POLICY ESSAY

COORDINATED COMMUNITY RESPONSES TO INTIMATE PARTNER VIOLENCE: WHERE DO WE GO FROM HERE?*

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For more than 30 years, advocates for preventing violence against women along with several government agencies have promoted the coordinated community response (CCR) model to address intimate partner violence (IPV) (see Fagan, 1984 as cited in American Prosecutors Research Institute [APRI] and National Council of Juvenile and Family Court Judges [NCJFCJ], 1998:2; Family Violence Prevention Services Act, 1994; Violence Against Women Act, 2005). Initially, at the heart of the CCR model was an emphasis on increasing perpetrator accountability and improving victim safety through the development and coordination of different agency responses, which include criminal justice case-management procedures as well as increased access to legal (e.g., protective orders) and social (e.g., shelter) services for victims. Today, many CCRs have moved away from a coordinated *agency* response to a coordinated *community* response that includes agencies and organizations that traditionally have not been associated with addressing IPV (e.g., schools, faith communities, and businesses); some have added primary prevention efforts (e.g., Domestic Violence Prevention Enhancements and Leadership Through Alliances [Centers for Disease Control and Prevention, 2008]). With all the efforts invested in CCRs and their subsequent transformations, do we know whether this approach is effective to reduce IPV?

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This article discusses the findings reported by Visher, Harrell, Newmark, and Yahner (2008, this issue) and, considering available evidence, suggests future directions for CCRs. Visher et al. examine the impact of CCRs on IPV reoccurrence by comparing cases that reached court disposition during the intervention period in two communities with similar cases in two comparable control communities in the same states based on in-person interviews with victims and offenders 2 and 9 months after case disposition. They also examined state and local law enforcement criminal history records for arrests before and after the sampled case, as well as data on intervention site victim services and probation supervision, in both intervention and control communities.

The findings by Visher et al. (2008) suggest that, although offender monitoring, supervision, and consistency in sanctioning improved in the CCR sites compared with the control communities, no differences were observed in victims' perceptions of their safety or reduced threats, intimidation, or risk of serious assault. However, these same authors report one positive impact on IPV, which is that communities with a CCR showed a reduced risk for any actual physical assault. This one impact on IPV was achieved, however, because of the large effects observed in just one of the two sites, even though the quality of implementation was judged to be equal. How do we interpret these results? Are the results a product of a statistical quirk or might CCRs have benefits for victims under certain conditions? Although we cannot make definitive conclusions about CCRs based on this one study, taken together with evidence from other studies, we believe coordinated responses that are *well designed* and *well implemented* can potentially be effective.

Various studies that evaluated the impact of coordinated criminal justice responses (Murphy, Musser, and Maton, 1998; Steinman, 1990; Tolman and Weisz, 1995), as well as those that evaluated the impact of coordinating both criminal justice responses and social service responses (Gamache, Edleson, and Schock, 1988; Shepard, Falk, and Elliott, 2002; Syers and Edleson, 1992), have reported findings that suggest reductions in reabuse. Although the findings are consistent, they have been inconclusive because all these studies lacked comparisons with a control community. Without these comparisons, we cannot rule out the passing of time or influence of external events that could have effects on reabuse. Visher et al.'s (2008) article corrects this methodological limitation by comparing intervention communities with similar control communities. Although these communities were not assigned randomly to intervention or control, the authors did adjust for demographic differences between the intervention and control communities to correct for potential baseline differences, at least for the demographics measured.

This evaluation design is a major advancement in the IPV intervention field, and the Department of Justice should be applauded for including an impact evaluation with a control group as part of this initiative. If only all of our interventions, programs, and policies were subjected to rigorous testing! Without careful evaluation, how would we ever know which interventions work or which cause harm?

We were not surprised to find the inconsistency of the impact of CCRs across sites or groups. Visher et al. (2008) believe that the increased effectiveness in that one site may have been caused by revoking probation for noncompliance, which is a component that was absent in the other site. The groups who benefited from the CCR model also have differed across previous evaluations, which may be the result of variation in specific components of CCRs across studies. For instance, Gondolf (2002) reported that CCRs had no impact on men with an extensive criminal record. Somewhat contrary to Gondolf's findings, the CCR model described in this issue seemed to have the strongest effect on perpetrators who had a high number of previous arrests. As the four CCR models in Gondolf's evaluation did not emphasize judicial and probation improvement and leadership, these findings together suggest that perhaps CCRs that emphasize judicial and probation improvement and leadership may be well suited for perpetrators with an extensive criminal history. Thus, which groups benefit from a particular CCR model may depend on the specific components of that model and the relative strength of those components.

Our own evaluation of the impact of 10 CCRs on IPV showed that reports of past-year exposure to IPV were significantly lower only for women in communities with CCRs that had been operating for at least 6 years as compared with control communities (Post, Klevens, Maxwell, Shelley, and Ingram, 2008). In this evaluation, no other differences were found between CCR and matched comparison communities for overall past-year exposure to IPV (men and women), knowledge or attitudes related to IPV, or knowledge and use of available IPV services. Given the numerous analyses conducted on these data (more than 60), we suspected that the one positive finding could have occurred by chance.

Nevertheless, two other potential explanations (i.e., contamination and cross-site variation in implementation) for these findings were explored in a more in-depth analysis of each specific site. Site-specific analyses revealed great variation in implementation but showed no significant differences in any of the 10 CCR sites—not even those that operated for 6 years—in women's past-year exposure to any (psychological, physical, or sexual) IPV after adjusting for age, income, marital status, and education. Differences in the methods of analysis (i.e., hierarchical linear modeling for the overall impact of the CCRs vs. simple logistic regression for site-

specific analyses) may explain the discrepancies in findings between the two studies. Although contamination (i.e., exposure to the intervention in the control community) may have been an explanation in at least two sites, the in-depth analysis found that certain services offered to victims in a CCR (i.e., safety planning, housing, and advocacy) were significantly correlated with greater rates of contact with IPV services (Klevens et al., 2008). Because some evidence was presented as to the positive impacts of safety planning, advocacy, and housing as stand-alone interventions, this finding led us to conclude that although coordination of services makes sense, it is important to identify which specific services/interventions are effective before efforts are made to combine and coordinate those services or interventions.

Another possible explanation for the variation across studies is the measures used to establish impact. Some null findings might be the result of measuring attributes that are unlikely to change in the time selected for follow up. For example, in Visher et al.'s (2008) evaluation, women's perceived safety was another outcome explored at 2 and 9 months after case disposition. Again, they found no differences between intervention and control communities. We believe it is unreasonable to expect an impact on perceived safety from an intervention of this sort after only 9 months. We suspect that once a woman has been abused, it may take many years, or she may never overcome her sense of vulnerability; that is, it would be inappropriate to expect changes in a measure of perceived safety as a result of this intervention in such a short time. Improved perceived safety might be achieved by preventing the initial occurrence of IPV.

Primary Prevention of IPV

The aim of primary prevention is to avert the initial occurrence of a problem (Last, 2006). To this end, primary preventive interventions target and modify factors that increase the risk of occurrence (Mercy, Rosenberg, Powell, Broome, and Roper, 1993). Relatively new evidence on the development and persistence/desistance of IPV suggests potential directions for the primary prevention of IPV perpetration. First, in contrast to studies with shelter-based samples, several national population-based studies suggest that most IPV is not necessarily chronic nor does it escalate over time, but instead it tends to be sporadic and often disappears (Aldarondo, 1996; Caetano, Field, Ramisetty-Mikler, and McGrath, 2005; Jasinski, 2001; Rand and Saltzman, 2003). However, chronicity and increasing severity do seem to be characteristic of the group of perpetrators who engage in more serious abuse when compared to less serious IPV offenders (Aldarondo, 1996; Caetano et al., 2005). Various longitudinal

studies have consistently identified two key precursors for this group of serious abusers: poor parenting and childhood or adolescent aggressive and antisocial behavior problems (Andrews, Capaldi, Foster, and Hops, 2000; Capaldi and Clark, 1998; Capaldi and Owen, 2001; Ehrensaft, Cohen, Brown, Smailes, Chen, and Johnson, 2003; Ehrensaft, Moffitt, and Caspi, 2004; Lavoie, Hébert, Tremblay, Vitaro, Vézina, and McDuff, 2002; Linder, and Collins, 2005; Magdol, Moffitt, Caspi, and Silva, 1998). Fortunately, we know a few things about effective interventions for improving parenting (e.g., Kaminski, Valle, Filene, and Boyle, 2008; Webster-Stratton and Reid, 2006) and treating childhood behavioral problems (Hahn et al., 2004; McCart, Priester, Davies, and Azen, 2006). Research is still needed, however, to establish the impact of these parenting, family, and child-based interventions on the occurrence of IPV.

Additionally, CCR models sometimes neglect to address the needs of the children of the perpetrator and/or victim (Post et al., 2008). Because witnessing IPV as a child is a risk factor for becoming a perpetrator of IPV (Schumacher, Feldbau-Kohn, Smith Slep, and Heyman, 2001), CCRs have the potential to prevent future IPV perpetration by addressing the needs of the children and the parenting skills of both the perpetrator and the victim. Special components that emphasize the impact of IPV on children and encourage positive parenting could be added to batterer interventions or women's support groups, or interventions could target these children directly. Although there have been successful efforts in the development and evaluation of interventions in this direction (Graham-Bermann and Hughes, 2003), again their effectiveness in preventing subsequent perpetration by those exposed to IPV as children still needs to be established.

The fullest potential of CCRs to prevent IPV may be in addressing community-level factors associated with the occurrence of IPV across communities. As more and more CCRs evolve into community coalitions, CCRs might be better positioned to address factors such as low social capital, poverty, and social norms supportive of violence (Heise and Garcia-Moreno, 2002) that contribute to the occurrence of IPV in their particular communities. However, the evidence regarding the ability of coalitions to produce long-term, community-wide changes is mixed (Butterfoss and Kegler, 2002); thus, we need more research to establish whether modifying community-level factors impacts IPV and whether entities such as CCRs can accomplish such community-wide changes.

So where do we go from here? Does this mean that policy makers and communities should wait until we have all the evidence regarding the effectiveness of CCRs to prevent the initial occurrence of IPV as well as to reduce the reoccurrence before moving forward? We think not. IPV is too frequent and serious a problem for victims, their families, and society to

expect communities to stand by while *definitive* evidence on CCR effectiveness becomes available. Additionally, even without definitive evidence regarding their effectiveness or what "best practices" to include in their models, CCRs are becoming an increasingly common community strategy for addressing IPV. Data from the 2004 CCR Survey by the Centers for Disease Control and Prevention, which was administered in 14 states, revealed that 383 CCRs were operating in these states (Strong, Ciemnecki, Finkelstein, Hawkinson, and Richardson, 2006).[1]

So we propose moving forward by bridging the science-to-practice gap that exists between what is known and how CCRs currently are being implemented. This "bridge" would build community capacity to select and implement components for their coordinated responses using the *best available* existing evidence. Based on reviews of the best available evidence, various strategies should be considered for inclusion in a CCR model to address primary prevention of perpetration as well as victims' needs and offender accountability. In this sense, primary prevention efforts in a CCR model should consider: (1) parent training focused on skill development, effective disciplinary practices, increasing positive parent-child interactions, and emotional communication (Kaminski et al., 2008); (2) family-based interventions that target children with antisocial behavior (Hahn et al., 2004; McCart et al., 2006); and (3) structured curricula combined with community-wide activities for teens (Whitaker et al., 2006). Services for victims in a CCR model should include advocacy, safety planning, certain types of counseling (Klevens and Sadowski, 2007); and arrest, protection orders tailored to victims' needs in conjunction with prosecution and sanctioning, as well as offers to drop charges for victim-initiated complaints, seem to be promising interventions—in certain contexts—to hold offenders accountable (National Institute of Justice, 2007).

However, at this time, little support is available to assist communities in building their readiness and capacity to implement, evaluate, and improve effectively their own CCR models based on the *best available evidence*. A CCR support system, which is similar to the prevention support system described by Wandersman et al. (2008) and the intermediary organization described by Florin, Mitchell, and Stevenson (1993), could help the development, maintenance, and evaluation of CCRs within each state. This support system could accumulate research on CCRs and lessons learned from CCRs that operate within that state; develop guidance on how to

1. Florida, North Carolina, Virginia, Delaware, Rhode Island, New York, Michigan, Montana, Ohio, Wisconsin, North Dakota, Kansas, California, and Alaska.

promote and strengthen collaboration among agencies; develop evaluation materials and sample protocols for each agency within a CCR based upon state law; and disseminate this information via training, technical assistance, and facilitation to CCRs operating within that state.

In sum, a coordinated response that is well designed and well implemented would be based on the best available research and practice knowledge, and set in a community that has developed the capacity to implement all components appropriately. It is this model that we believe could be an effective strategy to reduce rates of IPV. Other strategies might include broad dissemination of effective interventions together with building institutional and community capacity to implement these interventions.

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