Chapter 4

Evaluating Community-Based Services

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Although somewhat difficult to believe today, community-based services designed specifically to assist women with abusive partners were rare to nonexistent in the United States before the mid-1970s. During those early years, if battered women fled their homes they generally found themselves in the same shelters as catastrophe victims, alcoholics, and all other homeless individuals, as their only options for shelter were the Salvation Army, church homes, and shelter for homeless people. These assistance centers not only were few and far between but also were often full and rarely made provision for children. Furthermore, health controls of infectious diseases were few, most of the shelters included men, and often the shelters were unsafe. Most were also insensitive to the needs of women with abusive partners, often blaming women for their victimization.[1]

In the United States, the first shelters specifically for women with abusive partners developed out of the feminist movement of the 1970s, during which time consciousness-raising groups led to women talking, often for the first time, about the abuse they were experiencing in their homes. Feminists, community activists, and formerly battered women began organizing to develop new ways to meet the needs of battered women and to define the problem of ''domestic violence.'' Early shelters often involved no more than women opening their homes to battered women and their children, and none relied on governmental funding. Later came shelters that often shared facilities with local YWCAs or utilized institutional settings such as motels or abandoned orphanages. Many of these shelters were in large, older buildings

where women and children often shared space with other women or families due to limited space. The average shelter capacity of the early facilities was 15, and the average length of stay was two weeks. By 1980, 65 percent of shelters received some government funds, usually in the forms of grants through the Comprehensive Employment and Training Act (CETA).

Times have certainly changed since those early years. Today, there are approximately 3,000 domestic violence programs across the United States and approximately 3 million women and children receive services from community-based shelter programs annually. Funded largely by federal, state, and local dollars as well as private contributions, most of these programs provide emergency shelter, 24-hour crisis lines, and numerous support services. Unfortunately, the number of programs available is still much lower than the need, with the discrepancy between need and availability greatest in urban areas and disadvantaged communities. Although shelter funding has increased substantially in recent years, particularly since the original passage of the Violence against Women Act (VAWA) in 1994, many shelters still struggle financially to remain open. For every woman who receives shelter, another is turned away for lack of space.

THE SHELTER EXPERIENCE

Although domestic violence shelter programs are not all alike, most programs share certain basic characteristics. Typically, a shelter stay begins with a telephone call to a local shelter or crisis ''hotline,'' either from a woman who has just been assaulted or fears an assault or from a service worker at a facility that screens for domestic violence. Since a woman can only call when it is safe to do so, the proximity of a call to an actual threat or assault varies. The hotline volunteer or staff person who answers the call is trained to quickly assess the emergent nature of the situation, to provide emotional support, and to arrange immediate assistance for the caller. This might mean coming to the shelter, but it could also entail receiving medical attention at a local hospital or going to the home of a neighbor, friend, or relative.

If, after hearing the worker's assessment and the conditions of a shelter stay, the woman decides shelter is the best option, arrangements are made for her to get there safely. Few shelters pick up women at their homes because doing so could endanger both the woman and the worker. However, some women do not own or have access to cars and may also not have money for public transportation. In these cases, arrangements can be made for pickup. Because of safety concerns, many shelters will only meet callers outside their homes. Others have agreements for transport with bus or cab companies. In some communities, police will make emergency pickups.

Most women choose to enter shelter programs only as a last resort. The woman may have experienced a traumatic event and be suffering both physical and emotional pain. If she has children, she is trying to comfort them and think of their needs as well as her own. Few women look forward to entering a new environment that is often crowded with strangers, involves living collectively with many other women and children, offers little to no privacy, and includes numerous restrictions that come with such a living condition. If they can stay with friends or relatives, secure their own homes so that they feel safe living there, or afford to move either temporarily or permanently, these choices are generally deemed more desirable and less traumatic for women and their children. Unfortunately, many women lack the social and economic resources to choose any of these options, and for them a shelter is their best alternative.

Policies Regarding Adolescent Boys

Shelter programs differ in their policies regarding allowing women's adolescent children to stay as residents as well. Although most shelters allow all children younger than ages 12 or 14 years to stay with their mothers, some ask that women find other accommodations for their male adolescents. This regulation was created for a number of reasons. First, some boys have already grown quite tall and muscular by early to mid-adolescence and look more like men than children, frightening some residents. While most adolescent males pose no threat, some have a history of violence against their mothers or against other women. In some cases, shelters have created special facilities to house adolescent males or can place families with adolescent males in a free-standing apartment or motel room.

Rules regarding the older male children of residents illustrate a general dilemma to all shelters—how to balance the safety needs of residents while respecting and preserving the integrity of the mother and her children. One approach is to deal with situations on a case-by-case basis, talking directly with the adolescent male (who may actually be happier to stay with friends or relatives) and making exceptions to the rule when enforcing it means a woman will simply not come.

Other Shelter Rules

The ''typical'' domestic violence shelter resident is younger than 35 years of age, with two children, little income, and few options. When she arrives at the shelter she is likely to be assigned to a room with at least one other woman and her children. Bathrooms are often shared, and residents are expected to complete household chores to keep the shelter running smoothly. These chores might include

cooking, vacuuming, dusting, or helping with child care. Women are responsible for the whereabouts of their children at all times, with some shelters providing more respite from constant child care than others. Typically, children have bedtimes and adults must be in the shelter by a certain time at night unless they call and notify the staff. This way staff know if beds are available when new women call needing help.

While some rules are no doubt necessary to accommodate communal living arrangements for a diverse array of families, many shelters are now reexamining how their rules may make women's lives unnecessarily difficult or might result in women being denied services they desperately need. For example, many shelters will deny services to women who admit to having an alcohol or drug problem, or who suffer from some form of mental illness. While these decisions have been made to consider ''the greater good'' of all shelter residents, this has also meant that some of the women with the most complex needs are being denied services that could keep them safe.

Rules governing day-to-day living in the shelter can also prove more detrimental than helpful. For example, some shelters mandate that women get out of bed at a particular time, participate in mandatory shelter services, and complete chores in a particular way at a particular time. Whatever their original intent, these rules can also have had the unintended consequence of making women feel controlled rather than empowered. In response to this concern, at least one shelter in the United States has only one rule: ''If it's illegal out there, it's illegal in here.'' All other rules are negotiated by those living in the shelter at any time, with input and support from staff.

Assistance Received

The typical maximum length of stay at a domestic violence shelter in the United States has been 30 days, although most programs offer extensions as needed and many are now moving to longer stays given the lack of housing and other resources available in communities. During their stay, women are provided with much more than beds, meals, and laundry facilities. ''Counselor advocates'' work with women to identify and meet the family's unmet needs. This might include making arrangements with their children's school, negotiating a leave from work, finding employment or training opportunities, or obtaining health care. Women are also informed about their legal rights and are assisted in obtaining protection orders and legal assistance, if desired. Most shelters also run educational as well as support groups, where women receive both factual information about available services and a conceptual framework—such as the Power and Control Wheel—to help them understand what they've been through. These formal sessions are complemented by the informal opportunities to talk with other women

that arise in the normal course of a day. Safety planning is also a core service offered to women and their children in a shelter.

Residents themselves rank domestic violence shelter programs as one of the most supportive, effective resources for women with abusive partners. Most programs provide all services free of charge or at minimal cost and are philosophically committed to empower and respect women. More and more communities are recognizing the importance of domestic violence shelter programs and are either establishing or expanding such services in their communities.

Although shelters receive high ''effectiveness'' ratings in general from their residents, not all women feel that shelters are options for them, others are denied services (often because of mental health or substance abuse issues), and some are distrustful of the experiences they might have there. Lesbian women, for example, are much more likely to have negative shelter experiences and/or to believe that shelters are for heterosexual women only. If lesbians are less likely to report discrimination by staff or residents today than in the early days of the shelter movement, certain lesbians—those identified as playing the ''male'' role in a relationship, for instance—still report discrimination. Others fear shelters would be unsafe because their abusers, also being women, could gain entry into the shelters more easily than could male batterers. Finally, the distinctive dynamics of abuse in lesbian relationships are often not understood even by well-meaning shelter staff, leading to inappropriate services (see the chapter by Ristock in this volume). These issues of safety and discrimination are beginning to be addressed in many shelters, and a limited number of services have been developed that target lesbian survivors. However, the complexity of the problem still makes it difficult for most lesbian survivors to receive adequate assistance.

Two other groups that are underserved by shelters are abused women younger than age 20 and older women. This reflects in part the failure of shelters to accommodate the special needs of these populations and in part the perception by these groups that shelters are not for women ''like me.'' Although domestic violence may actually be more common against younger women than any other group, teens 16 to 18 often fall between the cracks because they are too young for adult protective services, yet too old to be protected by child welfare, even though they may technically be the responsibility of Child Protective Services. But teens younger than age 18 are excluded by law from shelter in many states unless they are legally emancipated or have a child. Even when they are technically eligible, older teens do not access shelter services for a host of reasons. They may not identify as being ''battered'' or ''abused,'' they may assume that shelters are for married or cohabiting women only, or they may believe that their abuse will not be taken as seriously as abuse against older women. There are also

special problems because they may still be in school. Safety planning with teens has become a regular part of many shelter services, but many gaps persist.

The problems facing older battered women who try to access service are also widespread. In some cases, the same barriers apply to older women that limit shelter use by lesbian women and teens. They may not identify themselves as ''battered,'' assume the shelter is for younger women with small children, or be unaware that shelters exist since services were nonexistent when they were younger.[2] Some may have more embarrassment or shame about discussing their abuse because of their membership in a generation that didn't talk about such things as freely. Other barriers reflect the limits of shelter programs. Some shelters are not fully accessible or otherwise able to cope with the special health or physical ability needs of older women. As importantly, services suited to younger women (such as job training or receipt of welfare) may be inappropriate for older women; levels of noise or activity in the facility may make older women uncomfortable; physical or mental conditions may limit their ability to complete work assignments; the time limits on a shelter stay may be too short to resolve the more complex problems presented by older women; and the substance of support groups for younger women may not apply to the experience of older women. In Wisconsin and several other states, shelter programs have partnered with advocates from the Office of Aging to form multidisciplinary teams that greatly enhance the appropriateness of service to older battered women, leading to a substantial increase in shelter utilization by this age group.

From the start of the battered women's movement, women of color have used shelters at a higher rate than white women. This utilization reflects a number of factors, including the higher poverty rate in the United States for women of color, greater rates of physical violence in low-income communities, the location of many shelters in inner-city neighborhoods, and the dearth of housing and other alternatives for low-income women of color. Nevertheless, some communities of color have had more difficulty accessing shelters than others, and some women of color, regardless of age, sexual orientation, or ethnicity, also hesitate to use shelters that are predominantly staffed by white women. While the shelter movement has struggled to overcome its race bias almost from the start, women of color are still underrepresented in leadership positions at shelters as well as on the staff at many facilities.

Language barriers remain a major barrier for women seeking shelter, as do shelter policies that feel more comfortable to those from the majority culture (e.g., chores needing to be done at specific times and the ban on corporal punishment of children). Migrant women are often working far from their homes and face multiple language, cultural, and structural barriers preventing their use of shelter programs. They

are by necessity very transient and unable to stay in one location for an extended period of time without losing their livelihood. Their children often work alongside them and may be prevented from fleeing with women by the abusive partners.

Immigrant women face language, cultural, and sometimes legal barriers to accessing services. In addition, immigrant women may face dietary problems in shelters and may also fear that their privacy will be compromised by shelter staff from their communities. Many women have reported that when resources were not respectful of their ethnic, cultural, or religious background, they either did not use the services or used them for only a brief period of time. It is important to understand the context of experiences of partner abuse by varying cultures, particularly in the area of service delivery. In addition, women from majority cultures need to educate themselves about the different needs of *all* shelter residents, and shelter staff need to reflect the population whom they are serving.

DOMESTIC VIOLENCE PROGRAMS BY, WITHIN, AND FOR COMMUNITIES OF COLOR

In response to the need for culturally specific services for survivors of domestic violence, an increasing number of domestic violence shelter programs are being designed specifically by and for women from their own communities. One example is the Asian Women's Shelter in San Francisco, California. The first domestic violence center to specifically serve the Asian and Asian American community, they offer, among other things, a multilingual access model that addresses the issue of language barriers that many Asian women face in seeking services from other shelters. Their services also are respectful of the values and traditions held by many Asian and Asian American women. For some Asian women, leaving an abusive man means leaving her children, family, and entire social network, and she may not be respected by her larger community. Because of this, some programs designed specifically for South Asian women (such as Manavi in New Jersey or Sakhi in New York City) emphasize advocacy and support rather than emergency housing.

Another example of a culturally specific family violence intervention program is Asha Family Services, Inc., in Milwaukee, Wisconsin. Many programs developed and staffed by white women specifically exclude any programs directed toward male perpetrators. Some in the African American community, however, believe it is important to employ a holistic family approach, meaning that services are available for survivors, children, and batterers, and services are designed to promote the healing of mind, body, and spirit. Founded in 1989 to meet this need of the African American community, Asha Family Services is a nonprofit, spiritually based family violence intervention and prevention

agency. The program strives to provide effective and comprehensive family violence intervention and prevention services. The agency also holds a state license as an outpatient mental health and substance abuse treatment facility.

Programs have also been designed to more adequately meet the needs of the Latina community. One of the best known such programs is Casa Esperanza (House of Hope), founded in St. Paul, Minnesota, in 1982. In addition to offering direct services to survivors, Casa Esperanza provides technical assistance to help other shelters improve their cultural sensitivity and works on a range of community issues related to abuse within the Latino/a community. Another such program is the Latina Domestic Violence Program of Congreso de Latinos Unidos, Inc., located in Philadelphia. This program also offers a range of services to Latina survivors of domestic violence, including counseling, assistance in accessing legal services, and community education and dating violence prevention education for youth. It is important to note that interventions designed to target the Latina community often also have services available for perpetrators, in addition to services they offer to women and children. This is important because the Latino/a community, in general, is very family centered. Respect and loyalty to the family, as well as family unity, are strong values in this community. Hence, programs serving this community must recognize and be respectful of these values and provide services that are inclusive of the male perpetrators for those Latinas who need or want their partners to be involved.

One program that provides support services specifically to Native American battered women and their children is the Lac du Flambeau Domestic Abuse Program of Lac du Flambeau, Wisconsin. This program offers emergency transportation to and shelter at the statewide Native American shelter, support groups, individual counseling, advocacy, a 24-hour crisis line, restraining order assistance, community education, a Children's Services project, and transitional living. All services are provided by Native Americans, honoring the traditions and strengths of the Native community.

These projects are just a sampling of the culturally specific domestic violence service programs across the United States. However, there is still great need for increased funding and cultural awareness so that such programs may expand in number and in scope.

THE MULTITUDE OF SERVICES OFFERED BY DOMESTIC VIOLENCE SHELTER PROGRAMS

Many people believe that domestic violence programs offer only crisis lines and residential (shelter) services. In fact, most domestic violence programs offer an array of services for women with abusive partners, including but not limited to support groups for women who

are not residing at the shelter, advocacy services, individual and group counseling, programs geared specifically toward children, referrals to other community-based services, and financial assistance.

One common program provided within domestic violence shelter programs (and sometimes through other community-based organizations) is the *support group*. These groups were initially created by shelter programs as a forum in which women could discuss their experiences and share information about resources with other survivors. While generic support groups still operate at many shelters, their function has expanded to both target specific populations of abused women (e.g., Latinas, lesbians, and mothers) and focus on particular circumstances (groups for women still in the relationship, for example, or for women who are no longer being abused but who still seek support with dealing with the aftereffects). Evaluations of such groups have been quite limited. However, one study evaluated 12 ''closed'' support groups (i.e., not open to new members once begun) for survivors. These commonly offered groups typically focus on safety planning, offering mutual support and understanding, and discussing the dynamics of abuse. After surveying 76 women before, immediately after, and six months following the group, the researchers reported significant improvements in women's self-esteem, sense of belonging, locus of control, and overall stress.[3] The study was limited, however, because fewer than half of the original 76 women completed the six-month follow-up assessment, and there was no control or comparison group.

The benefits of support groups were corroborated by a more recent study that did include an experimental design.[4] The eight-week group was led by a trained nurse and focused on helping women increase their social support networks and access to community resources. At the end of the eight weeks, the women who had participated in the group showed greater improvement in psychological well-being and reported higher feelings of social support than did women who had not participated in the group. Taken together, these studies offer promising evidence that support groups are effective in helping women feel more connected with others and less distressed over time.

In response to the lack of affordable housing in most communities and the understanding that many survivors continue to need support and services over time, a number of domestic violence agencies now offer *transitional housing*. Transitional housing programs are designed to help survivors and their children transition from a domestic violence shelter to a more permanent residence. The units often are apartments in which women can live for a set period of time or until they can obtain permanent housing while paying only a small percentage of their income for rent. Some programs only allow women to stay for two months, but it is more typical that women and their children can stay for 18 to 24 months. Many transitional housing programs include

other support services such as counseling, housing assistance, and employment assistance.

One model transitional housing program is Middle Way House, Inc., in Bloomington, Indiana. In 1998 they opened a 28-unit facility for low-income battered women and their children. Each family that enters the program is assigned a case manager with whom they work throughout their stay. Additional services offered through this program include support groups, 24-hour child care, legal advocacy, parenting workshops, employment assistance, and community activities. Families can stay for up to two years, and rent is determined by a family's income.

Another innovative program that some domestic violence agencies are now providing is the visitation center. One of the ways many batterers are able to maintain contact with women to continue their abuse after a relationship has ended is through access to the children they have in common. Abusive men often are legally entitled to visit with their children and can use those visits to harass and harm their ex-partners. In response to this, a number of domestic violence programs have opened visitation centers, through which they can minimize contact between the parents and also protect the children involved. These centers are designed in such a way that women do not have to have contact with their abusive ex-partners. Often the women enter through one entrance of the building while the fathers enter through another. There is a neutral mediator (usually a center worker) who takes the children to the visitation area and later returns them to their mother. All exchange between the two parties takes place through the center workers.

The Duluth Visitation Center, a model program that opened in 1989, is located in a YWCA building and includes family rooms, play areas, and a gym. In cases in which abusive men have been granted unsupervised visitation by the courts, the visitation center can serve as a drop-off and pickup site for parents. Women can bring their children in one door, while men use a separate door in a different section of the building. Staff oversees the exchange of the children and helps ensure that perpetrators and victims do not have contact. In cases in which batterers have been granted supervised visitation by the courts, staff remain in the same room with fathers and their children and are available to intervene if necessary to keep children safe.

EXPANDING SERVICES TO CHILDREN OF WOMEN WITH ABUSIVE PARTNERS

As mentioned earlier, the majority of women using domestic violence shelter program services have children accompanying them. Until recently, however, many programs had no services available specifically targeted toward children's needs. Lack of funding and human resources forced many domestic violence programs to focus exclusively

on the women using their services. This has changed significantly. Today, many domestic violence agencies have comprehensive children's programs, including support groups, counseling, play rooms, and educational resources. The Women's Center and Shelter (WC&S) of Greater Pittsburgh is one example of a program that offers an extensive array of services to children. Their children's program provides services to children of both shelter residents and nonresidents. These services include child care, age-appropriate support groups, school enrollment assistance, information and referrals to other agencies, individual counseling, after-school and summer recreation programs, and individual and systems advocacy.

A common intervention program for children exposed to domestic violence is the domestic violence *support and education group*. Groups generally run 10 to 12 weeks, and the curriculum is age appropriate. Sessions include serious topics as well as fun activities and snacks, and children learn about labeling feelings, dealing with anger, and honing their safety skills. One evaluation of such a program revealed that children learned strategies for protection in times of emergencies and regarded their parents in a more positive light. Mothers also reported a positive change in their children's behavioral adjustment.[5] A similar study, based on 371 children who attended a program over a four-year period, found that children improved their self-concepts, understood that violence in the home was not their fault, became more aware of protection planning, and learned new ways of resolving conflict without resorting to violence.[6] Although the majority of support and education groups for children are currently being operated within domestic violence programs, most are open to children regardless of whether they are staying at the shelter.

NONSHELTER-BASED COMMUNITY SERVICES FOR BATTERED WOMEN AND THEIR CHILDREN

Not all grassroots domestic violence programs are shelter based. Many provide support and advocacy within the community but refer women to other programs if emergency housing is needed. Rural areas, especially, are likely to have non-shelter-based domestic violence services. Women either receive services by phone (especially in more remote rural or frontier areas) or go to an office for in-person assistance, or, in some instances, advocates will go to women's homes and work with them there.

HOME-BASED ADVOCACY PROGRAMS

The idea of working with women in their own homes and communities is gaining popularity in many areas. One research study used a

true experimental design and followed women for two years in order to examine the effectiveness of one such program. In this case, advocates worked with women 4–6 hours a week over 10 weeks, in the women's communities. Advocates were highly trained volunteers who could help women across a variety of areas: education, employment, housing, legal assistance, issues for children, transportation, and other issues. Women who worked with the advocates experienced less violence over time, reported higher quality of life and social support, and had less difficulty obtaining community resources over time. One of four of the women who worked with advocates experienced *no* physical abuse, by the original assailant or by any new partners, across the two years of postintervention follow-up. Only one of 10 women in the control group remained completely free of violence during the same period. This low-cost, short-term intervention using unpaid advocates appears to have been effective not only in reducing women's risk of reabuse but also in improving their overall quality of life.[7]

Many services for battered women and their children are being offered, not just within free-standing domestic violence programs but also within a variety of systems throughout communities. Programs are growing in health care settings, in police stations and prosecutors' offices, in family service organizations, and on college campuses, just to name a few.

PROGRAMS IN HEALTH CARE SETTINGS

By the late 1970s, researchers had shown that domestic violence was the single major cause of injury for which women sought medical attention; that after the onset of abuse, battered women suffered a significantly elevated risk of a range of medical, psychosocial, and behavioral problems; and that health personnel neither identified the problem nor treated its victims appropriately. Starting in 1977 at hospitals in Boston and Seattle and building on hospital-community collaborations in establishing rape crisis teams, the earliest medical responses to domestic violence relied on multidisciplinary hospital-based teams of volunteer nurses and social workers. Since this time, virtually every major professional medical and nursing association has made domestic violence a priority; hundreds of hospitals have adopted screening protocols backed by referral networks for emergency shelter and other services; domestic violence training for clinicians is widespread; and domestic violence education has been widely introduced into the medical school curriculum.

Advocacy for Women and Kids in Emergencies (AWAKE) was the first program within a pediatric setting to link assistance for battered women with clinical services for their children. The program has its own satellite office in the Family Development Clinic at Children's Hospital in Boston, Massachusetts. Through this program battered

women and their children are paired with an advocate who assists them with everything, from legal issues to safety planning. Additional services include assistance with emergency housing needs, individual counseling, and weekly support groups offered in both English and Spanish. The program also provides training to medical staff as well as in the community.

Another early domestic violence program to be established in a public hospital was the Hospital Crisis Intervention Project (HCIP), founded at Chicago's Cook County Hospital in 1992. Staff and volunteers offer immediate assistance to battered women in the hospital and also train hospital staff to properly identify and treat domestic violence victims. In response to the cultural diversity of the patient population in Chicago, a multicultural staff is available to provide services in several languages. In New York City, each public hospital is assigned a ''domestic violence coordinator'' responsible for taking domestic violence referrals, training clinical staff, and implementing programs to improve services to victims.

The Medical Advocacy Project out of Mercy Hospital in Pittsburgh, Pennsylvania, is unique in that the hospital offers an apartment on hospital grounds for survivors when local shelters are at capacity. In addition, all women who come through the emergency department are screened for domestic violence, and a full-time advocate is on staff to assist survivors.

Programs Located within the Criminal Legal System

As laws and policies pertaining to domestic violence have improved, more women have contacted the criminal legal system for help in protecting themselves and their children. In response to this, some communities have created programs within police stations, prosecutors' offices, or legal offices to reach women in need of legal assistance.

One such program is *legal advocacy*, through which a highly trained domestic violence legal advocate offers information, support, referrals, and direct assistance to women through all stages of the civil or criminal legal process. Research on the effectiveness of legal advocacy efforts, however, is limited. The only published evaluation of such a program to date found that women who had worked with advocates in Washington, D.C., reported decreased abuse six weeks later as well as marginally higher emotional well-being, compared with women who did not work with advocates. Their qualitative findings also supported the use of paraprofessional legal advocates. All of the women who had worked with advocates talked about them as being very supportive and knowledgeable, while the women who did not work with advocates mentioned wishing they had had that kind of support while they were going through this difficult process.[8]

Another program is the *first response team*, which, like legal advocacy, can but does not necessarily need to be housed within the criminal justice system. One typical first response team, the Capital Area Response Effort (CARE), has been operating in mid-Michigan since 1995. When arrests are made in cases of domestic violence, the police call CARE and two volunteers go to the home of the victim to offer immediate support and assistance. Depending on the need, volunteers can refer women to local shelter programs, inform them about the legal process that has begun, offer referrals, or simply provide immediate emotional support. As needed, CARE volunteers also provide advocacy and accompaniment through the legal process. CARE is housed within a police department but staffed by domestic violence advocates. The staff is overseen by an advisory board composed of police, prosecutors, service providers, and others from the community.

Another example of a citizen-based response is the Domestic Violence Response Team (DVRT) in New Jersey. The DVRTs were authorized in 1987 through that state's Prevention of Domestic Violence Act to provide comfort and consultation to victims of domestic violence after police respond to a domestic violence call and secure the safety of the victim and other family members. DVRT volunteers come from all walks of life and are specially trained to provide critical information so the victim has a clear understanding of her options. A similar program in New York City was experimentally evaluated, and the researchers found that those survivors who had received the information and education were more likely to call the police over the next 6 months compared to an equally re-victimized group of women who had not received the intervention (Davis & Medina, 2001).[11]

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Although a first response team can provide immeasurable assistance to women after the police have been called, such help is limited if the police, prosecutors, judges, and probation officers are not cooperative in holding perpetrators accountable for their behavior. In response to this, an increasing number of communities have designed what the Minneapolis Domestic Abuse Project first termed community intervention projects (CIPs). Under many different names across the country, these projects involve coordinating criminal justice system and community efforts to respond more effectively to domestic violence. The police agree to contact the CIP after responding to a domestic violence call, and perpetrators are held in jail for a set period of time (usually at least overnight). The CIP then sends female volunteers to the survivor's home and sends male volunteers to visit the perpetrator in jail. Survivors are given information, referrals, and transportation to a shelter if needed, and perpetrators are encouraged to accept responsibility for their actions and to attend a batterer intervention program.

Prosecutors agree to aggressively pursue domestic violence charges, and judges agree to order presentence investigations and to mandate

jail time and/or batterer intervention if the perpetrator is convicted. Probation officers also play an important role in this coordination. They agree to incorporate the perpetrator's violent history and the survivor's wishes in the presentence investigation, and they hold perpetrators accountable if they do not obey the judge's mandates.

There is some evidence that CIPs do result in increased safety for survivors of domestic violence. One study found that CIPs resulted in increased arrests, increased successful prosecutions, and a larger number of perpetrators being mandated into batterer intervention programs.[9] Another study found that when police action was coordinated with other systems—a critical component of coordinated community intervention—perpetrators were significantly less likely to reoffend.[10] Equally important, when police action was *not* coordinated with other components of the system, perpetrators actually seemed to *increase* their use of violence against women.

Not all CIPs are identical across the country, and some are much more comprehensive than others. Not all communities have gained the cooperation of all necessary players (police, prosecutors, judges, probation officers, and advocates), but thousands of communities have adopted components of this model, with varying degrees of success.

Programs Developed through Family and Social Service Agencies

As more community members learn that domestic violence is a social problem requiring a comprehensive community response, programs are developing through a wider network of social service agencies. In 1980, for example, Dove, Inc. (Decatur, Illinois), a nonprofit social services agency organized by area churches as a cooperative community ministry, began its own domestic violence program. This program has developed an array of projects and services for battered women and their children, including but not limited to shelter, counseling, legal advocacy, parenting assistance, and an abuse intervention program for teens who have abused dating partners and/or family members. The program also houses an intervention program for abusive men.

Programs Developed through Universities

In 1994, Michigan State University (MSU) became the first university to establish and fund its own on-campus domestic violence shelter and education program. One of the largest campuses in the country, MSU recognized that universities are communities unto themselves and as such experience the same social problems that other communities face. Their program, which includes shelter services, advocacy, counseling, support groups, and community education, serves as a prototype for other academic settings.

CONCLUSIONS

Community-based services for battered women and their children have expanded exponentially in the last 30 years. As our knowledge about this complex issue has grown, as funding has increased, and as more community members are accepting responsibility for ending intimate male violence against women and children, community-based services have developed that reflect this growth.

While evaluations of many of these programs are quite limited, there is evidence to believe that these services are making a significant difference in women's lives. Women appear to be most helped by those services that are offered in an individualized and empowering manner by staff who are also actively collaborating with other community-based and legal agencies.

Today, most communities have at least some programs available for battered women and their children. Nonprofit domestic violence service programs offer an array of services to women and children, whether or not the family needs residential services. Many communities also have services provided through health care systems, the criminal justice system, and/or social service systems. Efforts have improved to ensure that services are culturally appropriate and respectful of the complex obstacles facing women with abusive partners. However, no community can be said to be doing enough. There are still too many survivors receiving insufficient help, and too many communities providing uncoordinated or inadequate assistance. Although funding has substantially increased for domestic violence services over the past 30 years, it continues to be woefully inadequate.

We have clearly come a long way, but our journey is far from over. Domestic violence victim support services will continue to develop and expand to meet the changing needs of women and children. At the same time, advocates nationwide eagerly anticipate the day when such support services for battered women and their children are no longer necessary.

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NOTES

1. S. Schechter, *Women and Male Violence* (Boston: South End Press, 1982).
2. L. Vinton, ''Battered Women's Shelters and Older Women: The Florida Experience,'' *Journal of Family Violence* 7, no. 1 (1992): 63–72.

3. L. M. Tutty, B. A. Bidgood, and M. A. Rothery, ''Support Groups for Battered Women: Research on their Efficacy,'' *Journal of Family Violence* 8, no. 4 (1993): 325–43; and L. M. Tutty, G. Weaver, and M. A. Rothery, ''Residents' Views of the Efficacy of Services for Assaulted Women,'' *Violence against Women* 5, no. 8 (1999): 898–925.

4. R. Constantino, Y. Kim, and P. A. Crane, ''Effects of a Social Support Intervention on Health Outcomes in Residents of a Domestic Violence Shelter: A Pilot Study,'' *Issues in Mental Health Nursing* 26 (2005): 575–90.

5. P. G. Jaffe, S. K. Wilson, and D. A. Wolfe, ''Specific Assessment and Intervention Strategies for Children Exposed to Wife Assault: Preliminary Empirical Investigation,'' *Canadian Journal of Mental Health* 7, no. 2 (1989): 157–63.

6. R. J. Gruszinski, J. C. Brink, and J. L. Edleson, ''Support and Education Groups for Children of Battered Women,'' *Child Welfare* 67 (1988): 431–44.

7. C. M. Sullivan and D. I. Bybee, ''Reducing Violence Using Community Based Advocacy for Women with Abusive Partners,'' *Journal of Consulting and Clinical Psychology* 67, no. 1 (1999): 43–53; and C. M. Sullivan, ''A Model for Effectively Advocating for Women with Abusive Partners,'' in *Domestic Violence: Guidelines for Research-Informed Practice*, ed. J. P. Vincent and E. N. Jouriles (London: Jessica Kingsley, 2000).

8. M. E. Bell and L. A. Goodman, ''Supporting Battered Women Involved with the Court System: An Evaluation of a Law School-Based Advocacy Intervention,'' *Violence against Women* 7 (2001): 1377–404.

9. D. J. Gamache, J. L. Edleson, and M. D. Schock, ''Coordinated Police, Judicial and Social Service Response to Woman Battering: A Multi-Baseline Evaluation across Three Communities,'' in *Coping with Family Violence: Research and Policy Perspectives*, ed. G. T. Hotaling, D. Finkelhor, J. T. Kirkpatrick, and M. Straus (Newbury Park, CA: Sage, 1988): 193–209.

10. M. Steinman, ''Lowering Recidivism among Men Who Batter Women,'' *Journal of Police Science and Administration* 17 (1990): 124–32.

11. Davis, R. C. & Medina, J. (2001). Results from an elder abuse prevention experiment in New York City (NIJ Research in Brief). Washington, DC: US Department of Justice, National Institute of Justice.