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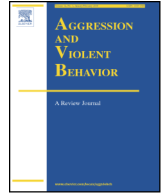

Coordinated community response components for victims of intimate partner violence: A review of the literature

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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.

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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 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.

1. 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 & Thoennes, 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 & Thoennes, 2000). In a sample of female shelter residents, Adams et al. (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, Vaeth, & Ramisetty-Mikler, 2008). Although there is evidence to suggest that violence in intimate relationships is often bidirectional and that women perpetrate a large amount of violence and for reasons other than self-defense (Hines & Douglas, 2011; Stuart, Moore, 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, & 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 and Prevention, 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, 1181 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, 1988), 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.

2. 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, Shelley, & 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 is 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, 2005; Allen, Watt, & Hess, 2008; Javdani & Allen, 2011), these organizations will not be reviewed here.

2.1. 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, 2004). 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

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