, I started to see warning signs including some controlling behavior and emotional neediness. One day, John told me he had been in an argument with his father and became so angry he nearly hit him. This was a shock to me because I grew up in a family that showed respect for one another and I had never witnessed violence. Through the years, I also learned John's mother emotionally abused him and his siblings by showing favoritism towards some of the children and not the others. I attributed John's negative behavior to

his dysfunctional family life. I felt that, perhaps, I could change some of his behavior by showing him love and having him spend time with my close-knit family. Unfortunately, it cost me years and almost my life to learn that you can change NO ONE but yourself.

HINTS OF TROUBLE: RED FLAGS

I began to notice John would get jealous when I talked with other men (especially his friends). He also became jealous if I spent too much time with friends or family. It became increasingly apparent that he wanted my attention at all times. After we were married and had children, John was jealous of the maternal relationship I had with our children. I explained to him that because he was gone so much with his job, he needed to spend time at home bonding with his children. He did not seem to understand this and his relationship with the kids grew more strained as they grew older. John seemed to have more pent-up anger as the years went on. I started to feel like I was always walking a balance beam around him. When I would try to discuss this, he would get agitated and turn it into an argument. I soon realized it was easier to just appease him. I noticed the kids' demeanor change as well as my own when John arrived home because we never knew what type of mood he would be in.

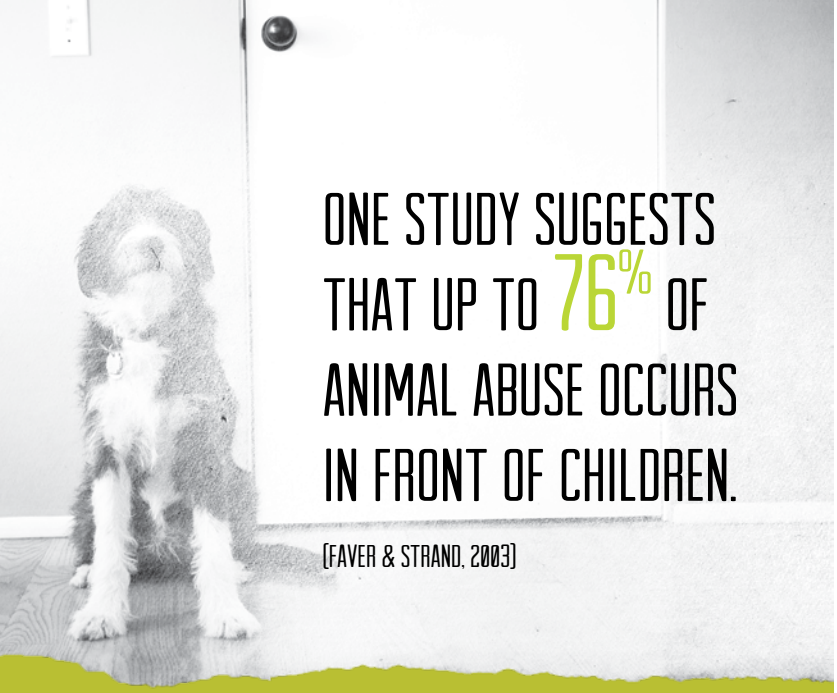
GROWING PATTERN OF ABUSES

In the last couple of years of our marriage, the abuse slowly escalated to physical violence. It started with John throwing the TV remote at me and grabbing my arm. The first time he struck me and threw me to the ground, he looked into my eyes and said, "If you tell ANYONE about this, you are DEAD." He not only raped me on many occasions, he sodomized me in ways that were meant to hurt and demean me. John would even sexually assault me after beating me until I was bleeding, bruised, and broken. (For further discussion on sexual abuse, see page 36). He also made me call him "God" and would often use objects besides his fists or feet to beat me. He would call these objects "his friends."

The growing emotional, physical and sexual abuse made me feel like my head was spinning. What was I doing that made him so angry? I felt if I could just make his life less stressful, perhaps he would return to the person I fell in love with years ago. I could sometimes calm him down and make him feel better, but other times no matter what I said or did, it did not help the situation. He had a great career and a wife and kids who were always there for him. I hoped if we kept showing our love and support for him, things would get better.

> **I finally came to the realization that I was never going to be able to help John and the best thing for me and the children would be to get out of the marriage—but it was too late.**

Little by little, John started to isolate me from my friends and family. For example, throughout my adult life, my father and I talked on the phone every Sunday morning at 8am. In the last few months before his arrest, John forbade me to



ONE STUDY SUGGESTS THAT UP TO 76% OF ANIMAL ABUSE OCCURS IN FRONT OF CHILDREN.

(FAVER & STRAND, 2003)

DOMESTIC VIOLENCE AND PETS

When families experience domestic violence, pets are also at risk. Many people view their pets as members of the family and have an emotional connection with them; abusers know this. Abuse targeted towards a pet is a form of power and control and includes, but is not limited to, the following tactics; threatening to harm or "get rid of" a pet, hurting or killing a pet to punish the victim, forcing victims to watch or participate in the abuse, depriving a pet of food and/or medical care, threatening to harm the pet if victim flees or discloses abuse and fighting over custody of pets. Additionally, animal abuse has been connected to increased severity of domestic violence and more controlling behaviors by the abuser (Simmons & Lehmann, 2007).

CONTINUED ON PAGE 16

KATE'S STORY

continue this tradition and I had to make up excuses to my dad as to why I didn't call him. John would also get extremely angry if I talked with friends or neighbors when I picked up the children from school. He would time me when I went to the grocery store or ran other errands and constantly checked my cell phone. He would get angry with the children if they wanted to go with me to run errands or sit next to me at restaurants or at home.

John also abused our dog. We got her when she was a puppy and began training her with an electronic collar for the invisible fence. He did not use the collar as intended, but instead would shock her on a whim whenever he felt like it. If our dog did not respond to his commands, he would kick and scream at her. John only allowed her in certain areas of the house. One time, the dog came into a room she was not allowed into and John threw her down the stairs. I tried to stop John, but the more I tried to protect our dog, the angrier he got. On numerous occasions he threatened to kill her. I was so afraid that someday he would actually get mad enough to carry out this threat, I considered finding a safe home for her and telling John she ran away. Luckily for us, our sweet dog is still with us and is healthy and happy.

SURVIVAL TACTICS

So it began for me, the horrible months and months of knowing we had to get out. The violence had become so intense. The verbal abuse and emotional trauma worsened with each passing week and the physical and sexual abuse turned to torture.

> **This was no longer just a husband and father turned bad, but a monster.**

When the violence began, John would at times seem remorseful for physically abusing me. However, as the abuse became more frequent and more torture-like in nature, he seemed to enjoy the pain and suffering he inflicted on me. I felt so alone and isolated but knew I couldn't leave or tell anyone. I would reschedule appointments as I was always afraid someone might notice bruises or other injuries. I would only go to appointments if my injuries were well hidden.

When John first started to physically assault me, he would beat me in areas I could cover with clothing. Towards the last few months, he did not seem to care any longer and made me come up with excuses, even to our children, as to why I had bruises on my eyes, face, or hands. I knew that if I was to ever seek medical help for my injuries and didn't have a convincing enough story as to why I had these injuries, John would kill me. I desperately wanted to figure out how to get my children, our dog, and myself out of this situation, but knew there was not a good way out. We were trapped either way.

I felt my life was in danger and I wanted to make sure someone would be able to put the story together and rescue my children if something happened to me. I began secretly documenting the abuse by taking photos of my injuries and noting the date and description of what happened. I kept the photos in a safe deposit box. I only did this occasionally as one time, while printing out pictures at home, John forgot something on his way to work and returned to the house unexpectedly. I scrambled to hide the pictures, as I knew my life would end if he saw them. It was emotionally painful and made me physically ill to document what my husband was doing to me; he was supposed to be the one person who should always protect me and our children.

While trying to come up with an escape plan, I made sure I gave a neighbor, my best friend and my sister each other's contact information. I also gave my neighbor the extra key to the safe deposit box. I was careful not to give them too much information, as I knew I would be killed if someone confronted him and their life could possibly be in danger, as well. There were a couple of instances where I thought, perhaps, in a moment of weakness, that I may have not sounded convincing enough when assuring my best friend and sister that I was okay. During one phone conversation, my sister asked if she should come for a visit, and I told her, "not yet." Those words seemed so strange to my sister but I had convinced her there was just a lot of stress with work and raising teenage kids and things were bound to get better.

KATE'S STORY

With a broken and battered body, I knew I was running out of time. There were days (although few and far between) when John would seem like his old self, and then, all of a sudden, he would snap for no reason. In the weeks before the final incident, he forced me into signing over the house to him and removed my name from our checking and savings accounts. While he was away from the house on work trips, he would assign me tasks to complete that did not allow me to sleep much. He would often call or text in the middle of the night to make sure I was awake and working on whatever he instructed me to do. He told me he was plotting ways to get rid of me if I did not obey.

I learned about the local domestic violence program, or "shelter", about one year before the final incident. I do not remember exactly how I learned of it but I know I either saw it in the newspaper or found it on the Internet. I kept the information in a folder marked "school" at work. Later, I put the hotline number in my phone as a distributor's number for work. I felt afraid to call the hotline number. I did not know if my information would be kept confidential or if they were obligated to call the police. I felt helpless and did not think they could really help with our situation.

The weekend before John's arrest, I thought I had a plan. I came up with a story that was not true, but I was hoping John would believe me and stop the abuse. I told him I had talked to a battered women's shelter worker and told her what was going on. I told him if I did not call the worker back on Monday, the shelter would know the abuse was still taking place. This plan totally backfired on me. He threw me to the ground, sat on my chest and choked me. I believe the only reason I lived through that night was because I convinced him to stop choking me so I could show him the number I was supposed to call was fake. It was actually a pre-paid cell phone I had bought. I lived through the night, but just barely.

I knew my days were numbered. If I took the kids and left, he would hunt us down and, without a doubt, kill me and most likely the kids as well. If I stayed, I knew my broken body was not going to be able to withstand much more. On the night of John's arrest, he had taken me to our basement — he beat me while I begged for mercy. He received a call on his cell phone and instructed me to wait in the basement bedroom for him. He stayed in the other room and took his phone call. After a few minutes, John came out into the hallway while still on the phone and stared at me before going back into the room. Something clicked for me at that moment: He knew he could control me from 5,000 miles away, so why did he feel compelled to make sure I was still waiting in that bedroom? I knew then I was probably not going to survive the night and had to escape NOW and take my chances—even without a plan.

ESCAPE WITH GREAT RISK

Barefoot and with broken bones and a battered body, I left the room, grabbed a cordless phone and then limped upstairs to rescue the children. I found my daughter upstairs, showed her a bruise and said, "We have to go." My daughter

grabbed my hand and we headed for my son's room. Through the bathroom door, I heard his shower going. I knew I had to get out of the house and call 911 to survive and, at this point, we were running out of time – we still needed to make it back downstairs and out of the house before John came up from the basement. As painful as it was to leave him, I was confident John would not physically hurt our son.

My daughter and I escaped out the front door and were able to make it to a neighbor's house where we called 911. When the police and fire department arrived, John had realized we were no longer in the house. He locked the front door and had our son lie to the police when they called the house. John instructed him to say they were at the grocery store and not in the house. These were excruciatingly long minutes for me. The fire department was trying to get me to go to the hospital, as they were very concerned about the extent of my injuries.

> **However, I was not about to go anywhere until I knew my son was safe.**

Because there was a gun in the house, the police were not sure if they had a hostage situation on their hands and had to proceed with caution. After what seemed like an eternity, the officers were able to obtain a house key from a neighbor and get my son out safely. John was arrested on the scene.

SAFE BUT TERRIFIED STILL

Because of the extent of my injuries, I was taken to a trauma hospital and admitted under an alias for my protection. The head trauma doctor, nurse and the Assistant District Attorney all said they had never seen someone survive such horrific domestic violence injuries. Over the next few months, I had numerous surgeries, daily wound care, and physical therapy. I was unable to drive for months and felt so fortunate that family and friends swooped in to help me and the children. The whole community was in shock and offered their assistance. My friends' spouses were appalled and embarrassed that a man they knew could commit such heinous acts.

> **I'm not sure how I would have made it without the love and support of family, friends, and the community.**

My family and friends who came from out of state were so impressed with the caring support offered by the police, District Attorney's office, neighbors, friends, and even total strangers.

As blessed as I was at the time to have such loving support, each day was still a battle. Not only did I have to concentrate on healing physically and taking care of the children, I was also faced with the unknown of what would happen with the criminal trial. My family and I met with the District Attorney's office and a domestic violence shelter advocate to come up with a plan should John be allowed out on bond before the trial; fortunately, his bond was denied. A jury of his

KATE'S STORY

peers convicted him and, because of the heinous, appalling, cruel nature of his crimes, John will spend the rest of his life in prison for his horrific, torturous acts of violence.

A DAY IN THE LIFE OF A SURVIVOR

On top of everything we had been through, our tough journey was far from over. John's company fired him the day of his conviction. As the main breadwinner for the family, we depended on his salary.

> **We lost our main source of income as well as our medical insurance.**

As a domestic violence survivor, there are no benefits as there may be for a spouse who is a widow or widower – no life insurance or medical benefits, just the hard realization that it is now solely up to me to figure out how to provide for my children and get them through college. With that being said, I realize we still have it better than victims who leave with nothing but the clothes on their backs and those who have to go into hiding for the rest of their lives.

After the trial and sentencing, I still faced the divorce proceedings. Now a convicted felon, John attempted to continue his control by requesting a divorce trial. This meant more attorney fees for me and having to face John once again in court. In the years since his arrest, John is still trying to show his control by filing frivolous lawsuits. Each time this happens, it forces me to hire an attorney to answer these suits. So far, I have spent in excess of $200,000 on attorney fees.

As domestic abuse survivors go, my children and I are physically safe, but still deal with the emotional side of readjusting our lives. The children have to cope with the emotional scars of what their father did, how he treated them, their mother, and their dog. I have to live with physical and emotional scars that will never go away. I wake up every day knowing someone else may be going through something similar and have vowed to help other domestic violence survivors in any way I can. I must be strong for my children as they give me strength every day. We no longer have the financial stability of a paycheck, medical insurance, or college savings; that money has gone to pay attorneys. There is no guarantee John will ever stop abusing us with the frivolous lawsuits, and there is no way to ever forget what we have endured.

On the positive side, I have learned to never take anything for granted and to enjoy the little things in life. I am blessed to hear my children's laughter and to see them smile and thrive as young adults. I am so grateful to have an opportunity to start a new life. Also, our beloved dog now has free rein throughout the house and even sleeps in the bed with the kids or me. No one should ever have to endure domestic violence and I will fight each day so others will never have to experience "a day in the life of a domestic violence victim."

Pseudonym used

ONLY 12% OF DOMESTIC VIOLENCE SHELTERS ACCEPT PETS.

(NCADV, 2008)

DOMESTIC VIOLENCE & PETS

Abuse of the family pet has devastating effects on children living with domestic violence. One study suggests that up to 76% of animal abuse occurs in front of children (Faver & Strand, 2003). A child's relationship with a pet is usually non-violent and unconditionally loving; this bond may be a key source of comfort during trauma. In turn, when a pet is hurt or killed, a child may feel guilty about not being able to protect the pet from abuse. Witnessing animal abuse can be a risk factor for becoming a perpetrator of abuse; children exposed to family violence are three times more likely to abuse animals (Currie, 2006).

The strong bond between human and animal is what makes pet abuse such an effective control tactic; the multiple barriers to escaping safely with pets compound the issue. One study suggests that nearly 50% of individuals delayed escaping an abusive relationship because of concern for their pets. This number increases to 65% if the pets have already been abused (Carlisle-Frank, Frank, and Nielsen 2004). Most domestic violence shelters are unable to allow pets to accompany their owners to the shelter. In fact, only 12% of domestic violence shelters accept pets (NCADV, 2008). Pets may not be welcome at a family member or friend's house, public housing or a rental property either. When the victim leaves the pet at home, safety becomes a concern if the victim returns to the home to provide care for the animal. Also, the abuser may threaten or harm the animal as a way to pressure the victim to return home.

Over the last nine years, the Fatality Review Project has found that pet abuse, more often than not, goes undocumented. In part, this is due to the fact that survivors are reluctant to bring up the issue for fear they will not be taken seriously. It is the role of advocates and other helping professionals to help survivors overcome barriers so every member of the family can be safe; we must start the conversation by asking survivors about pet abuse.

RECOMMENDATIONS DOMESTIC VIOLENCE & PETS

Below are some recommendations to help address domestic violence and pet abuse in your profession:

WHAT ADVOCATES CAN DO	• Ask about pets, both on the crisis line and during shelter intake: "Do you have pets or other animals? Are you concerned for their safety?" • Make arrangements for sheltering, veterinary care, and transportation of animals to safety as needed. (See information on page 18 about services offered by Ahimsa House) • Incorporate questions about pet abuse into risk assessment and safety planning. • Include pets in Temporary Protective Orders, as applicable, in documenting acts of family violence and in provisions pertaining to property and/or other relief. Be specific: Include names, species, breeds, and descriptions of pets. • Help the client document any prior pet abuse in detail. Take photographs of any visible injuries, if possible. Involve law enforcement/animal control when appropriate. • Locate past veterinary records, both for documentation of injuries and for documentation of ownership/care of the animal. • Document any injuries or health conditions of the animal, both in written and picture form. • Develop relationships with animal welfare agencies and veterinarians in your community.
WHAT FAMILY VIOLENCE INTERVENTION PROVIDERS CAN DO	• Ask about pets at intake and during class. • Talk about pet abuse as a power and control tactic. • Assess participant's level of insight into past pet abuse. • Talk with victim liaisons to make sure they are aware of pet abuse disclosed by the participant, especially plans to harm or kidnap pets.
WHAT LAW ENFORCEMENT CAN DO	• Ask about pets when on a domestic violence call or investigation; make referrals to services as needed. • Document the presence of pets in the police report; make note of pet's behavior and appearance, especially injuries. • Become familiar with animal cruelty laws and local ordinances. • Assist with enforcing provisions regarding pets and Temporary Protective Orders. • Develop a working relationship with Animal Control Officers. • Assist with transporting animals, when possible.
WHAT MENTAL HEALTH PROFESSIONALS CAN DO	• When assessing family systems, consider pets as part of the family. • Assess potential trauma of witnessing animal abuse. • Assess child survivors for perpetration of animal abuse. • Become familiar with the AniCare model of assessment/treatment of animal abuse by children and adults, or connect with professionals who use this model. More information about this model can be found here: http://www.animalsandsociety.org/pages/anicare.
WHAT LEGAL PROFESSIONALS CAN DO	• Know animal cruelty laws. • Ask about pets during criminal and civil proceedings. • Include pets on Temporary Protective Orders. • Help survivor establish proof of pet ownership. • Pursue animal cruelty charges when appropriate. • Include testimony and evidence regarding animal cruelty.
WHAT FAMILY VIOLENCE TASK FORCES CAN DO	• Invite representatives from Animal Welfare and Animal Control Agencies to Task Force meetings.

ONE STUDY SUGGESTS THAT NEARLY 50% OF INDIVIDUALS DELAYED ESCAPING AN ABUSIVE RELATIONSHIP BECAUSE OF CONCERN FOR THEIR PETS. THIS NUMBER INCREASES TO 65% IF THE PETS HAVE ALREADY BEEN ABUSED.

CARLISLE-FRANK, FRANK, AND NIELSEN 2004]

In Georgia, Ahimsa House is a nonprofit organization focusing on the link between domestic violence and animal cruelty. A 24-hour hotline is available for victims, advocates, law enforcement and other professionals to access information and obtain assistance specific to domestic violence incidents involving animals. Ahimsa House offers the following services:

- Assistance with including pets in safety planning
- Guidance on keeping pets safe from the abuser via the courts, including establishing proof of pet ownership and listing pets on TPOs
- Temporary safe housing for animals (any species) while victims seek safety
- Transportation of pets to safety
- Veterinary care, including basic vaccinations and treatment of injuries due to abuse
- Assistance in locating pet-friendly transitional housing, including financial assistance with pet deposits
- Consultation to professionals on investigation or prosecution of animal cruelty in domestic violence cases
- Expert testimony in cases involving the link between domestic violence and animal abuse
- Professional training and public outreach initiatives to raise awareness about the connection between pets and domestic violence as a component of coordinated community response to domestic violence

All services are free of charge and available anywhere in the state. Call 404-452-6248 (crisis line) or 404-496-4038 (main line).
For more information, visit www.ahimsahouse.org.

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MARIA'S STORY

Maria* and her husband, Carlos*, were married for 20 years and had three children together, ages 12, 13, and 15 at the time of the homicide. Both Maria and Carlos were employed. Records and interviews do not show that Maria and Carlos had a long history of documented physical violence. Maria reported there had been two instances in which Carlos had been violent towards her during the months leading up to the homicide.

One night, Maria told her husband she was leaving him and he became extremely upset. He told her to take off her pants. When she refused, he put a pillow over her face and attempted to rape her. She was able to fight him off. However, he then forced their youngest child to go upstairs and get his medication. He made Maria and their two sons watch as he took over 100 pills that were prescribed to him for his bipolar disorder. While he was taking the pills, he told his children if they moved, he would kill their mother. He then dragged Maria outside of the home by her hair. He threatened to kill her while holding a knife to her throat.

Maria called the police to report the assault. When they arrived, police were unable to locate Carlos at the scene but issued an arrest warrant for aggravated assault. Later that evening, Maria again called the police because she heard Carlos moaning somewhere in the house. Police eventually located Carlos hiding in the attic; by this time, he was semi-conscious. They attempted to coax him down but, in his stupor, he fell through the rafters into the living room. He was taken to the hospital for treatment. Afterward, he was involuntarily committed to a psychiatric hospital for an evaluation for 10 days. On his release, he was arrested, taken to jail, and charged with aggravated assault. He was allowed a $20,000 bond three weeks later. During his time in jail, Carlos continuously called and harassed Maria.

One day before his release from jail, Maria was granted a Temporary Protective Order (TPO). Maria was given safety planning information from a legal advocate from a local domestic violence shelter who was at the courthouse. Court documents note that Maria told the judge she intended to file for divorce. At the 12-month TPO hearing, Maria told the judge Carlos had come to her office and had followed her in a car to her friend's home twice. He also called her mother and sister and told them Maria was cheating on him and he was not taking his medication. A 12-month TPO was granted by the judge a week later. As part of the TPO, the judge ordered that Carlos have no contact with his children until he received psychological testing and was found to no longer be a danger to himself or to his children. Although Maria had requested it, child support was not included in this order.

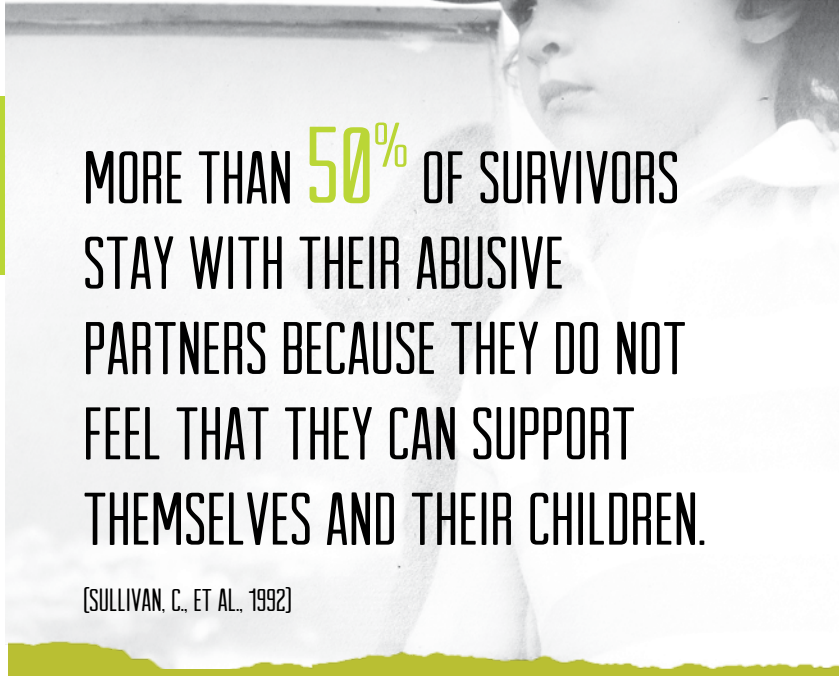
Maria was clearly moving to separate herself from Carlos' abuse and was moving on with her life. However, raising three children without the financial and parenting support of Carlos was a challenge. One week after the 12 month TPO was issued, Carlos filed a motion for contempt.

He stated that Maria had improperly contacted him about needing money for their children and had violated the protective order. He also said that Maria had called him because she was arguing with their oldest son and had taken the house keys away from him. Carlos picked up his son, even though he was not supposed to be around him. The court found Maria not in contempt because the TPO was not against her.

About one month later, Maria's sister saw her with Carlos at a grocery store. She asked Maria why she had Carlos "back at home" but Maria did not really address her sister's question. Two days later, Carlos called Maria at work; according to her co-workers, this was not uncommon as he often called to harass her. Maria told Carlos she would be filing for divorce and moving out of the house during his upcoming trip out of the country. Later that day, Maria's new boyfriend visited her at work. A few minutes after he left, Maria also headed out. She never made it to her car. As she was locking the door to her office, Carlos approached her in the breezeway. He pointed a gun at her and yelled, "I'm going to kill you, bitch!" Maria cried out for help as bystanders ran to call the police. However, it was too late. Carlos shot and killed Maria before he shot and killed himself.

During the investigation, it was discovered that Carlos had stolen the gun from the glove box of his co-worker's truck a few days before the murder-suicide. Maria's sister and brother-in-law are raising the three children.

Pseudonym used



MORE THAN 50% OF SURVIVORS STAY WITH THEIR ABUSIVE PARTNERS BECAUSE THEY DO NOT FEEL THAT THEY CAN SUPPORT THEMSELVES AND THEIR CHILDREN.

(SULLIVAN, C., ET AL., 1992)

ECONOMIC ABUSE & CHILD SUPPORT

When thinking about domestic violence, what comes to mind for most people are images of physical abuse. However, economic abuse happens just as frequently, can be just as damaging, and can have long lasting consequences in the life of a survivor. Economic abuse involves a range of tactics employed to control a survivor's ability to acquire, use and maintain economic resources. These tactics include, but are not limited to, preventing her from getting or keeping a job, demanding her paycheck, controlling the family resources, damaging her credit, and refusing to pay child support. These controlling tactics result in a lack of economic security that severely limits a survivor's options, especially if she is considering leaving or attempting to leave an abusive relationship.

CONTINUED ON PAGE 21

ECONOMIC ABUSE & CHILD SUPPORT

For survivors who want to stay in their relationship, economic abuse prevents them from establishing equality with their partners and from having autonomy or freedom with finances. For survivors who want to leave, economic security is a primary determinant of whether they remain in the abusive relationship or return after leaving. More than 50% of survivors stay with their abusive partners because they do not feel that they can support themselves and their children (Sullivan, C., et al., 1992). Often, survivors find themselves choosing between two impossible situations: leaving an abusive relationship and plunging into poverty OR staying in an abusive relationship and continuing to have a roof over their heads, clothes on their backs, and food on their tables. For survivors who have children, leaving an abusive relationship without economic security may not even be a consideration.

For survivors with minor children, public benefits and child support can be an important component to safety and economic security. The monthly financial support provided through Temporary Assistance for Needy Families (TANF), food stamps, and child support can help some victims of domestic violence support their children on their own, safely away from the abuser. However, several barriers exist to accessing these sources of support. Often, the process is complicated and requires time and transportation which some victims do not have. Advocates do not always have adequate training on how to access these resources and assist victims with the complicated paperwork.

Victims may be reluctant to engage these sources of financial support due to the policies and procedures that are in place. In order to apply for TANF, it is a requirement that the state's child support agency also be engaged. Although there is a Family Violence Option waiver available for this requirement, such waivers are infrequently granted. This prevents many victims from choosing to access those funds. Whether it's because they fear sending the perpetrator to jail, worry that he may lose his license, or a host of other reasons, this policy creates more barriers for some victims needing financial assistance for their children.

In addition to the systemic barriers, there can also be enormous safety risks associated with pursuing child support from an abusive partner. The abusive partner may retaliate violently in response to the establishment of paternity or enforcement actions. If the survivor has left the relationship, the abuser may gain knowledge of her whereabouts and gain access to children to whom he poses a threat. Threats to seek custody of the children may also escalate. The re-entry of an abusive partner into the survivor's life is not only undesirable, it can be extremely dangerous – especially under these circumstances. Survivors are attuned to these threats: according to research,

> **90% of domestic violence victims want to pursue child support only if they can do so safely (Pearson, J., & Thoennes, N., 2000).**

Again, survivors may find themselves choosing between economic security and safety.

In order to weigh the risks and make informed decisions, survivors need accurate and complete information about their responsibilities in the child support process and the options, resources, and confidentiality protections available to them. Additionally, because there are specific safety risks at each stage of the process, ongoing safety planning is usually necessary.

6 EMPLOYMENT STATUS AND SOURCES OF INCOME IN REVIEWED CASES 2004-2012

How were both employed and what were their sources of support?

KEY POINT (CHART 6)
75% of victims were employed at the time of the homicide. Employers and co-workers have the potential to increase victim safety through training on recognizing symptoms, supporting victims, and making referrals.

EMPLOYMENT STATUS	VICTIM	PERPETRATOR
	%	%
Employed	75%	60%
Unknown	10%	17%
Unemployed Student	1%	2%
Retired	2%	1%
Disabled	4%	4%
Unemployed	8%	16%

SOURCE OF INCOME	VICTIM	PERPETRATOR
	%	%
Personal Wages	71%	58%
Unknown	11%	20%
Other Forms of Income	15%	13%
No Personal Income	3%	9%

7 LIVING SITUATION AT THE TIME OF THE HOMICIDE 2005-2012

8 PERCENTAGE OF CASES WHERE THE PERPETRATOR AND VICTIM SHARED MINOR CHILDREN 2005-2012

RECOMMENDATIONS ECONOMIC ABUSE & CHILD SUPPORT

Below are some recommendations to help you address domestic violence, economic abuse, and access to financial resources for survivors.

WHAT ADVOCATES CAN DO	• Increase your understanding of the child support process, as well as the various ways that victims can access child support, including the advantages and disadvantages of each option. • Increase your understanding of the unique safety concerns associated with accessing child support. • Provide victims with information about potential risks at all stages of the child support process. • Build relationships with your local child support office and engage in cross training.
WHAT CHILD SUPPORT WORKERS CAN DO	• Universally screen for domestic violence, and create safe and confidential opportunities for victims to disclose domestic violence. • Utilize a "yellow light" approach to pursuing child support where domestic violence is indicated, making room for individualized strategies for case management and enforcement. • Maintain confidentiality. • Build relationships with domestic violence programs and your state domestic violence coalition, and engage in cross training. • Formulate strategies to address the specific risks faced by domestic violence victims when accessing child support. *The recommendations for Child Support workers are from the Federal Office of Child Support Enforcement, Administration for Children and Families, Department of Health and Human Services, in collaboration with the National Resource Center on Domestic Violence.
WHAT JUDGES CAN DO	• Consider including child support when issuing Temporary Protective Orders, when the survivor feels it is safe to do so.
WHAT CIVIL ATTORNEYS CAN DO	• Understand the risks involved when including child support in divorce orders in cases in which family violence may be an issue.
WHAT FAMILY VIOLENCE TASK FORCES CAN DO	• Invite representatives from the local child support office to Task Force meetings.

RESOURCES

For more information on economic abuse: http://www.clicktoempower.org/

Economic Security for Survivors Project (Wider Opportunities for Women) Policy Brief, October 2012: Protection Orders and Survivors: http://wowonline.org/documents/ProtectionOrderBrief2012.pdf

Economic Empowerment of Domestic Violence Survivors: http://www.vawnet.org/Assoc_Files_VAWnet/AR_EcoEmpowerment.pdf

Economic Stress and Domestic Violence: http://www.vawnet.org/Assoc_Files_VAWnet/AR_EconomicStress.pdf

The Family Violence page of the Office of Child Support Enforcement, Administration for Children and Families, Department of Health and Human Services: http://www.acf.hhs.gov/programs/css/family-violence

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THINK DOMESTIC VIOLENCE IS JUST ABOUT VIOLENCE?

LOOK CLOSER.

MABLE'S STORY

Mable* was married to Richard* for 15 years. This was his third marriage. He had a history of violence against his previous wives; his first wife survived being shot by him and he stalked his second wife after she left him. Richard also was a convicted felon for a range of criminal offenses including voluntary manslaughter and aggravated assault against other men.

About seven years into their marriage, Richard pushed Mable down the stairs of their home. At the hospital, the doctors determined the lining of Mable's brain was torn during the fall, causing brain leakage. Following this incident, Mable was unable to work and received disability for the remainder of her life. Prior to going on disability, she managed a convenience store and was also a butcher at a local grocery store.

After the injury to her brain, Mable's family began to notice changes in her personality and her ability to control her emotions. Her family also disclosed that this was when she began drinking beer heavily. Mable attempted rehabilitation programs, such as Alcoholics Anonymous (AA), for alcohol addiction several times before her death. Records show she was charged with DUI and failure to maintain her lane at some point during her marriage to Richard.

> **Mable's family and friends do not feel Richard was supportive of her efforts to recover from alcohol addiction. Specifically, they said he would bring home cases of beer for her, successfully sabotaging her progress.**

Richard's violence towards Mable was widely known by her friends and family. Mable's adult daughter recalled seeing her mother with black eyes on numerous occasions. In the months prior to Mable's death, she saw her with a broken nose and a broken rib. Mable expressed fear of her husband and stated he had threatened to kill her several times. Mable's friend from AA said she saw bruises on her from time to time.

The police were reportedly called to the marital residence several times in the years before the homicide, although no police reports could be located. Mable confided in her daughter that the police were not very helpful to her. Richard would be calm and nice to the police when they arrived. He would roll his eyes and say to them, "I don't know what I am going to do with her." Mable was usually visibly upset when the police arrived and most of the time she had been drinking. At times, she would need medical treatment for her injuries. When the medical staff would question her about the incident related to her injuries, she would tell them she could not remember.

Within the year before her death, Mable moved out of the marital residence and moved in with a new boyfriend. She remained in contact with Richard while they were separated. In the months before her death, Mable moved back in with Richard but she had plans to leave him and live with her friend she knew from AA. Before she could move out, Richard killed her in their home by beating her to death with a blunt object.

Pseudonym used

CHALLENGES WITH CO-OCCURRING ISSUES: SUBSTANCE ABUSE & MENTAL HEALTH

The process of fatality review involves taking an in-depth look at domestic violence-related homicides. This lens allows us to see the "big picture" and provides more context as to what the lives of the victims were actually like. The Project has found that domestic violence is usually happening within a constellation of other issues. Frequently, domestic violence creates new problems and/or exacerbates existing problems in the victim's life. We have identified two specific issues that frequently co-occur with domestic violence and create additional barriers to victims achieving safety: substance abuse (SA) and untreated mental health needs (MH).

There are several ways in which SA and MH can intersect with domestic violence in a victim's life:

- The SA and MH issues may pre-date the current domestic violence situation and can be retriggered or exacerbated by the abuse.
- The trauma associated with current or past abuse by an intimate partner may lead to the use of drugs and alcohol as a way to self-medicate or cope with the abuse.
- The substance abuse may be connected to the current domestic violence and used as a form of power and control by the abuser.
- Trauma responses brought on by the abuse can be mislabeled as a mental health problem.
- A mental health problem can be brought on by the abuse as a result of the trauma.
- Some victims may think they have a mental health disorder because their abuser is telling them that they are "crazy" or doing things to make them think they are "crazy."

INCREASED BARRIERS FOR VICTIMS

Survivors with co-occurring SA and MH issues face considerable barriers to achieving safety.

ABUSERS USE SUBSTANCE ABUSE AND MENTAL HEALTH ISSUES TO GAIN AND MAINTAIN POWER AND CONTROL OVER THE VICTIM.

Some victims with MH disorders may be financially dependent on their abuser, need help paying for medication, or may be covered through their abuser's health insurance. The abuser may threaten to stop helping her pay for medication or cancel her insurance coverage if she leaves him. An abusive partner might be in control of the victim's access to drugs, alcohol, or medications. He may also pressure her to get high with him, coerce or force her to deal or use drugs, or interfere with her SA recovery (as seen in Mable's story). One victim was forced by her husband to get drunk and engage in sexual activities she was not comfortable with, often with other people. On some occasions, she would black out from the alcohol use. After these traumatic incidents, she would have what she described as an "emotional breakdown."

SA and MH issues can also be used by abusers to undermine victims in custody disputes, and to discredit them with family, friends, and court

CHALLENGES WITH CO-OCCURRING ISSUES: SUBSTANCE ABUSE & MENTAL HEALTH

systems (Warshaw, C., Brashley, P. and Gill, J., 2009). In Gina's story (see page 29), her husband threatened to tell the court about her drug use in an upcoming custody hearing if she did not reconcile with him. This tactic of threatening to expose or exploit a victim's SA or MH issue is extremely effective, especially for women with children, victims with previous criminal histories, and those on probation. In another case, the abuser went so far as to spike the victim's drink with cocaine the night before a scheduled drug test causing her probation to be revoked.

Barriers can also be created as a result of the isolation, embarrassment, and shame commonly associated with SA and MH issues. The negative stigmas and negative internalized social norms associated with these issues prevent victims from reaching out to the systems in place to assist them. The victim may blame herself for the abuse or feel as though she deserved it, especially if she was under the influence of a substance at the time of the assault.

Further, the same stigma that prevents victims from reaching out for help also influences service providers. People bring to this work their own morals, values, and biases; it can be difficult to set aside personal beliefs and resist the urge to make judgments and assumptions about victims with SA and MH issues. Sometimes, behaviors connected to these issues are misinterpreted and can lead to victims being labeled "noncompliant," "difficult," or "hard to get along with." The choices the victim makes may not be sensible to advocates and service providers. Service providers may assume the victim is dangerous, untrustworthy, abusing the system, or does not really want assistance. These assumptions, labels and biases create further barriers for victims to get the help they need.

The complexity of SA and MH can complicate advocacy and support by service providers. The sheer number of problems a person is dealing with may leave service providers feeling overwhelmed, frustrated, and even angry. These feelings often lead to burnout. This frustration is due in part to a lack of knowledge; frequently, advocates are not equipped to address SA and MH issues. And, in many communities, SA and MH services may not be available or affordable for those who need them. In certain communities, the nearest SA or MH facilities may be counties away. Further, due to reduced funding, low staffing, and high demand, services are not always delivered in a timely manner. Additionally, residential services for SA and MH issues are not widely available and are often expensive. Victims with limited income and/or no insurance coverage may not be able to afford services. Even victims with insurance coverage may struggle to afford these services.

This frustration is compounded by how the social service system is set up. Service providers tend to narrowly focus on one issue at a time; a domestic violence shelter focuses on domestic violence, a drug and alcohol treatment center focuses on substance abuse, a mental health center focuses on psychiatric issues, and so on. This single-focus model requires a survivor go to different agencies to get help for each issue. For victims in crisis experiencing trauma and other barriers, it can be daunting. The fragmented nature of social service delivery can be exacerbated when programs do not coordinate.

Some domestic violence programs and service providers' policies and protocols may act as barriers for victims seeking assistance.

Sometimes victims may be screened out or refused services if they have an active SA problem or their MH symptoms are severe. Other times, victims may be excluded from receiving services if they break domestic violence shelter rules regarding drugs and alcohol, violate curfew, or fail to keep appointments. SA and untreated MH issues can impair judgment, making safety planning and case management more difficult. These challenges do not mean the victim does not want help; it means the victim is still operating in a crisis mode, influenced by addiction and MH status, and is unable to comply with the goals that were set for them.

SA and MH issues can also complicate how the criminal legal system responds to victims of domestic violence. A victim may avoid calling police due to fears that her claims of abuse may be dismissed if she is drunk or high or that she may be arrested or reported to child welfare for illegal activity such as selling and using drugs. Furthermore, when SA and MH issues are identified or suspected by the criminal legal system, the domestic violence can get lost, downplayed, or even excused. The violence may be viewed as "mutual combat" or as a symptom of the SA or MH disorder and not an issue on its own. In situations such as a dual arrest, victims who are identified as perpetrators by the legal system are usually not linked with helping services.

RECOMMENDATIONS

When SA and MH needs go unmet or the barriers they create become overwhelming, the assistance offered by service providers is less likely to be effective. We recommend incorporating a trauma-informed approach to services by utilizing a holistic, trauma-informed lens—examining every aspect of the person, her situation, her experiences, her barriers and struggles—to provide victims with the resources, services, encouragement and empowerment they need. Adopting this approach will help break down the institutional, societal and personal stigma around issues of SA and MH issues and unresolved trauma. (Please see page 30 for more information on trauma-informed care.)

Furthermore, developing partnerships between domestic violence, SA and MH agencies in your community may help link victims with the assistance they need in a more comprehensive way. In communities where SA and MH services do not exist or are inaccessible for victims of domestic violence, we recommend an increase in advocacy for more funding to expand these valuable services.

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1. Warshaw, C., Brashley, P. and Gill, J. (2009). Mental health consequences of intimate partner violence. New York: Oxford University

GINA'S STORY

Gina* and Derek* met through a mutual friend and were married a year later; they had only been married for six months at the time of the homicide. Gina had three children from previous relationships and worked part-time as a school bus driver. Derek did not work because he was disabled from a car accident. Court documents indicate he was a convicted felon (for non-violent offenses) prior to killing his wife.

During the homicide investigation, her family and friends revealed they were aware of Derek's abuse towards Gina. One of her children talked about two instances when he saw Derek hit his mother in the face. He also stated Derek was mean to him and his brothers. Her youngest child's father took pictures of her after an incident where she had a black eye and a broken nose. She told him she did not go to the doctor because she had drugs in her system. Gina's best friend felt she changed dramatically for the worse after she met Derek. She began to look aged and withdrew from her family. She also became less devoted to her children and did not work as steadily.

Interviews with family and friends indicated Gina and Derek both used drugs. It is thought that Derek was selling "crank" and "ice." Gina confided in her best friend that she was selling drugs for him. She also said that she was scared because he had threatened her and she didn't feel like she was able to leave the relationship safely.

Despite her fear, Gina left Derek several times over the course of the year-and-a-half relationship. One time, she applied for housing through Housing and Urban Development (HUD) and leased an apartment in a neighboring city.

> **The last time Gina left Derek, she returned to him after he threatened to testify against her in the upcoming custody hearing for one of her children.**

He told her that he would not testify if she reconciled with him. Gina never made it to the hearing, which was scheduled for the day after she was killed.

The night of the homicide, Gina and Derek were fighting in the car. Gina got out of the car and walked to a nearby gas station to use the phone and call for a ride. A customer in the store heard her story and offered to take her home. Gina agreed but, because this person was a stranger, she made an agreement with the store clerk that she would call him when she got home to let him know she was OK. She arrived home safely and called the store clerk to let him know. While she was on the phone, Derek shot her in the chest with a 12-gauge shotgun. The store clerk hung up and called the police. Derek was arrested when the police arrived.

There is no indication Gina sought assistance from outside resources regarding the domestic violence or drug use during her relationship with Derek.

Pseudonym used

TRAUMA-INFORMED CARE

Domestic violence and other lifetime trauma can have significant emotional and behavioral impacts. Yet, the systems to which survivors and their children turn are frequently unprepared to address the range of issues they face in trying to access safety and heal from the traumatic effects of abuse. In recent years, the domestic violence movement has begun to realize that understanding trauma is critical to working with survivors of domestic violence and sexual assault.

WHAT IS TRAUMA? TRAUMATIC REACTIONS ARE NORMAL RESPONSES TO ABNORMAL SITUATIONS.

Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and has lasting adverse effects on the individual's functioning and physical, social, emotional and spiritual well-being. Traumatic experiences often involve a threat to life or safety of self or others. However, any situation that leaves a person feeling overwhelmed mentally, physically and emotionally can be traumatic, even if it doesn't involve physical harm. Trauma can result from a one-time traumatic incident such as being a victim of a crime or surviving a natural disaster. It can also result from long-term exposure such as being in combat or being abused by a family member. Generally, the adverse effects related to ongoing trauma are more severe and long-lasting than the impact a one-time traumatic incident has on a person, though every person's experience is unique.

Trauma responses are subjective and personalized; what one person may experience as traumatic may not be traumatic to another person. The cause of trauma and the resulting responses are beyond a person's control and are different for everyone. Some common trauma responses are feelings of vulnerability, helplessness and fear; these emotions can have long-term effects on how a person thinks, behaves and interacts with the world around them. Trauma can also lead to physical reactions including but not limited to: numbness, fatigue, sleep disturbances, headaches, stomach aches and a compromised immune system.

During a traumatic event, a number of physiological changes immediately occur in the body. These changes are characterized as "fight," "flight" or "freeze" responses. These instinctive reactions to danger are the human body's way of protecting itself. The body keeps a "memory" of traumatic events so it is prepared to respond next time there is danger. A trauma response can be triggered when something happens that reminds a person of the original trauma, and the body reacts as if there is danger, even if the danger might not be real. The body's "memory" is what makes trauma cumulative; experiencing multiple traumatic events in a lifetime can cause overlapping trauma responses that build upon each other.

HOW ARE DOMESTIC VIOLENCE AND TRAUMA RELATED?

For most people, experiencing abuse by an intimate partner is traumatic. There are two

TRAUMA-INFORMED CARE

unique issues that make domestic violence-related trauma different from other kinds of trauma. First, the betrayal of trust by a loved one is especially damaging. The abuser is likely someone the survivor interacts with on a daily basis; the physical and emotional connections that are part of an intimate relationship are the very things that make this so complex. Second, domestic violence is not a one-time traumatic incident; it is an ongoing pattern of traumatic events. The chronic nature of domestic violence can cause multiple and prolonged trauma reactions that can be difficult for the survivor to manage and challenging for a service provider to understand.

Survivors of domestic violence may have adopted long-term patterns and coping mechanisms in an effort to survive lifetime trauma. Behaviors that are interpreted by the system as manipulative or unhealthy may reflect strategies survivors have developed to keep themselves safe or cope with the trauma they have experienced. These behaviors may include staying up all night and sleeping all day, seeming constantly "on guard" and jumpy, being extremely sensitive to the reactions of others, withholding information or misrepresenting facts. The emotionally destabilizing effects of trauma can make it difficult for survivors to make decisions, follow plans, and tend to everyday tasks. When survivors seek help, this behavior often leads to labels such as "difficult," "noncompliant" or "hostile." Furthermore, when a survivor has co-occurring issues such as a substance abuse problem or mental health challenge (diagnosed or mislabeled by others), she is less likely to get a supportive response from the system.

WHAT ADVOCATES CAN DO

Trauma-informed services are not specific types of services, but a set of principles that place trauma at the center of our understanding of survivors. The Center for Mental Health Services National Center For Trauma-Informed Care (NCTIC) cites that a trauma-informed approach is based on the recognition that many behaviors and responses expressed by survivors are directly related to traumatic experiences. Implementing a trauma-informed approach involves utilizing the trauma lens to shape services and interactions with the goal of minimizing trauma triggers.

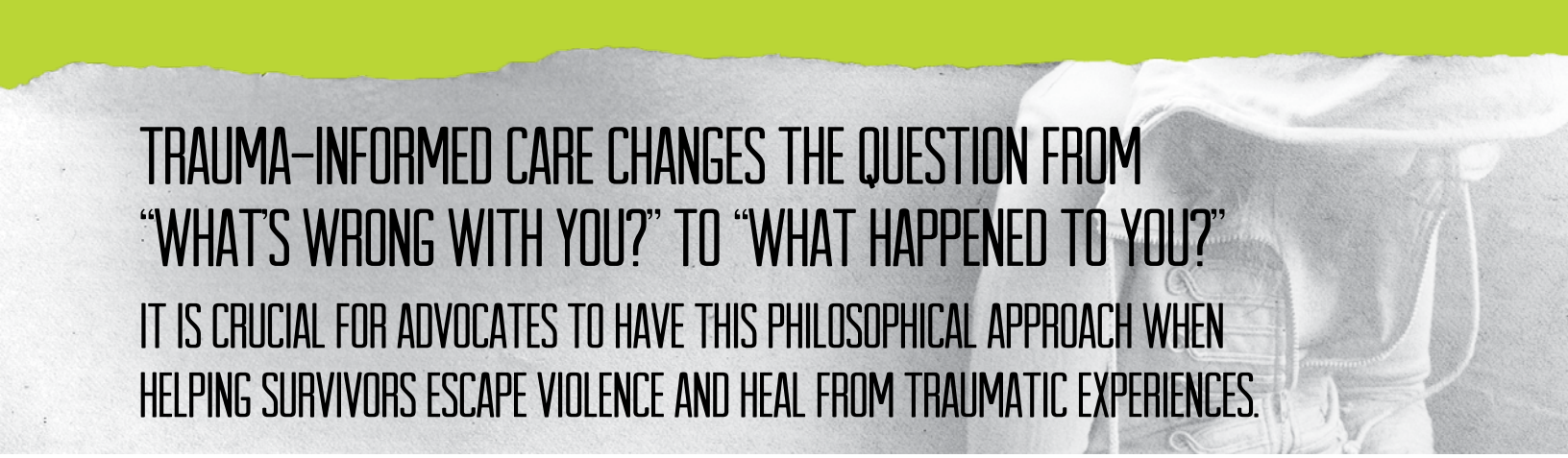
There are five core components of a trauma-informed approach to domestic violence advocacy. These include:

1. Providing survivors with information about the traumatic effects of abuse
2. Adapting programs and services to meet survivors' trauma-related needs
3. Creating opportunities for survivors to discuss their responses to trauma
4. Offering resources and referrals to survivors
5. Reflecting on our own personal practices and our programs' practices with a trauma-informed lens

A key component of this approach is expanding the notion of safety. While domestic violence advocates are understandably concerned first and foremost with a survivor's physical safety, a trauma-informed approach addresses the emotional safety of survivors as well.

TRAUMA-INFORMED CARE CHANGES THE QUESTION FROM "WHAT'S WRONG WITH YOU?" TO "WHAT HAPPENED TO YOU?"

IT IS CRUCIAL FOR ADVOCATES TO HAVE THIS PHILOSOPHICAL APPROACH WHEN HELPING SURVIVORS ESCAPE VIOLENCE AND HEAL FROM TRAUMATIC EXPERIENCES.



Without a trauma-informed framework, services intended to assist a survivor may inadvertently trigger a trauma response or fall short of helping a survivor with her needs. Trauma-related responses such as panic attacks, an exaggerated startle reflex, and irritability over minor provocations are often confusing for advocates because the reaction may not appear to match a seemingly neutral event or interaction. This can lead to a breakdown in the relationship between the advocate and the survivor. Providing education to advocates on how traumatic experiences impact individuals can counterbalance this disconnect.

VICARIOUS TRAUMA

Survivors are not the only people affected by trauma. On a daily basis, advocates and others listen to sad, emotional and tragic stories. The emotionally taxing nature of this work results in responders internalizing the feelings and emotions of those they are working with and developing trauma reactions in a process commonly referred to as vicarious trauma or secondary trauma. These trauma reactions can inhibit an advocate's ability to support survivors in a compassionate and empathetic way. Some of the warning signs of vicarious trauma can include anger and cynicism, disbelief or mistrust of survivors, victim blaming, diminished creativity in addressing problems, emotional numbness and feeling hopeless or helpless.

The impact of vicarious trauma on advocates and others can be minimized by utilizing a trauma-informed approach when setting organizational policies and incorporating these principles into the ways in which organizations support and supervise employees. The process of becoming trauma-informed is one that requires a comprehensive look at the organization as a whole—from structure, to policies, down to programming and specific practices. Many resources exist to guide organizations through this process. For more information, please contact the Georgia Coalition Against Domestic Violence at 404-209-0280.

Special note: The principles of trauma-informed care are universal but the applications are different for particular groups.

While we are focusing here on domestic violence advocates, any service provider or agency can become trauma-informed. For more information, visit http://www.nationalcenterdvtraumamh.org.

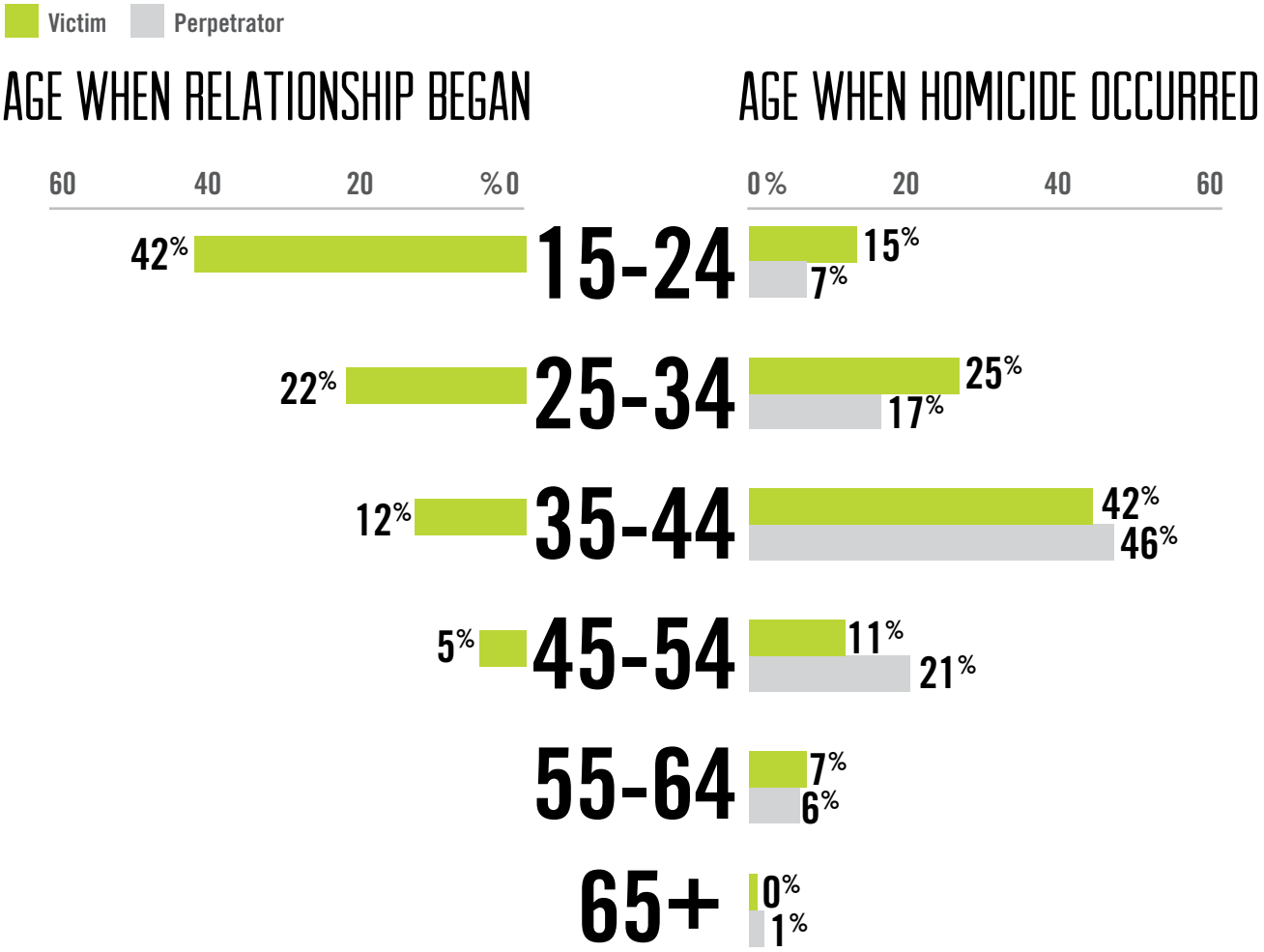
REFERENCES:

1. "Real Tools: Responding to Multi-Abuse Trauma. A Tool Kit to Help Advocates and Community Partners Better Serve People with Multiple Issues." Debi S. Edmund, M.A., LPC and Patricia J. Bland, M.A., CDP. 2011 Alaska Network on Domestic Violence and Sexual Assault.

2. "Trauma-Informed Care: Best Practices and Protocols for Ohio's Domestic Violence Programs." Funded by: The Ohio Department of Mental Health. Sonia D. Ferencik, MSSA, LISW and Rachel Ramirez-Hammond, MA, MSW, LISW.

9 WHAT AGES WERE THE VICTIMS AND PERPETRATORS IN REVIEWED CASES? 2004-2012

What proportion of victims and perpetrators were in each age range at death? How old was the victim when this lethal relationship began?



KEY POINTS (CHART 9)

In our reviews, the average age of victims at death was 36 years; perpetrators' average age was 40 years at the time of the homicide.

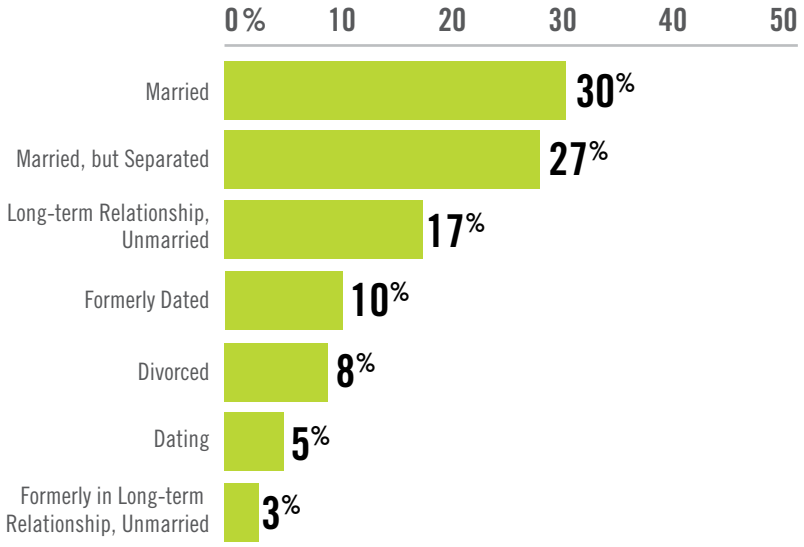
46% of victims were 16-24 years old when they began their relationships with the partners who eventually killed them. 27% of victims were teenagers (ages 15-19) when they began relationships with the partners who eventually killed them. Five of the victims were just 15 when their relationships began.

Our lack of recognition of, resources for, and effective responses to teen dating and young relationship abuse represent critical missed opportunities for early interventions.

NOTE: Statistics were gathered through convenience sampling of 86 homicide victims and 82 perpetrators.

10 WHAT WAS THEIR RELATIONSHIP STATUS? 2004-2012

What proportion of victims and perpetrators were in each relationship category at the time of the homicide?

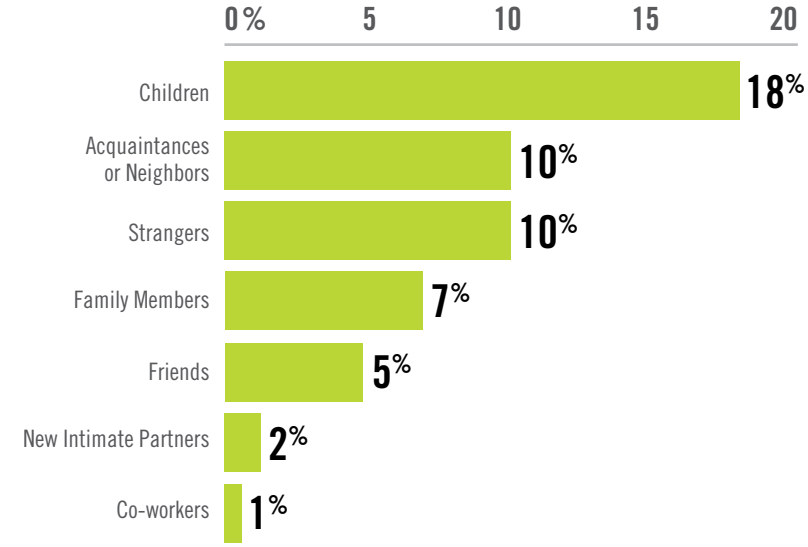


KEY POINTS (CHART 10)

This chart does not reflect the fact that many victims were contemplating leaving the relationship and taking steps to do so. Victims are at the highest risk of being killed by their abusive partners when they separate from them; both rates and seriousness of physical abuse increase during periods of separation and divorce.

Even when a victim's desire to leave is not spoken aloud, any increase in their behaviors or steps to gain independence may signal loss to their partner, placing some victims at high risk for violence. Many victims had mentioned to a family member, friend, or co-worker they were considering leaving their abusive partner. Taking a new job, increasing social activities, saving money, and changing locks on doors can all signal to a domestic violence perpetrator that the victim is serious about leaving and is actively taking steps to separate from them.

11 WHO ELSE WITNESSED THE FATALITY? 2004-2012



KEY POINTS (CHART 11)

In 48% of cases, someone witnessed the homicide. 18% of those witnesses were children.

There is a critical need to assist children dealing with the traumatic effects of witnessing a homicide and losing one or both parents.

12 PERPETRATOR'S HISTORY AS KNOWN BY THE COMMUNITY 2005-2012

What was the perpetrator's behavioral or criminal history?

KEY POINTS (CHART 12)

In 86% of the cases reviewed, the perpetrator had a history of some domestic violence against the victim prior to the homicide. A good indicator of future and possibly lethal violence is past violence.

In only 25% of the cases did the perpetrator inflict serious injury on the victim in an incident prior to the homicide. This suggests that while serious or visible injury is a predictor of future and possibly lethal violence, it will not always be present in cases where victims are later killed.

38% of perpetrators were known to have either threatened or attempted suicide prior to the homicide.

NOTES: We define perpetrator as the individual who committed the homicide and victim as the individual who was killed. Eight female perpetrators killed male partners; one female perpetrator killed a female partner. One male perpetrator killed a male partner. All remaining homicides were men killing women.

*Includes cases reviewed in 2005-2012 data only. Information for this chart was gathered primarily through available protective order petitions, police reports, prosecutor files, homicide investigations, and interviews with family and friends. Project coordinators then categorized these behaviors based on commonly used guidelines for lethality indicators.

		% of cases where this factor was present
VIOLENT OR CRIMINAL BEHAVIOR	History of DV against victim	86%
	Threats to kill primary victim	56%
	Violent criminal history	50%
	Stalking	44%
	Threats to harm victim with weapon	39%
	Child abuse perpetrator*	32%
	History of DV against others*	27%
	Inflicted serious injury on victim*	25%
	Sexual abuse perpetrator	22%
	Threats to kill children, family and/or friends*	19%
	Strangulation	19%
	Harmed victim with weapon*	17%
	Hostage taking*	8%
CONTROLLING BEHAVIOR	Monitoring and controlling	53%
	Isolation of victim*	30%
	Ownership of victim*	22%
MENTAL HEALTH ISSUES AND SUBSTANCE ABUSE	Alcohol and drug abuse	52%
	Suicide threats and attempts	38%
	Depression*	32%

**Includes cases reviewed in 2005-2012 only*

DOMESTIC VIOLENCE & SEXUAL ABUSE

Nationally, 1 in 6 women and 1 in 33 men have been the victim of an attempted or completed rape in their lifetime (National Institute of Justice & Centers for Disease Control & Prevention, 2001). Because rape and sexual assault are shrouded in shame and silence, this subject is rarely talked about; victims seldom disclose to family and friends what has happened to them and even less so to systems designed to help them. Subsequently, this crime often goes undocumented and unprosecuted. Survivors who do disclose are often not believed or are told they should have done something to prevent the assault from happening.

> **A note on language: The term sexual assault is generally used to describe types of sexual violence, such as rape and sexual harassment. The term rape is most often used to describe forced sex without consent.**

The term sexual abuse can have different meanings in different contexts, particularly depending on the age of the victim and relationship to the perpetrator. In the context of this report, sexual abuse refers to a form of sexual assault that occurs in an intimate relationship. Sexual abuse may include types of abuse that are not commonly thought of as being "violent" such as criticizing someone sexually, recklessly or purposely exposing them to sexually transmitted diseases, and reproductive coercion. Sexual abuse is a powerful tool used by abusive partners to gain and maintain power and control over their intimate partners and includes a range of behaviors:

- Making embarrassing comments or sexual jokes,
- Unwanted touching,
- Demanding monogamy while having affairs,
- Reproductive coercion, such as pressuring a victim to become pregnant and/or sabotaging contraception,
- Demanding sex after a physically violent or verbal assault,
- Forcing or pressuring her to engage in unwanted sexual activities,
- Rape and forced sex

RESEARCH SHOWS THAT SEXUAL ASSAULT OR FORCED SEX OCCURS IN APPROXIMATELY 40–45% OF BATTERING RELATIONSHIPS.

(CAMPBELL, ET AL. 2003)

However, in the 94 cases reviewed by this Project, sexual assault history is almost never documented; in fact, documentation is conspicuously missing. For victims of sexual assault by an intimate partner, the silence previously noted is further supported by common beliefs regarding a woman's sexual responsibilities in a relationship, a man's ownership of his partner and her sexuality, and that rape is not possible in an intimate relationship. This is not surprising as it was only

DOMESTIC VIOLENCE & SEXUAL ABUSE

in 1996 that Georgia's rape statute was amended to allow for prosecution of marital rape by adding "the fact that the person allegedly raped is the wife of the defendant shall not be a defense."

While the psychological impacts of being a victim of sexual abuse by an intimate partner are devastating, this issue is often minimized or not addressed at all in social service settings. Many women are not comfortable bringing up this aspect of the abuse and many domestic violence advocates are not comfortable having the conversation and consequently do not ask about sexual abuse as part of their screening and intake. Advocates and service providers miss the opportunity to help survivors heal from the trauma associated with sexual abuse by not overcoming their reservations about this topic. Advocates can take advantage of the opportunity to break down the stigma, silence and shame surrounding sexual assault by having conversations with survivors about this issue, validating their experiences and feelings, and providing supportive resources when the survivor is ready to talk about what she has experienced.

RECOMMENDATIONS

We offer the following recommendations as a way to better support victims of sexual abuse:

WHAT ALL COMMUNITY MEMBERS CAN DO	• Spread awareness that domestic violence includes sexual abuse. • Upon disclosure, tell the survivor that you believe her, and you are sorry for what happened to her. Tell her there is nothing she could have done to prevent the assault from happening and she did nothing to make the sexual assault happen. • Be compassionate and understanding; a survivor may not be ready to reveal or discuss what she has experienced. Do not force a survivor to discuss sexual violence. • Provide survivors who disclose abuse with resources for a local domestic violence agency and/or a sexual assault center.
WHAT ADVOCATES CAN DO	• Request ongoing training on responding to sexual violence. • Build partnerships between domestic violence and sexual assault agencies to provide cross training, provide a "warm referral" and collaborate to meet victims' needs. • Incorporate a trauma-informed approach to your work. (See page 30.) • Ask about sexual abuse but do not force the issue with a survivor. Understand some survivors may not feel comfortable disclosing sexual abuse, even when asked. • Provide a support group for survivors of sexual assault at your program. • Understand that substance use is a common response to sexual violence and a way of coping with what has happened.
WHAT FAMILY VIOLENCE INTERVENTION PROVIDERS CAN DO	• Ask participants about sexual abuse towards their partners and acknowledge it as a tactic of power and control in their relationship.

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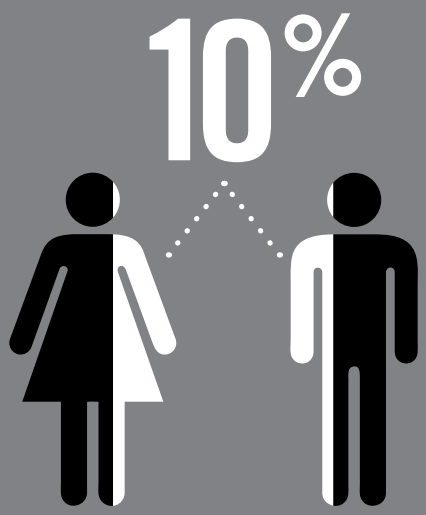
1. National Institute of Justice & Centers for Disease Control & Prevention. Prevalence, Incidence and Consequences of Violence Against Women Survey. 1998.
2. Campbell, J.C., Webster, D., Koziol-McLain, J., Block, C.R., Campbell, D., Curry, M.A., Gary, F., McFarlane, J. Sachs, C., Sharps, P., Ulrich, Y., and Wilt, S.A. (2003). Assessing Risk Factors for Intimate Partner Homicide. In Intimate Partner Homicide, NIJ Journal, 250, 14-19 (pdf, 6 pages). Washington, D.C.: National Institute of Justice, U.S. Dept. of Justice.

WOMEN'S USE OF VIOLENCE



*in cases reviewed

In 2011, the Project decided to undertake the challenging but necessary endeavor of exploring women's use of violence and all of its complexities. With our community partners reporting increases in dual arrests, women being ordered to complete Family Violence Intervention Programs, and women killing their male partners, the Project wanted to look more closely at how and why women use violence in order to increase our understanding of this issue so we can form recommendations and continue efforts in Georgia to keep all individuals safe. The loss of any life is a tragedy and we are committed to working to prevent all domestic violence-related homicides from occurring in Georgia.

During the past year, we have worked with communities in Georgia to review five cases where women have killed their male partners, adding to three cases reviewed in previous years. We reviewed several different types of cases—some women were victims acting in self-defense, some had past experiences with abuse, and some had long histories of being violent toward their partner and others in their life. The reviewed cases had a range of different outcomes—some women accepted plea deals, one was exonerated of her charges, and one died by suicide immediately after killing her partner.

This year, the Project developed a partnership with a woman's prison in Georgia. Jennifer Thomas, Program Manager for the Georgia Commission on Family Violence, worked closely with the Project as she facilitated groups with women who were serving life sentences. Many of the women Jennifer worked with had killed their male partners. This new partnership provided the Project with a chance to further our understanding of women's use of violence by listening to women who have used violence as they tell their personal stories.

During her time at the prison, Jennifer shared the 2011 Domestic Violence Fatality Review Annual Report with the women in the group she facilitated. After reading the report, a woman stated, "I feel like you were looking into the windows of my house when you wrote this." The other women in the room quickly shared with Jennifer that they felt the same way. This statement was powerful for us as a Project because it spoke to the reality that the lives of women who had been incarcerated for killing their male partners did not look much different from the lives of the women who had been killed by their male partners. The women who killed their male partners experienced the same dynamics of power and control from their partners as we have seen in our reviewed cases when women were killed.

> **We have learned that many abused women face the reality of these two tragic endings: losing their life at the hands of their abuser or losing their freedom by killing their abusive partner.**

By taking a concerted effort to look at the differences in how and why women use violence, we are in no way excusing the behaviors of women who kill their partners—they are perpetrators of domestic violence homicides. However, the reality is that prior to many of these homicides, most of the women who killed their male partners were victims of abuse and domestic violence in some way. Further research indicates that most women who kill their male partners have been victims of their partners' abuse prior to the homicide. The circumstances of these homicides are not always consistent with legal definitions of self-defense; thus, a significant number of women who kill their abusers are prosecuted, most for murder or manslaughter (Rasche, C.E., 1993, & Jurik & Winn, 1990). In the cases we have reviewed, this holds true. Often, past trauma and victimization are not included in a prosecutor's decision to

bring charges against a woman who has killed her partner and, as we have learned, many women tend to admit their guilt and don't identify as a victim of abuse.

EARLY THEMES

Our early findings on the topic of women's use of violence have only confirmed our original hypothesis and other supporting research; this issue is complicated and complex. However, through interviews with women at the prison and what we have learned through our fatality reviews, we have expanded our understanding of the struggles and barriers that existed in the lives of women who used violence. The following 11 themes repeatedly surfaced in the stories of women who killed their male partners.

PERCEPTION

1. **Violent homes with strict gender roles.** Growing up in a home where their father abused their mother left a lasting effect on many of the women. They learned as a child that violence within an intimate relationship was normal and this idea carried over into their adult relationships. One woman's mother taught her it was easier to stay in the abusive relationship than leave because the children would be happier. As a child, another woman believed if her mother had just "shut up" her father would not have been so abusive.

2. **Not seeing themselves as victims.** Many of the women did not identify as victims of abuse or domestic violence though what they were experiencing was in fact domestic violence. It was not until they were incarcerated and began to talk with other women who shared their same experiences or attended a family violence class that they began to see themselves as victims of domestic violence. There are several reasons why many of these women did not identify as a victim of abuse. First, few people want to see themselves as victims or be seen as victims. The stigma associated with the word "victim" prevents many women from identifying themselves as such. Secondly, there is a great deal of shame associated with being a victim. One woman said she didn't reach out for help because she didn't want to tell anyone the man she loved beat her up. Not identifying as a victim of abuse often prevented the women from reaching out to local domestic violence agencies or disclosing the abuse to anyone in their life.

> **Another reason why some of the women did not see themselves as victims of domestic violence is that they were victims of emotional and psychological abuse, but not physical abuse.**

After years of being in an abusive relationship, women learned how to appease the demands of their abusive partners to prevent arguments by drastically altering their life to what was expected of them by their partner.

3. **"The look in his eyes."** Many women thought their partner would have killed them that night if they had not taken action to stop him. The phrase "the look in his eyes" was often heard and the perception the abuse was going to escalate the night of the homicide was common. We know a tool of domestic violence used by abusers is threatening behavior—often, abusers only have to look at their victims in a certain way or make a certain threatening motion to make the victim comply. Sometimes, an abuser only has to use physical violence against his partner one time; from then on, he need only refer to that instance or threaten her in a certain way to control her. This becomes a pattern in the relationship that plays out in several different ways. One woman shared that her abusive partner would say "why don't you get ready for bed" and she would know that she was going to be beaten or raped that night.

SEXUAL ABUSE

4. **"He'd raped me for the last time."** Many women shared that they were sexually abused by their male partners as part of the ongoing abuse. While most often the sexual abuse was perpetrated against the women, one man killed by his wife had sexually molested her 11-year-old daughter for two years. (For further discussion on sexual abuse, see page 36.)
5. **Childhood sexual abuse.** Beyond sexual assault in their adult intimate relationships, many of the women disclosed they were survivors of childhood sexual abuse from a very young age. Most of the women did not receive any counseling services to deal with the unresolved trauma, grief, and loss which come with surviving such an experience, leaving them feeling isolated and alone. The women who disclosed the abuse to family members as children were often not believed. From this early experience of not being believed or supported, many of the women expressed that they did not see themselves as victims of domestic violence in their adult intimate relationships and therefore did not consider reaching out to a domestic violence agency for support and assistance. One woman said she was sexually molested by her father beginning at the age of 3. This experience led her to leave home at an early age, escaping the abuse, and incidentally marrying young after becoming pregnant. The man she married later became physically abusive.

UNINTENDED OUTCOMES

6. **"I didn't mean to kill him."** The reasons the women used violence did not reflect the reasons we have seen men use violence in past reviews. Many of the women said they did not intend to kill their partners with their violence. The actions that put them in prison were not based on power and control; most only wanted to put an end to the violence or sexual abuse.
7. **Intense remorse and regret.** The women who killed their partners expressed intense remorse for causing the death of the men

most still claim to love and have feelings for. One woman stated in her testimony, "I loved [him]. I still do." During our interview with another woman, she became very emotional when talking about her husband and stated, "If he had never met me, he'd still be alive" before breaking down and crying.

COMPOUNDING ISSUES

8. **Unmet mental health needs.** Several of the women and their partners suffered from mental health-related issues that many times went untreated or misdiagnosed. One woman who killed her partner reported hearing voices in the months before the murder. Another had been treated at a mental health facility for depression and a seizure disorder. Suicidal ideations were also common among their stories.

> **As the women struggled with how to leave the abusive relationship, many of them stated they had either considered or attempted suicide.**

Feeling isolated and trapped in their relationships provided very few options for them. Not identifying as a victim of violence, many of these women did not reach out for assistance. Further, many women felt they could "fix" or "help" a partner who had ongoing mental health issues. These feelings were often rooted in socialized gender roles and her "responsibility as a woman" to her male partner. This caused women to minimize their own mental health needs and put his first. One woman's partner was a military veteran and had been diagnosed with Post Traumatic Stress Disorder; she regularly accompanied him to his appointments at the Veterans Affairs Medical Center in attempts to address his ongoing symptoms.

9. **Chronic substance abuse and use.** Ongoing substance use and abuse were recurrent in the stories of the women who used violence, not only in their own lives but in the lives of the men they killed. Several women had struggled with substance abuse since they were teenagers, when they turned to drugs and alcohol to cope with trauma they had experienced in their lives. Most of the women did not seek assistance for their substance abuse issue because of the feelings of helplessness and powerlessness as a result of years of abuse and trauma.
10. **Criminal histories.** Many of the women had criminal histories ranging from violent offences to petty crimes. Some women shared that they used violence as a way to protect themselves, because it was how they had learned to solve conflict in relationships, and it was a way for them to feel like they had power and control over their own lives. However, the violence usually intensified once they fought back against their partner. This placed them in a double bind; they were attempting to stay safe by using violence but did not feel they could ask for help because they had also been violent. Some women used other ways to regain a sense of power and control in their lives, such as shoplifting.

One woman said it was the only time she felt she had any sense of control in her life, because she determined when she would shoplift and what she would steal.

JUSTICE SYSTEM RESPONSE

> "HE'D RAPED ME FOR THE LAST TIME."

11. **Plea deals.** A significant number of women took plea deals instead of going to trial after the homicide. For some, this felt like the right thing to do because they admitted their guilt and wanted to protect those they loved, especially their children, from the emotional impacts of a trial. For others, they were afraid of going to trial and receiving a harsher sentence. In six of the eight cases we reviewed, the women accepted plea deals (one woman was exonerated of her charges after using Battered Person's Syndrome as a defense and one died by suicide immediately after killing her male partner). Using Battered Person's Syndrome as a defense was not usually considered because the women did not identify themselves as victims and they were not seen as victims following the homicide.

RECOMMENDATIONS WOMEN'S USE OF VIOLENCE

The trends identified over the past year reflect a lifetime of unresolved trauma for many of the women who killed their male partners. The impact of overlapping forms of abuse coupled with socialization which normalized violence and the fact that many had criminal histories all affected the women's ability to live violence-free. Their past experiences influenced what they believed their options were, before and after the homicide. The trends speak to the need for our communities, agencies, and systems to think critically about the support and services we provide and how we may be helping or harming some victims of domestic violence, specifically those victims with compounding issues including past trauma, criminal backgrounds, substance abuse and mental health needs. (For further discussion on substance abuse and mental health, please see p. 26.)

WHAT ALL COMMUNITY MEMBERS CAN DO	• Spread awareness that domestic violence does not just mean physical violence. • Break down socialized gender roles for children and adults. • Believe disclosures of childhood sexual abuse and link childhood survivors of sexual violence and abuse to supportive resources. • Ensure child survivors and witnesses of domestic violence receive wraparound services to address the trauma they have experienced. • Help identify normal vs. abusive behavior in relationships.
WHAT ADVOCATES CAN DO	• Incorporate trauma-informed care into agency practices and protocols. (See Page 30.) • Engage women on issues of past trauma, substance abuse, sexual assault, and childhood sexual abuse with compassion and understanding. • Ensure accessibility of services to victims with criminal histories, even when they have been identified as perpetrators or are being prosecuted. • Partner with substance abuse and mental health providers to provide a holistic approach and support for all survivors of domestic violence.
WHAT FAMILY VIOLENCE INTERVENTION PROGRAMS CAN DO	• Implement FVIP curriculum specific for women's use of violence. • Work with your local Family Violence Task Force to address the issue and reduce the number of victims of domestic violence being sentenced to FVIP programs.
WHAT LAW ENFORCEMENT CAN DO	• Ensure proper primary aggressor identification and charges for all family violence crimes. • Provide resources to and refer all victims, not just victims of physical violence, to local domestic violence agencies.
WHAT LEGAL PROFESSIONALS CAN DO	• Consider lifetime trauma, Battered Person's Syndrome, and compounding issues and experiences when prosecuting domestic violence cases.
WHAT SUBSTANCE ABUSE AND MENTAL HEALTH PROFESSIONALS CAN DO	• Incorporate a trauma-informed approach into your practice. (See Page 30.) • Collaborate with local domestic violence agencies to ensure appropriate services are available for victims of domestic violence with substance abuse and mental health issues. • Arrange to receive ongoing training on domestic violence through your local domestic violence agency.

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1. Rasche, Christine E. (1993). Given reasons for violence in intimate relationships. Homicide: The victim/offender connection. Cincinnati, Ohio: Anderson.
2. Jurik, N. & Winn, R. (1990). Gender and homicide: A comparison of men and women who kill. Violence and Victims 5:4, p. 236.

IMPLEMENTATION INITIATIVES

Conducting fatality reviews yields two kinds of recommendations: those that are specific to a local community and those that can be applied on a statewide level. In response to our key findings that law enforcement, faith communities and employers play a key role in connecting victims of domestic violence to resources, the Project has developed the following resources. These resources are designed to help communities across Georgia, (whether or not they have conducted a fatality review) implement findings and recommendations from the Project to increase support for victims and to increase victim access to domestic violence programs.

ROLL CALL TRAINING MANUAL

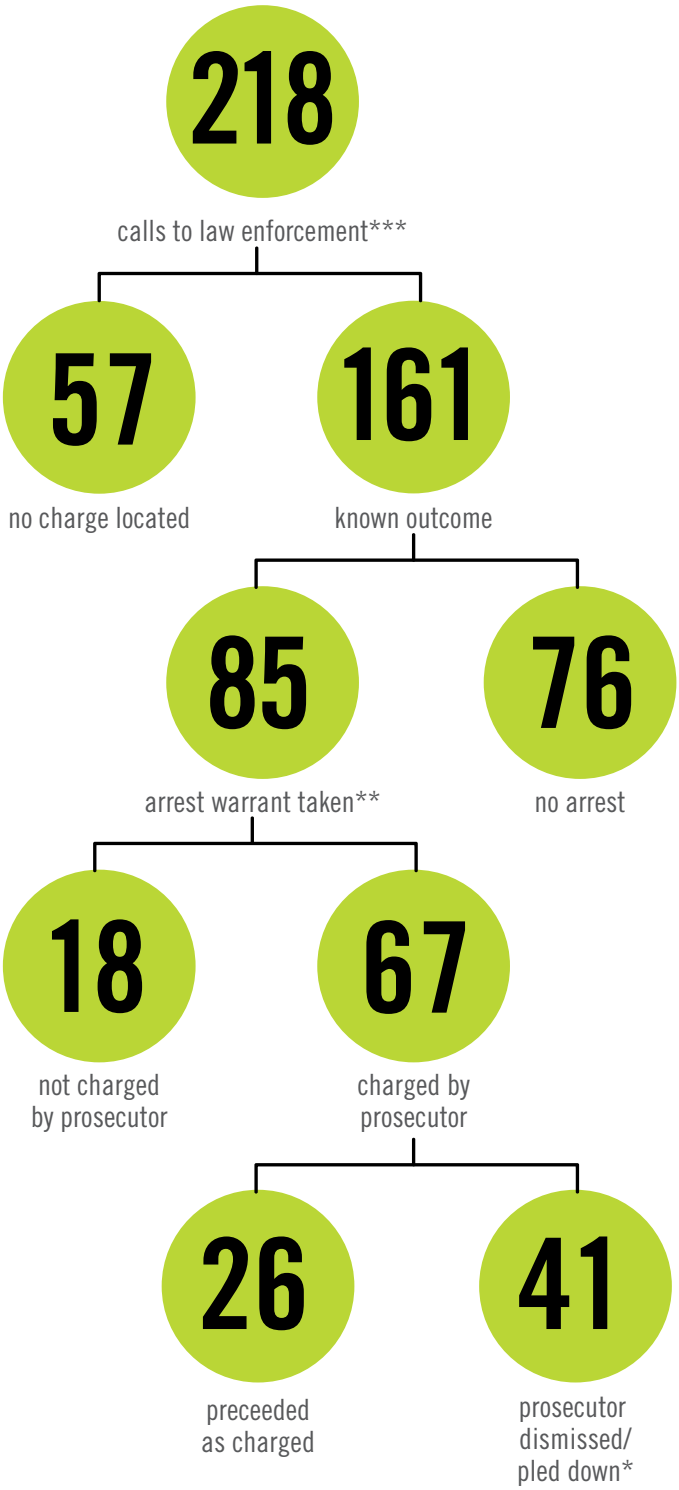
Consistently, fatality reviews confirm the crucial role law enforcement plays in connecting domestic violence victims with life-saving services available to them in their communities. Victims and perpetrators had contact with law enforcement in the five years prior to the homicide at a much higher rate than any other community agency (see page 8). This contact provides an ideal opportunity for responding officers to offer resources, information and referrals to victims on the scene. However, local law enforcement officers are not always aware of what services exist and how to connect victims with those services.

The Roll Call Training Manual is a resource designed to address this gap and help Family Violence Task Forces equip officers with the tools they need to make accurate referrals to victims of domestic violence. The manual is available to Family Violence Task Forces in Georgia who are interested in implementing roll call trainings in their communities. In addition to PowerPoint presentations, handouts and other resources, the Roll Call Training Manual contains six scripted Roll Call trainings covering mandated family violence response, primary physical aggressor identification, victim services and law enforcement, incident reporting, family violence protection orders and stalking.

A key component to the Roll Call training series is the recruitment of and partnership with several suggested presenters including domestic violence advocates, prosecutors, judges and judicial staff, chiefs of police and other leaders in law enforcement to assist with presenting the information to law enforcement officers. Drawing on the expertise and knowledge of the suggested presenters enriches the training program and encourages participant engagement. Developing these relationships is valuable beyond the roll call trainings as it engages a variety of influential community members invested in keeping victims of domestic violence safe and holding abusers accountable. If you are interested in starting roll call trainings in your community, please contact Jenny Aszman at GCFV at 404-232-1830 for technical assistance. You may also order a free copy of the manual online at www.gcfv.org.

13 DETAIL OF INVESTIGATION AND PROSECUTION OUTCOMES 2004-2012

What was the end result of contacts with 911 and law enforcement?



KEY POINTS (CHART 13)

When law enforcement was called to the scene, 61% of the time no arrest warrant was taken or no evidence of a charge could be located. This percentage includes cases where the law enforcement officer did not take a warrant because the perpetrator had left the scene. It also includes cases in which the perpetrator remained on the scene and the officer advised the victim to take the warrant herself.

These practices send a message to the victim that the crime committed against her is not being taken seriously by the criminal justice system. Additionally, they send the message to perpetrators that the criminal justice system will not hold them accountable for their behavior.

A review of the case histories reveals that calling law enforcement does not always result in increased safety, justice, or perpetrator accountability. In those cases where law enforcement was called and the outcome is known, only 42% were charged by the prosecutor, and 61% of those were subsequently either dismissed or pled down.

NOTES: *The "dismissed/pled down" category includes cases that were dismissed because the victim was killed before the case proceeded to prosecution.

**The arrest warrant is either taken on-site during the initial call or may be instigated by victim at a later date.

***A substantial percentage of these contacts with law enforcement originated through means other than 911 calls.

IMPLEMENTATION INITIATIVES

SAFE SACRED SPACE CURRICULUM

Fatality reviews consistently show that survivors and victims of domestic violence turn to their faith community for support whether or not they disclose the abuse. Faith communities have tremendous potential to respond effectively and compassionately to those who are experiencing domestic violence, yet often times they are not prepared to do so in a meaningful and effective way. Even when leaders and members are aware of a domestic violence problem in their congregation, many feel helpless to protect the victim, and powerless to stop the violence and hold the abuser accountable.

The Safe Sacred Space Curriculum, developed in partnership with the FaithTrust Institute, builds on local resources to create a shared learning experience between domestic violence advocates, clergy, lay leaders, community organizers and sacred communities of faith. The curriculum encourages the development of close relationships between faith communities and domestic violence advocates to best assist victims of domestic violence. The curriculum addresses the basics of domestic violence, local and statewide resources available, appropriate responses to domestic violence and mandated reporting protocols.

In an effort to provide technical assistance and encourage communities to use this curriculum, the Project hosted a webinar in August 2012 addressing the topics of engaging the faith community and how best to use the Safe Sacred Space Materials. The recorded webinar and the Safe Sacred Space Curriculum materials are located at www.gcfv.org.

DOMESTIC VIOLENCE IN THE WORKPLACE TOOLKIT

FATALITY REVIEWS REVEALED THAT IN 75% OF CASES, THE VICTIM WAS EMPLOYED OUTSIDE THE HOME.

However, a majority of employers do not have a Domestic Violence in the Workplace Policy and are not otherwise prepared to respond to this issue in a way that promotes victim safety. Responding to the gap is critical because employers are uniquely positioned to safely and confidentially link survivors to support and resources. The Domestic Violence in the Workplace Toolkit is a resource for domestic violence programs and Family Violence Task Forces interested in engaging and educating their local business community. The toolkit includes PowerPoint presentations, handouts, marketing materials, training agendas, and model domestic violence in the workplace policies. Please refer to pages 23-24 in the 2011 Annual Report for more information on the impact of domestic violence in the workplace (www.fatalityreview.com). To request your free copy of the toolkit, please contact Taylor Tabb at GCADV 404-209-0280 or ttabb@gcadv.org.

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The Georgia Commission on Family Violence (GCFV) and the Georgia Coalition Against Domestic Violence (GCADV) are grateful to the many individuals who continue to make Georgia's Domestic Violence Fatality Review Project possible.

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Jenny Aszman, Co-Coordinator, Fatality Review Project, GCFV

Taylor Thompson Tabb, Co-Coordinator, Fatality Review Project, GCADV

Jennifer Thomas, Program Manager, GCFV

The Georgia Coalition Against Domestic Violence (GCADV) brings together member agencies, allied organizations, and supportive individuals who are committed to ending domestic violence. Guided by the voices of survivors, we work to create social change by addressing the root causes of this violence. GCADV leads advocacy efforts for responsive public policy and fosters quality, comprehensive prevention and intervention services throughout the state. Being a coalition means working together for a common cause. We know that now and in the years to come, we will be up against enormous challenges that promise to test our capacity for conviction and perseverance. It is as vital as ever we remember the foundation for the future success of this Coalition lies in our hands, all of us, collectively. As we coalesce around our common cause, we do so with the voices of domestic violence survivors and their needs for safety always in the forefront of our minds. To learn more or get involved, please visit www.gcadv.org.

The Georgia Commission on Family Violence (GCFV) is a state agency created by the Georgia General Assembly in 1992 to develop a comprehensive state plan for ending family violence in Georgia. GCFV works throughout the state to help create and support task forces made up of citizen volunteers working to end domestic violence in their communities. In addition, GCFV conducts research and provides training about domestic violence, monitors legislation and other policies impacting victims of domestic violence, certifies all of Georgia's Family Violence Intervention Programs, and coordinates the statewide Domestic Violence Fatality Review Project with GCADV. Please visit www.gcfv.org for more information.

SPECIAL THANKS

A special acknowledgement goes to the family members and friends of homicide victims who were willing to share with us the struggles their loved ones faced.

We are grateful to Allison Smith, GCADV, who again conducted data analysis for the project, allowing us to display aggregate data in this report.

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REVIEW TEAMS

We acknowledge the commitment of the Fatality Review participants from around the state who devoted their time, energy and expertise to work towards creating safer communities. The teams listed below are those who reviewed a case this year.

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The case reviewed by the Atlanta Judicial Circuit involved cross-over with the Stone Mountain Judicial Circuit and the Gwinnett Judicial Circuit. The following representatives from DeKalb County and Gwinnett County attended the review and provided additional information and valuable insight.

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Kayla Watson, Circle of Hope

ROCKDALE JUDICIAL CIRCUIT

Judge Nancy Bills, State Court

Derek Marchman, Family Violence Project Director

Angeletha Mintah, Close to Home, Inc.

John Mumford, Sheriff's Office

Joyce Rogers, Coroner's Office

Debra Sullivan, District Attorney's Office, Chair

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Disclaimer: The views, opinions, findings, and recommendations expressed in the Georgia Domestic Violence Annual Report do not necessarily reflect the views of individual GCFV Commission members, all GCADV member programs, funders or individual team members, and are the product of analysis by the joint GCFV and GCADV Project Team.

THIS REPORT IS DEDICATED TO ALL THOSE WHO LOST THEIR LIVES TO DOMESTIC VIOLENCE AND TO THEIR FAMILY MEMBERS, FRIENDS AND SURVIVING CHILDREN WHO MUST GO ON WITHOUT THEM.

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