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Coordinated Community Response Components for Victims of Intimate Partner Violence: A Review of the Literature

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Abstract

Intimate partner violence (IPV) against women is a serious problem throughout the world. Each year a substantial number of women experience psychological, physical, and sexual aggression from an intimate partner, with many women experiencing serious mental and physical health outcomes as a result of their victimization. A number of services are available to women who sustain IPV (e.g., shelters, advocacy, legal protection), and the combination of these services has been termed a Coordinated Community Response (CCR) to IPV. The purpose of the present manuscript is to review the individual components of CCRs for IPV victims, examine the extant literature on a number of the individual CCR components, and suggest directions for future research on CCRs for IPV victims. Our review demonstrates that there is a significant lack of research on various CCR components, that research on the integration of CCR services is limited, and that theoretical guidance for CCR programs is almost non-existent. Directions for improving research on CCR components are suggested.

Keywords

Coordinated community response; domestic violence; victimization; women

Intimate partner violence (IPV) is a serious problem throughout the world that requires the attention and collaboration of researchers, practitioners, and local communities to identify effective means of reducing violence. This article reviews research on Coordinated Community Response (CCR) program *components* for female victims of IPV within the United States. This approach involves an integrated response to IPV by community providers and systems, designed to provide abused women with the necessary resources to increase personal well-being and reduce their risk of reabuse. The systemic actions of these components are typically directed by community councils consisting of advocates and leaders from local agencies. We first provide an overview of the extent of the problem of

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IPV among women, review the components of CCR programs, describe major research findings on these components, and end with a discussion and suggestions for future research on CCR programs and components. It should be noted that the purpose of this article is not to comprehensively review all outcome studies on CCR components (e.g., a meta-analysis) or evaluate CCRs as a whole. Rather, the objective of the present paper is to identify critical gaps in our present knowledge on CCR components, suggest important avenues for empirical investigation, and to provide ideas and directions for improved coordination and integration of services for victims of IPV.

Intimate Partner Violence: An Overview

Intimate partner violence includes physical, sexual, and psychological aggression, as well as stalking behaviors, committed in the context of a romantic relationship (Anderson & Danis, 2007; Riggs & O'Leary, 1996; Shorey, Cornelius, & Bell, 2008). Economic abuse, which entails the use of controlling behaviors that limit a partner's ability to acquire, maintain, and use financial assets (Adams, Sullivan, Bybee, & Greeson, 2008) is also a common practice among perpetrators of IPV. Research demonstrates that IPV affects 1.9 million women in the United States each year and 1 in 4 women during their lifetime (Tjaden & Thonnes, 2000). For instance, in their lifetime, 4.1% of women will experience stalking from a current or former partner, 4.5% of women will experience forcible rape from a partner, 20–30% will experience physical aggression, and upwards of 80% will endure psychological aggression (Archer, 2000; Lawrence, Yoon, Langer, & Ro, 2009; Tjaden & Thonnes, 2000). In a sample of female shelter residents, Adams and colleagues (2008) found that 99% of women had experienced some form of economic abuse from their partner during their relationship. When more serious forms of aggression are concerned, research using probability samples of representative couples in the United States suggests that 6% of women will experience severe physical aggression each year (Caetano, Field, Ramisetty-Mikler, & Lipsky, 2008). Although there is evidence to suggest that violence in intimate relationships is often bi-directional and that women perpetrate a large amount of violence and for reasons other than self-defense (Hines & Douglas, 2011; Stuart, Moore, Gordon, Hellmuth, Ramsey, & Kahler, 2006), the consequences of female IPV victimization are often more severe than male IPV victimization (Archer, 2000; Jordan, Campbell, & Follingstad, 2010).

The consequences of IPV for women are numerous. Female victims of IPV report various psychological difficulties, including depression (Anderson, Saunders, Yoshihama, Bybee, & Sullivan, 2003), posttraumatic stress disorder (PTSD) (Lawyer, Ruggiero, Resnick, Kilpatrick, & Saunders, 2006; Nathanson, Shorey, Tirone, & Rhatigan, 2012), anxiety (Coffey, Leitenberg, Henning, Bennett, & Jankowski, 1996), substance abuse (Lipsky, Caetano, Field, and Larkin, 2005; Nathanson et al., 2012), and low levels of self-esteem (Salazar, Wingood, DiClemente, Lang, & Harrington, 2004), along with facial and head trauma (Tjaden & Thoennes, 2000). Furthermore, IPV may be the most common cause of physical injury for women (Stark & Flitcraft, 1988). Consequently, the cost of IPV on the health system is staggering, with estimates that IPV costs the United States $5.8 billion dollars annually (Centers for Disease Control, 2003), and IPV victims' healthcare costs are 19% higher than non-victims each year (Rivara et al., 2007). Sadly, the most serious consequence of IPV for women, death, is shockingly common. For instance, in 2005, 1,181

women were killed by an intimate partner, which is an average of three women per day (Bureau of Justice Statistics, 2006).

Additionally, victims of IPV often report a lack of adequate resources to effectively live on their own (Chalmers & Smith, 1984), which may cause some women to be dependent on their abusive partners for economic stability (Johnson, 1992). This economic dependence is often a barrier for women to permanently leave their abusive partner (Anderson & Saunders, 2003), if they wish to leave, which may place them at risk for continued abuse. In fact, research has shown that many female victims of IPV often become homeless if they attempt to leave their abusive partner due to a lack of resources for adequate housing (Williams, 1998). Moreover, women who do have their own jobs or academic pursuits report that IPV inhibits their ability to regularly attend work and school (Riger & Staggs, 2004). Thus, it is clear that IPV victimization is a devastating problem.

Coordinated Community Response (CCR)

In an attempt to increase the efficacy of services provided to IPV victims, and to lessen the chances of that women will be reabused, many domestic violence agencies have adopted a Coordinated Community Response (CCR) approach in recent years to improve services to victims of IPV. It should be noted that a CCR to domestic violence began in response to domestic violence perpetration, and this approach was subsequently applied to victims (Gamache, 2012). This review focuses exclusively on a CCR to domestic violence victimization and because the history of CCRs has been outlined elsewhere (e.g., Shepard & Pence, 1999).

Although there is no standardized protocol for implementing a CCR (Klevens, Baker, Shelly, & Ingram, 2008), these programs involve an ecological approach to helping victims of IPV, which includes community-wide agencies such as the police, legal system, social service providers (e.g., victim advocates), government, health care systems, and educational and vocational programs (Sullivan, 2006). In a coordinated response, local councils of service providers (e.g., police, advocates, health care providers) are formed to respond to IPV. These councils form relationships between service providers, filling the “gaps” in service provision that often accompany IPV victims (Allen, 2005). In essence, the network of services and systems in place are designed to provide a more comprehensive response to IPV victims and, in turn, reduce or eliminate violence from their lives and provide victims with necessary resources. Thus, one part of the system (e.g., advocates) helps victims obtain services from other parts of the system (e.g., orders of protection; health care). In contrast, in an uncoordinated system victims are left to seek multiple services themselves, likely reducing the chances that they will seek help due to frustration and fatigue with having to navigate the myriad set of services available (Greeson & Campbell, 2013). Thus, a CCR to IPV victimization has the potential to help victims receive multiple needed services, many of which victims may not know exist or are available to them, without putting unnecessary strain and burden on victims. Below we briefly outline the individual components of a CCR to IPV. Because coordinating councils have been reviewed elsewhere (e.g., Allen, 2006; Allen, Watt, & Hess, 2008; Javdani & Allen, 2011), these organizations will not be reviewed here.

Advocacy

Advocacy programs generally involve paraprofessionals working with, and on behalf of, victims of domestic violence at both an individual and institutional level (McDermott & Garofalo, 2006). Advocates help meet the individual needs of abused women, navigating them through various local resources that may meet their needs and desires (Allen, Bybee, & Sullivan, 2004). Often, advocates may have been women who have been previously abused themselves, making some advocacy interventions largely driven by previous victimization experiences. Perhaps the most notable individual service that advocates provide abused women is help with legal options that are available them, such as orders of protection and filing criminal charges against their offender. There are even a number of law schools that allow and encourage their students to provide free legal advice and advocacy to victims of IPV (Bell & Goodman, 2001; Sullivan, 2006). Advocacy services have been extended to helping abused women find adequate housing, education, counseling, financial planning, and job placement (Salazar, Emshoff, Baker, & Crowley, 2007). It is thought that advocacy programs, when implemented in a supportive context, will increase the social support of abused women, improve their ability to access community resources, and provide them with a sense of empowerment (McDermott & Garofalo, 2004; Sullivan & Bybee, 1999).

At the institutional level, advocates attempt to change institutional and legal policies and practices that work against abused women (Pence & Shepard, 1999). This often includes training law enforcement on domestic violence, lobbying legislators, working with healthcare providers, and working with the criminal justice system at a local level (McDermott & Garofalo, 2004; Sullivan, 2006) in hopes of providing a supportive voice for abused women.

Criminal Justice System

This component of CCRs includes the police, legal offices, and prosecutor offices (Shepard & Pence, 1999; Sullivan, 2006). Criminal justice system services are varied, but the primary service provided to abused women is helping them to obtain civil protection orders (e.g., McFarlane et al., 2004). Additionally, many police departments have implemented a community-based, victim service component in their response to domestic violence calls (Hovell, Seid, & Liles, 2006). This often involves citizens trained in domestic violence or victim advocates, often referred to as a first response team (Sullivan, 2006), accompanying police officers on calls of reported domestic violence to provide emergency treatment, crisis intervention, and referrals to services for victims and their children (Hovell et al., 2006). Furthermore, many police departments have contracted with community agencies, such as domestic violence shelters, and agree to contact them after they respond to a domestic violence call (Sullivan, 2006) so these agencies can seek out victims and offer their services.

Child Services

For many women, children are a primary concern when it comes to deciding whether to stay or leave their abusive partner. Many women may or may not seek services for this very reason, as uprooting children may outweigh, for some women, the relative risks of remaining in an abusive relationship (Sullivan, 2006). The majority of women who seek services at a domestic violence shelter bring children with them (Poole, Beran, & Thurston,

2008). Thus, some CCR components, such as shelters, have trained advocates who help mothers who bring their children with them to a shelter gain tutoring and counseling for their children and, if needed, teach the women about child care (Sullivan, 2006). Clothing, food, and transportation to and from school are also services commonly offered by shelters for children of abused women. Moreover, it is clear that children exposed to domestic violence report increased mental health symptoms (e.g., Levendosky, Huth-Bocks, Shapiro, & Semel, 2002), and some shelters and other CCR components (e.g., counseling services; health care) may also provide counseling services to children to help them cope with the effects of witnessing abuse (Poole et al., 2008). Having resources available for children may make it more likely that women will seek needed services.

Health Care

Because a number of abused women sustain physical injuries due to the victimization, many shelters collaborate with hospitals and local healthcare providers to provide support and services for abused women. That is, there are often trained advocates and shelter workers housed in large medical settings so that immediate interventions can be provided for abused women (Sullivan, 2006). Advocates from these settings can provide abused women with the information and resources needed (e.g., shelter, legal advice, etc.) to help them escape abuse. A CCR approach to programming also encourages local healthcare services, such as emergency rooms and physician offices, to have effective screening procedures for IPV. If IPV victimization is discovered through screening, healthcare providers can then provide appropriate referrals.

Counseling

Increasingly, domestic violence shelters are offering individual and group counseling to victims of IPV (McNamara, Tamanini, & Pelletier-Walker, 2008). The content and structure of counseling services provided to abused women may vary across shelters, but some of the most common counseling services include treatment for grief, substance abuse, psychoeducation regarding abuse and its consequences, feminist-oriented counseling, and other individualized counseling depending on the presenting problem (e.g., depression, PTSD) (e.g., Bennett & O'Brien, 2007; McNamara et al., 2008). Furthermore, it appears that a common theme across shelters is the exploration of battering from a power, control, and gender inequality perspective during counseling for abused women (Bennett, Riger, Schewe, Howard, & Wasco, 2004). Group therapy and peer counseling are also routinely provided to abused women in shelters (Bennett et al., 2004). Although counseling services for abused women are provided in shelters, and this is where the majority of research has been conducted to date, a CCR approach would incorporate mental health professionals from locations other than shelters (e.g., community mental health centers, private practice) to help respond to IPV and provide services to victims.

Vocational

In response to the economic abuse that many abused women experience, CCR services have extended to contracting with local businesses in hopes of finding victims a place of employment in the short term and, in the long run, economic independence (Chronister, Wettersten, & Brown, 2004). Further, CCR programs may attempt to disseminate

information about domestic violence to local employers in an effort to make them aware of this enormous social problem.

Education and Media

Educational interventions provided by CCR programs can be both preventative and raise awareness. Examples of primary prevention efforts include advocates who provide lectures, workshops, or pamphlets to local middle schools, high schools, and colleges. Media campaigns have also been developed to disseminate information to the public on the negative effects that IPV has on victims (e.g., Oliver, 2000). For instance, police officers and shelter workers may attend local schools and discuss the negative physical and psychological consequences that IPV can have. They can also provide information on where victims of IPV can seek refuge and help if needed. This information can also be provided through media sources, such as television and newspaper ads, and flyers in local community centers and businesses (Oliver, 2000). Moreover, victim advocates may work to educate elected officials, policy makers, and educational administrators about the scope and impact of domestic violence.

Research on Individual CCR Components

Advocacy Research

To date the majority of research on CCR components have focused on advocacy interventions. The most well known research to assess advocacy interventions has been conducted by Sullivan and Bybee (1999), who developed and implemented an intensive advocacy program for abused women after they had sought help at a domestic violence shelter. Advocates received extensive training in empathy and active listening skills, how to access, mobilize, and generate community resources, and how to handle potential dangerous situations, as well as information concerning common facts on abused women. Advocates were assigned to work with a single abused woman (n = 135). A control group (n =130), which did not receive any services post-shelter, was retained to assess the effectiveness of the advocacy intervention. The advocacy intervention consisted of five phases, including assessment (e.g., getting to know client; assessing needs), implementation (e.g., mobilizing relevant community resources), monitoring (examining the effectiveness of implementation), secondary implementation (e.g., continued services based on needs), and termination (slowly removing self, over time, from client). Advocates often helped their women obtain housing, education, legal assistance, employment, child care, health care, and social support.

Results demonstrated that two years post intervention women in the advocacy intervention group reported less abuse and higher social support and quality of life relative to the control group. Mediational analyses revealed that advocacy intervention increased social support and success at obtaining community resources, which led to improvements in quality of life (Bybee & Sullivan, 2002). However, three years post-intervention the advocacy intervention group was no longer at a decreased risk for experiencing abuse from an intimate partner relative to the control group (Bybee & Sullivan, 2005).

In an attempt to better understand advocacy services, Allen and colleagues (2004) investigated how abused women (N = 143) prioritized their needs and help-seeking behaviors using the Sullivan and Bybee (1999) advocacy intervention framework. Cluster analyses revealed five distinct categories of community resource seeking among their sample of women: low activity, high activity, education and employment, legal, and housing. However, women generally had needs in multiple areas, such that they did not focus their attention on obtaining just one type of service. Results of the intervention also revealed that women in each cluster, except the high-activity cluster, were effective in obtaining the community resources they sought. The authors concluded that, since women sought services in a variety of domains (e.g., housing and legal assistance), advocacy programs need to be comprehensive in nature, focusing on multiple areas pertinent to abused women's lives. Additionally, advocacy interventions need to be idiographic in nature, as not all women share the same needs and desires in obtaining community resources.

Sullivan, Bybee, and Allen (2002) designed and implemented an advocacy program for abused women and their children. The advocacy intervention was based on previous work by Sullivan and Bybee (1999) for the mothers, and children's advocacy focused on recreational activities, obtaining material goods, and help with school. Furthermore, children were encouraged to attend a 10-week support and education group designed by the researchers to focus on teaching the children about safety and feelings, as well as respect for others and themselves. A trained advocate was assigned to work with each abused woman and their children individually for a period of 16 weeks, and advocates were instructed to emphasize transferring advocacy skills to the abused women so they could, in the future, obtain services for their children and themselves. Forty-five abused women and children were assigned to the advocacy intervention groups and 33 abused women and children were assigned to a control group.

Eight months post-intervention, results demonstrated that women in the advocacy intervention group reported less depression as well as greater levels of self-esteem than the control group. Additionally, women in the advocacy condition sought help for a large number of needs, including housing and employment. Children in the intervention group also reported beneficial outcomes, such as increased self-competence compared the control group, which showed no significant improvement in self-competence. These findings should be interpreted with caution, however, since the sample size was small.

In a break from traditional advocacy offered at domestic violence shelters for women, Bell and Goodman (2001) implemented and evaluated a law school-based advocacy program for abused women aimed at reducing abuse, improving social and emotional well-being, and successfully obtaining civil protection orders (CPO). Eighty-one women who were seeking a CPO against their offenders at a domestic violence intake center participated in this study, 22 in the experimental condition and 59 in the control group. Victims of IPV were paired with two trained law-students from the beginning to the end of their case. Victims had frequent interactions with their advocates, an average of 4 conversations per week, from the initial point of contact until they returned to court to officially file for a CPO. Primary emphasis of the law-based advocacy was to assist victims in preparing for their CPO hearings and to provide them with legal representation, but other services routinely included

were emotional support, safety planning, and community referrals. Results of the study showed that the advocacy intervention group reported significantly less physical and psychological reabuse and marginally significant increases in emotional support relative to the control group. There were no group differences on tangible support and depression. Notable limitations of this study included a small sample size and a failure to randomize participants to groups.

In one of the most methodologically sound studies to date, DePrince, Labus, Belknap, Buckingham, and Gover (2012) longitudinally examined the impact of a community-based victim advocacy outreach intervention compared to a criminal justice system-based referral program on women's distress and safety following a police-reported IPV incident (N = 236). In the advocacy outreach condition, advocates called women and focused on specific services available (e.g., shelter, counseling) and how they may cater to each woman's individual needs. Women were informed that the conversation was confidential. In the criminal justice condition, an advocate from the prosecutor's office or police department called women, informed them that the call was not confidential, and provided limited information about community-based agencies that may be available. Women were randomly assigned to conditions and followed for one year. Results demonstrated that women in the advocacy outreach condition reported less PTSD, depression, and fear than women in the referral condition. Although no differences between groups in reabuse were evident, women in the advocacy outreach condition reported greater readiness to leave their abusive partner. Secondary analyses of this study also demonstrated that women in the advocacy outreach condition, relative to women in the criminal justice condition, were more likely to be engaged in the prosecution of their abuser (DePrince, Belknap, Labus, Buckingham, & Gover, 2012).

Criminal Justice System Research

Although there has been a relatively large amount of research conducted on the criminal justice system's response to the perpetration of IPV, there has been a dearth of research on the criminal justice system's response to victims of IPV that is combined with other components of CCR programs. As stated previously, first response teams are often used by police departments on domestic violence calls to assist victims in finding shelter and support, if needed. However, only one study has examined the effects of these teams on the victims of IPV (Sullivan, 2006). Carr (1982) investigated the effects of a first response team on victims of IPV one year after implementation and found that 79% of victims found the team helpful. However, no other data from this study were reported.

One of the most well known criminal justice services for victims of IPV are orders of protection, also known as civil protection orders (CPOs). Jordan (2004) reviewed research on CPOs for victims of IPV finding that women typically only seek these orders after experiencing a frequent amount of violence and after being involved in the relationship for a substantial period of time. Additionally, research has shown that not all women who seek CPOs receive one, with estimates that only 24% to 64% of women seeking protective orders actually obtain one (Harrell & Smith, 1996; Zoellner, et al., 2000). However, victims often fail to return to court to appeal for the order to become permanent (Harrell & Smith, 1996).

Lastly, there has been little research on victim satisfaction with protective orders, making it difficult to evaluate the effectiveness of these orders from the victim's perspective (Jordan, 2004). However, with research showing that orders of protection are violated between 20% and 40% of the time (Jordan, 2004), it is unlikely that victim satisfaction with these orders is very high. As noted earlier, advocacy interventions that specifically target CPO obtainment has been conducted (e.g., Bell & Goodman, 2001) with promising outcomes. Thus, it is clear that continued research in this area is needed.

Counseling

McNamara and colleagues (2008) examined the effectiveness of a short-term counseling intervention designed to increase coping skills and functioning for abused women seeking help at a domestic violence shelter. Counselors used a feminist orientation along with elements of cognitive-behavioral therapy, solution focused therapy, and family or systems therapy, with each woman receiving individualized services focused on their needs. Results showed a positive impact of counseling, such that abused women who received counseling reported improvement in coping skills and life functioning. However, there was no control group in this study, attrition was high, and there was no assessment of how the counseling affected future risk for re-abuse.

Bennett et al. (2004) reviewed findings on the effectiveness of counseling for abused women from 54 Illinois domestic violence shelters. Counseling consisted of individualized, group, and family, although not all women received each type of counseling and counseling services and types varied across shelters. Findings showed that abused women reported improvements in their decision-making skills and increases in support, self-efficacy, and coping skills. Other research on counseling for abused women has shown positive effects on self-esteem, anxiety, and social support (Mancoske, Standifer, & Cauley, 1994; Tutty, 1996). However, this research has been plagued by methodological problems, including a lack of control groups to determine whether counseling services resulted in improvements relative to women who did not receive services.

More recently, Johnson and colleagues (2009; 2011) have developed and implemented a cognitive-behavioral intervention for sheltered abused women with PTSD that they termed *Helping to Overcome PTSD through Empowerment* (HOPE). HOPE focuses on establishing physical and emotional safety and stability and the reduction of PTSD through cognitive restructuring and skill building. Moreover, the HOPE protocol emphasizes empowerment and the collaboration with other local resources (e.g., case managers). Results of a randomized clinical trial of HOPE demonstrated that women in the HOPE condition ($n = 35$) reported less reabuse 6-months post-treatment, as well as reductions in PTSD, relative to a standard shelter services comparison group of women ($n = 35$) who received no individual therapy (Johnson et al., 2011). Although the data are promising, it is not clear how the HOPE protocol may impact access to additional resources that are included in CCR approaches, such as legal resources, health care, etc. Moreover, the existing counseling research is almost exclusively limited to women seeking services at domestic violence shelters. The extent to which CCRs engage mental health services outside of shelters and the comparative effectiveness of IPV victim counseling in these settings has not been studied.

Child Services

Minimal research has been conducted on how CCR programs can provide abused women with assistance for their children. As reviewed earlier, Sullivan and colleagues (2002) implemented an advocacy intervention for children who accompanied their abused mothers to a shelter, finding positive outcomes for both the children and mothers. However, research has yet to be conducted on how abused women appraise the services offered to them for their children. Moreover, there is wide variability in the services provided to children at domestic violence shelters (Poole et al., 2008), making it difficult to determine what services are actually being provided. Poole and colleagues (2008) discuss the types of services that some domestic violence shelters may provide to children (e.g., group therapy; play and art; individual services), and how some shelters may provide services for women to help increase their bond with their children. Unfortunately, however, outcome studies are lacking and the existing literature at this time appears to primarily reflect anecdotal evidence about services and outcomes. Poole and colleagues (2008) review the extant literature on the more methodologically rigorous studies on child services/parenting services within domestic violence shelters and, thus, they will not be reviewed again here.

Education, Vocational, Media

Although educational interventions have been provided in middle schools and high schools designed to address IPV and make adolescents and young adults aware of this social problem (Foshee et al., 1996), research is lacking in understanding educational needs of abused women who seek refuge at domestic violence shelters. Indeed, research has indicated that abused women seeking shelter rarely have a college education and some lack a high school diploma (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008), making educational interventions a potentially important component of CCR programs. Additionally, there is a dearth of research examining how CCR programs have helped abused women find employment (Chronister et al., 2004) and how that employment affected their relationship with their abuser. That is, did employment give women the economic independence needed to leave their abuser and live on their own? Furthermore, research is also lacking in victim's assessment of media campaigns and how they affected their decision to seek help.

Health Care

Emergency room staff and physicians are increasingly screening for IPV victimization among their patients (Weeks, Ellis, Lichstein, & Bonds, 2008) in hopes of providing abused women with the best care possible. Recent research has begun to examine whether screening and referral for IPV in healthcare settings improves abused women's quality of life and risk for reabuse. For example, MacMillian and colleagues (2009) examined whether women screened (n = 347) for IPV during a healthcare visit (i.e., in emergency departments, family practices, or obstetrics/gynecology clinics) evidenced greater quality of life and lower reabuse 18-months post screening relative to women who did not receive IPV screening (n = 360). Clinicians of women who screened positive for IPV during their visit were informed of this information and subsequent referrals and/or discussions of IPV were made at their discretion. Results demonstrated no significant differences between groups in IPV or quality of life, although sample attrition was high (41–43%). Similarly, Klevens and colleagues

(2012) randomized women at three primary health care clinics to receive either (1) no IPV screening or referral, (2) IPV screening plus a referral list (for women who screened positive for IPV), or (3) a referral list only with no IPV screening. Women were contacted 12-months after their health care visit and assessed for differences in reabuse, quality or life, health care visits, and proportion of women who contacted a domestic violence agency. Results demonstrated that were no significant group differences on any outcome.

Other studies have examined whether healthcare screening for IPV with referral or counseling can improve outcomes specifically for abused pregnant women, and results appear to be more positive with this population (see O'Reilly, Beale, & Gillies, 2010 for review). For example, McFarlane, Soeken, and Wiist (2000) examined the effectiveness of three different types of interventions among physically abused Hispanic women seeking services at a prenatal clinic. Women were assigned to either (1) a brief intervention that consisted of a referral list and information about safety planning, (2) unlimited, free counseling until delivery of their child, or (3) outreach, which involved contact with a trained advocate that focused on both parenting and safety from abuse. Two-months post-intervention, women in the outreach condition reported less violence than women in the counseling intervention, but not brief intervention. These effects faded, however, at 6, 12, and 18-month follow-ups. Thus, there is ample room for improvement in healthcare delivered services for abused women. Moreover, it is not clear whether healthcare services are being incorporated into the larger CCR approach, suggesting that there is room for improvement in the integration of healthcare services into other victim-based services.

Directions for Future Research on CCR Programs

The above review demonstrates that there are significant gaps in our knowledge about specific CCR components and services (e.g., criminal justice, media/educational, vocational), although certain services have received fairly extensive research attention (e.g., advocacy; counseling). Indeed, the most methodologically sound research studies have demonstrated that both advocacy and counseling interventions are effective in helping abused women seek additional help and resources and improve their quality of life/mental health functioning. However, the true purpose of a CCR approach to domestic violence is to have multiple agencies working together to combat this serious problem and to help victims, and the dearth of research that has examined CCR components other than advocacy and counseling is notable. Thus, it is clear that there is a need for continued research on individual CCR components, and below we detail specific suggestions for continued research on CCR components and programs, which will hopefully increase our understanding of the services that may best help victims of IPV.

Examination of Barriers to Service Utilization/Underserved Populations

Notably, there has been an absence in many studies with CCR components to acknowledge the tremendous barriers to service utilization that many women face. Thus, these studies may not provide a comprehensive picture of IPV services for victims, as some marginalized groups may avoid contact with traditional IPV services and associated research. For example, a review of IPV research in immigrant populations indicated that across numerous cultures, immigrant women are less likely to seek formal support from law enforcement and

service agencies (Raj & Silverman, 2002). Women without legal status report avoiding police contact following IPV due to fear of deportation (Bauer, Rodriguez, Quiroga, & Flores-Ortiz, 2000; Vidales, 2010). Instead, immigrant women may seek support from community and church leaders. Unfortunately many women report that such individuals encourage continued submission to male partners (Raj & Silverman, 2002; Kulwicki, Aswad, Carmona, & Ballout, 2010).

Additionally, many abused lesbian women do not seek services from shelters and domestic violence hotlines because many may perceive these services as being for heterosexual women (Renzetti, 1998). Some lesbian victims report unwillingness to seek general IPV services due to fear of encountering homophobia or having to educate service providers on lesbianism during their time of crisis (Turell & Herrmann, 2008). One qualitative study in which service providers in the Chicago area were asked about their experiences with lesbian domestic violence identified other specific barriers to the provision and receipt of care (Merlis & Linville, 2008). Service providers described feeling motivated to deny the existence of lesbian IPV due to a desire to promote the lesbian community as a close knit, safe, and non-violent space. These professionals also discussed how IPV clients had expressed difficulty seeking services and informal social support because this may have involved the additional stress of coming out. In terms of shelter services, providers discussed how it is difficult to ensure lesbian victims' safety as perpetrators can gain access to facilities. To our knowledge, no effort has been made to comprehensively evaluate the prevalence and efficacy of IPV programs for lesbians specifically within general community services since the national survey of domestic violence agencies conducted by Renzetti in 1991 (Renzetti, 1996). This survey indicated that although many organizations expressed a desire to be inclusive of all sexual orientations, they lacked lesbian specific programs and failed to educate their staff and volunteers about issues such as homophobia. Thus, there is a need for CCR research to be conducted with marginalized populations (i.e., immigrant women, lesbians) and determine how barriers to service utilization can be minimized.

Research on Each Component of CCRs and their Integration

Due to CCR programs involving a number of organizations and services in their approach to helping abused women, it is important for researchers to investigate how each organization and service uniquely and jointly affects victims of IPV. By far the most research conducted on CCR services has been on advocacy interventions, an important first step in understanding how these programs can help abused women. Indeed, advocacy interventions appear to help abused women in a number of domains, including accessing additional resources and reducing risk for abuse. However, if researchers and practitioners are to implement the most effective services and treatments for women seeking help, further research is needed on each component of CCR programs.

There is a dearth of research examining the impact that educational, vocational, media, healthcare, and child services have on the safety and well being of abused women, a notable limitation in providing effective services to victims. Since a large proportion of abused women bring their children with them to shelters (Poole et al., 2008), and since a large majority of abused women are unemployed and economically dependent on their abusive

partners (Adams et al., 2008), research is desperately needed in these areas. Future investigations should assess how vocational interventions designed at gaining employment for abused women, as well as how child services provided to women may help them remain free from future abuse and increase their overall well-being. Additional research is also needed on understanding the reasons for and against filing CPOs, as this service is under-utilized by abused women, and on first response teams for victims of IPV. Moreover, continued research is also needed on the counseling services provided to abused women to help them cope with their abuse and resulting consequences (e.g., PTSD). The HOPE program (Johnson et al., 2011) is a notable first step in methodologically rigorous treatment outcome studies for abused women, and continued research is needed in this area that further elucidates how counseling services may impact the resource utilization of other CCR services. Finally, the majority of research on individual CCR components has been conducted with women seeking shelter, and research should determine whether CCR components are able to effectively reach and help IPV victims who do not seek shelter services.

One additional component of CCR approaches to IPV, which has been largely ignored to date in discussions of CCRs, are religious and faith-based services. Historically, the religious organizations have played a paradoxical role in addressing IPV, with some women reporting they experience empowerment through religious communities while others report that religious teachings have been used as a justification for gender inequity and abuse (Bent-Goodley, St. Vil, & Hubbert, 2012). The impact of African American religious communities on IPV has been discussed the most frequently in the literature. One descriptive study of African American seminarians found that the majority of students felt that domestic violence is a prevalent issue that church leaders should address but that many congregations lack the training and resources to do so (Brade & Brent-Goodley, 2009). Simultaneously these students denied beliefs that might obfuscate the presence of IPV in their communities (e.g., domestic violence is a private family matter). However, some churches have implemented efforts such as annual services discussing IPV, or IPV ministries (scripture oriented support groups) for batterers and victims (Bent-Goodley, et al., 2012). No research to date has evaluated the effectiveness of these endeavors or how they may fit into the large CCR approach. Future research should determine how religious/faith-based services may be effectively implemented into a large community response to IPV.

Probably the most daunting task for the evaluation of CCR programs for victims of IPV is assessing these programs from a system-wide perspective (Salazar et al., 2007; Shepard, Falk, & Elliott, 2002) once sufficient research on each component of CCR programs has been completed. That is, how does each individual component of these programs affect other components of the program? For example, to fully understand the effectiveness of advocacy interventions designed to provide women with legal options, such as filing a civil order of protection, one must assess the criminal justice response to the order of protection and the victim’s view on how effective these services were. Although it may be easier to evaluate one specific component of CCRs in isolation, to know and understand the effectiveness or ineffectiveness of one component of these programs, one must also understand the interrelations between components. However, to date the services available to many abused women do not appear to involve the coordination of community agencies and are still

largely separate and suffer from a lack of communication among agencies. Therefore, prior to the investigation of a system-wide CCR approach to IPV victimization, there is considerable work that is needed on the integration of services within communities. Although it is outside the scope of this paper to outline how this may be accomplished, a good example to draw from comes from Child Advocacy Centers, which respond to cases of child maltreatment, has a national protocol for these centers, an accreditation process, and mandatory services that must be provided (see Chandler, 2000; Cross et al., 2008). A national protocol for a CCR to IPV victimization may help to increase the chances that all victims will have the opportunity to receive any and all needed services for their safety and well-being. Once integrated, research should directly compare CCRs from different communities to determine if the efficacy of these programs varies across locations. However, we believe that the present review underscores the need for further research on the effectiveness of individual elements of CCRs and the level of integration between them. Until these factors are better understood the impact of entire CCRs as systems may be difficult to determine.

Theoretical Considerations

Another notable absence from many CCR programs, and specific CCR components, is a focus on theory-guided service provision. Moreover, research on CCR components has also been largely atheoretical. This may be a product of a larger problem with IPV research in general, as the majority of IPV research, both with victims and perpetrators, has been largely absent of theory (Shorey et al., 2008). From a research standpoint, the incorporation of theory into investigations of CCR components will be an easier task than incorporating theory into the development of CCR programs. Having a theoretical framework to guide investigations into CCRs may help to better understand the mechanisms that are responsible for the improved outcomes in many CCR components (e.g., advocacy) and also where improvement is needed. One useful framework for this purpose may be Foa, Cascardi, Zoellner, and Feeny's (2000) conceptual model of psychological and environmental factors associated with women's influence on IPV. Specifically, these authors argue that both psychological (e.g., problem-solving skills; trauma) and environmental (e.g., barriers to care; income) factors affect women's ability to stay or leave their partner and curtail violence from their lives.

The conceptual framework of Foa and colleagues (2000) is similar to CCRs in that it takes an ecological, broad-based approach to investigating IPV from the viewpoint of the victim, acknowledging that there are many interrelated and diverse factors that influence women's decision making process about seeking help, staying or leaving their partner, and in helping remain violence free. Because certain components of CCRs are likely targeting different factors that may positively impact abused women (e.g., CPOs target safety; counseling targets mental health), this framework may lend itself nicely to the investigation of the various components that comprise CCRs, allowing researchers to integrate findings into a broader whole. In turn, this theory-guided research could help to impact the development and refinement of CCR services, as the effectiveness of services will be delineated, and this information could then be incorporated into CCR services for their improvement/ enhancement.

Conclusions

In summary, the current manuscript reviewed the existing literature on individual CCR components for victims of IPV. Our review identified a number of CCR components that have demonstrated effectiveness in helping abused women increase their quality of life and reduce their risk for reabuse (e.g., advocacy interventions). Unfortunately, however, the vast majority of services that are incorporated into CCRs suffer from a lack of empirical research investigating their efficacy or has not demonstrated consistently positive outcomes for victims (e.g., health care screening and referral). A number of areas were identified for improvement in research into CCRs, as well as how CCR components should attempt to better integrate services, which is the true purpose of CCRs. However, our review indicates that this integration may not be occurring in many areas. Still, CCRs have received increased research attention in recent years, and it is likely that continued investigations in this area will help to identify the components of CCRs that are most effective for keeping abused women safe and that should be integrated into a large community effort to reduce and respond to IPV.

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Highlights

- Intimate Partner Violence (IPV) is alarmingly prevalent.
- Services for victims of IPV have received increased attention.
- We review components of coordinated community response (CCR) programs for victims of IPV.
- There is a serious lack of empirical evidence for a number of components included in CCRs.
- Continued empirical and theoretical work on CCRs for victims is needed.