



Original article

Health Indicators, Social Support, and Intimate Partner Violence Among Women Utilizing Services at a Community Organization

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A B S T R A C T

Purpose: Intimate partner violence (IPV) against women is a significant public health concern. This study examines the physical and mental health status and relationship to social support for women seeking services to end IPV at a walk-in community organization that serves the community at large, including a shelter for abused women.

Methods: One hundred seventeen (117) English-speaking women between the ages of 18 and 61 years participated in a self-administered survey. Physical, mental, and oral health, social support, and IPV homicide lethality were measured using standardized instruments.

Results: Social support was the most important factor related to better health. The participants who had more social support reported better physical ($p < .05$), mental ($p < .01$), and oral health ($p < .05$), and a lower level of psychological distress ($p < .01$) and depression ($p < .01$) compared with participants who reported less social support. The participants living in the shelter reported worse physical health ($p < .05$) but better mental health ($p < .05$) than the participants not living in a shelter. Older age and low income were related to oral health problems, whereas older age, low education level, and unemployment were related to poor mental health.

Conclusion: The present study adds to the evidence that social support contributes to improving physical and mental health for women who experience IPV. The findings also suggest the importance of providing or referring women to mental health services.

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Introduction

Intimate partner violence (IPV) against women is a significant public health concern. One quarter to one half of all women in the United States will be victims of IPV in their lifetimes (Black et al., 2011; Bonomi et al., 2007; Coker et al., 2002; Rodriguez, Valentine, Son, & Muhammad, 2009). IPV can lead to adverse health and social outcomes among women, their families, and communities (Goodman, 2006). Many women who experience IPV suffer mental and physical health consequences that may negatively affect their social functioning (Hathaway, Mucci, Silverman, Brooks, Mathews & Pavlos, 2000) and hinder their ability to obtain health or mental health care services, seek

safety, and change their abusive situation, care for their children, or seek employment (Rodriguez et al., 2009; Wilson, Silberberg, Brown & Yaggy, 2007).

Little is known about the health status and social support for women who seek help at a walk-in community organization, or how a community organization can respond to the health or mental health problems among its clients. Most studies on the health of women who experience IPV have been conducted in health care settings and residential shelters (e.g., Goodkind, Gillum, Bybee & Sullivan, 2003; Rodriguez et al., 2009; Straus et al., 2009; Sullivan & Bybee, 1999). These studies show that poor social support compromises the mental and physical health of women who experience abuse and highlights the need for short- and long-term advocacy programs. However, women who experience IPV and seek services to end abuse from non-shelter-based services such as community walk-in centers may experience different types of physical and mental health problems and social support needs than women seeking help at a health care or shelter setting.

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The objective of this study was to identify physical and mental health issues associated with IPV among women seeking help at a walk-in community organization to understand unmet needs for planning intervention and prevention programs. We chose to study women who sought help at a Family Justice Center (FJC) in a large western city. FJCs originally started in San Diego, California, in 2002 and have been recognized as a successful model for IPV prevention and intervention (Gwinn, Strack, Adams, Lovelace & Norman, 2007–2008). FJCs provide a range of free services from housing assistance to obtaining a protection order in one location in a non-shelter setting for community members seeking to end IPV. The wraparound model of service delivery provided by the FJC in a supportive non-shelter environment is designed to strengthen a women's ability to cope with the impact of the violence while she is accessing and understanding the multiple and complex services available to alleviate and end violence.

There are 54 FJCs located in 25 U.S. states. Each FJC site has processes and staffing to assess and provide for victim safety during the intervention process (Gwinn & Strack, 2010). All FJCs are unique and mirror the needs of the local community, and include the key partners who provide services to families experiencing IPV. The FJC where we conducted our study provides walk-in services including advocacy, shelter, support groups, guidance counseling, and access to public benefits, police, legal advice, and employment options. The FJC is in a downtown location that includes a crisis shelter and transitional housing for 200 women and their families.

Methods

Study Population

This study was reviewed and approved for human subjects protection by the university's institutional review board. This cross-sectional study was conducted in collaboration with the FJC staff during 4 months in 2012. The FJC staff members were involved in developing the survey instrument, the study protocol, recruitment strategies, and interpreting the study results. The FJC serves approximately 50 to 70 clients per month. Clients eligible for the study were women aged 18 years or older who speak and read English and were seeking walk-in services at the FJC. The investigators were at the FJC at random time blocks every week during the study period. After a women's initial intake interview, the FJC staff asked eligible women if they wanted to participate in a health survey. After undergoing informed consent, each participant filled out a self-administered survey that took approximately 15 minutes to complete. The investigators were available to answer any questions while participants were taking the survey. After completion, participants received cash remuneration of \$10.

Measures of Health

As we were developing the survey, the staff expressed concern and interest in understanding more about the mental health needs of women accessing the services at the FJC. In addition, dental health was added to our health concerns because several of the staff noted poor oral hygiene among some of the clients. As a result, three measures of mental health and one measure of physical and one measure of oral health were selected for inclusion in the survey.

Measures of physical and mental health

The Short Form (SF)-12 uses 12 items and a 5- or 3-point Likert scale (e.g., 1 [all of the time] to 5 [none of the time]) to measure physical and mental health functioning (Ware, Kosinski & Keller, 1996). The SF-12 provides two composite scores, a physical component summary (PCS) and a mental component summary (MCS). Each score is standardized to a mean (SD) of 50 for the U.S. population with a range of 0 to 100 (Ware, Kosinski, & Turner-Bowker, 2002). Higher scores indicate better health functioning (McDowell, 2006).

The General Health Questionnaire (GHQ) is a 12-item tool designed to measure psychological distress. Respondents report if they had recently experienced a particular behavior, using a 4-point scale (less than usual, no more than usual, rather more than usual, or much more than usual) and generates a total score from 0 to 12. Higher scores indicate worse psychological distress (Goldberg et al., 1997). A score of 3 was used to determine the cutoff point for psychological distress (Goldberg et al., 1997).

The Patient Health Questionnaire (PHQ-9) is a nine-item survey that uses a 4-point Likert scale (from 0 [not at all] to 3 [nearly every day]) to measure depression. PHQ-9 scores for the level of depression severity are defined as minimal, 0 to 4; mild, 5 to 9; moderate, 10 to 14; moderately severe, 15 to 19; and severe, 20 to 27 (Kroenke, Spitzer & Williams, 2001). The PHQ-9 score was used for describing the overall level of self-reported depression. The responses were not verified by a clinician.

The Michigan Oral Health-related Quality of Life Scale (MOHRQoL) Adult Version measures a respondents' overall perception of their oral health, including function, pain, psychological and social aspects, and injuries to the teeth or mouth (Inglehart & Bagramian, 2011). The MOHRQoL includes 14 items measured using a 5-point Likert scale (e.g., "My teeth and gums cause discomfort" on a scale from 1 [strongly disagree] to 5 [strongly agree]). We used the grand mean of the responses for analysis, which generates a score from 1 to 5. Higher scores indicate worse oral health-related quality of life. Although the MOHRQoL is not normed, a recent study reported an average score of 2.16 among general adult dental patients (McFarland & Inglehart 2010).

Measures of Social Support and Sociodemographic Characteristics

Social support was measured by the 19-item Medical Outcomes Study Social Support Survey (MOS-SSS; Sherbourne & Stewart 1991). A respondent was asked whether social support was available in four domains. For example, "Someone whose advice you really want" (emotional/informational support), "Someone to take you to the doctor if you need it" (tangible support), "Someone who hugs you" (affectionate support), and "Someone to have a good time with" (positive social interactions). The MOS-SSS uses a 5-point Likert scale (1 [none of the time] to 5 [all of the time]). Higher scores indicate more social support. The grand mean from each participant was used for data analysis.

Measure of IPV Severity

The severity of IPV was measured with the 20-item Danger Assessment, a validated instrument designed to assess risk factors for IPV homicide in intimate relationships (Campbell, Webster, & Glass, 2009). The instrument uses a weighted system to score yes/no responses to risk factors associated with intimate partner homicide. Risk factors include past death

threats, partner's employment status, and partner's access to a gun. The Danger Assessment algorithm identifies four levels of danger based on an overall score: Variable danger (score of 0–7), increased danger (score of 9–13), severe danger (score of 14–17), and extreme danger (score of 18 and above). The FJC staff uses the Danger Assessment at client intake and felt strongly that we should not burden a participant by using the tool for our study. We obtained the Danger Assessment scores from the FJC intake records upon the participant's written agreement for the release of this information. All participants agreed to release the information. Unfortunately, only half of the respondents ($n = 60$) had a completed assessment in their intake files owing to processing errors at the initial FJC intake interview or when a client was referred from another organization. As a result, the Danger Assessment scores were used only for descriptive statistics.

Data Analysis

Data were analyzed using SPSS (version 19; SPSS, Inc., Chicago, IL). Descriptive statistics were used to describe the distribution of the demographic characteristics of the participants, physical and mental problems, and social support reported by respondents. Descriptive data are presented as proportions for categorical variables and mean values with standard deviations (SDs) for continuous variables and frequencies and percentages for categorical variables. To compare the participants by living situation (living in a shelter to not living in a shelter), we used Pearson chi-square and t -test. All analyses were two-tailed and p values less than .05 were considered significant. Multiple regression was conducted to test the impact of social support and sociodemographic characteristics (e.g., age, Hispanic ethnicity, low educational achievement), on each physical and mental health measure. In addition to social support and living in a shelter, the demographic variables were drawn from previous studies on factors affecting physical and mental health among women who experienced IPV (e.g., Vijayaraghavan et al., 2012; Bonomi et al., 2006; Golding, 1999).

Results

Participant Characteristics

Table 1 shows the sociodemographic characteristics of the 117 participants. The average age was 32 years. Almost half (48.7%) were Caucasian (non-Hispanic). More than half of participants (51.2%) reported at least some college education, and approximately 30% reported full- or part-time employment. Although nearly half (45.3%) of participants reported having health insurance, only one fourth (24.8%) reported having dental insurance. More than half of the women (64.1%) reported an annual income of less than \$10,000. Although 35% of participants were married, only 8% reported living with their husband; about 60% lived with their children.

Seventeen percent ($n = 20$) of the women lived in the shelter located in the same location as the FJC. Selected demographic characteristics were compared for women by living situation in Table 2. Participants were similar on most characteristics except on health insurance; shelter living participants were less likely to have health insurance ($p < .05$) compared with women not living in the shelter.

The average Danger Assessment score for the 60 participants was 19.67. Only one of the participants had a score of less than 8

(variable danger). Ten participants (16.7%) scored from 8 to 13 (increased danger). Thirteen participants (21.7%) had a score 14 to 17 (severe danger), and 36 participants (60%) had a score of 18 or more (extreme danger). We compared the means of the health outcome variables by the Danger Assessment severity scores but no difference was found. We also compared physical and mental health between the participants with a Danger Assessment score and those without a score. There was no significant difference in the physical and mental health between the two groups.

Physical and Mental Health and Social Support

Table 3 compares the scores for physical and mental health, social support and severity of IPV by living situation. Most of the women in the study experienced poor mental health as well as substantial distress, moderately severe depression, and Danger Assessment scores in the extreme danger category. The overall PCS score for all women was 48.1, and the MCS score was 33.7, both below the general population score of 50. The mean General GHQ-12 score was 7.7, twice as high as the cutoff score of 3, indicating high levels of psychological distress. The average PHQ-9 score was 14.8, with 48% of the respondents reporting moderately severe to severe depression. The average MOHRQoL score was 2.2, which was the same as the general adult dental patient (McFarland & Inglehart 2010). Approximately one third (33%) of the participants reported injuries to their teeth or mouth; most of the causes of the injuries were related to intimate partner abuse. The overall average score of the social support scale (MOS-SSS) was 3.0 out of a potential of 5. Higher scores indicate more social support. Among the four dimensions, the participants had the highest support on emotional/informal support (mean = 3.1; $SD = 1.2$) and the lowest support on tangible support (mean = 2.5; $SD = 1.4$).

Physical, mental, and oral health were significantly associated with a women's living situation. Women living in the shelter reported better mental health functioning, but worse physical and oral health compared with women not living in a shelter.

Predictors of Health Outcomes

The results of the multiple regression analysis are presented in Table 4. The multiple regression models were significant as shown by the F - and p -values and explained a considerable amount of response variance based on the values of R^2 . Dependent variables were the health outcome measures. Independent variables were age, Hispanic, high school diploma or less, employment, health insurance, dental insurance, annual household income less than \$22,000, and living in a shelter. Social support from MOS-SSS was also an independent variable.

Overall, social support was related to better health. Participants who had more social support reported better physical ($p < .05$), mental ($p < .01$), and oral health ($p < .05$), and a lower level of psychological distress ($p < .01$) and depression ($p < .01$) compared with participants who scored lower on the MOS-SSS. Although the participants living in a shelter reported worse physical health ($p < .05$), they reported better mental health ($p < .05$) than the participants not living in a shelter.

Five demographic characteristics—age, education level, income, employment, and health insurance—affected health status. Older age was associated with worse physical ($p < .01$) and oral health ($p < .01$). Lower educational level was related to worse physical health ($p < .05$), whereas lower income was associated with more oral health problems ($p < .05$) compared

Table 1
Prevalence of Sociodemographic Characteristics (*n* = 117)

Sociodemographic Characters	<i>n</i> (%)
Age, mean, range (SD)	32, 18–61 (10.1)
Ethnicity	
Caucasian, Non-Hispanic	57 (48.7)
Caucasian, Hispanic	36 (30.8)
African or African American	10 (8.5)
Asian or Pacific Islander	1 (0.9)
Native American	7 (6.0)
Other	4 (3.4)
Unknown (refused)	2 (1.7)
Educational level	
Did not graduate high school	21 (17.9)
High school graduate	31 (26.5)
Some college	42 (35.9)
College graduate	10 (8.5)
Graduate school training	8 (6.8)
Unknown (refused)	5 (4.3)
Current work situation	
Employed full-time	21 (17.9)
Employed part-time	13 (11.1)
Unemployed/student	43 (36.7)
Other	35 (29.9)
Unknown (refused)	5 (4.3)
Health insurance (yes)	53 (45.3)
Types of health insurance	
Through employment	10 (8.5)
Through spouse's employment	5 (4.3)
Medicaid	35 (29.9)
Medicare	4 (3.4)
Other	15 (12.8)
Dental insurance (yes)	29 (24.8)
Annual household income (US\$)	
<10,000	75 (64.1)
10,000 ≤ 22,000	15 (12.8)
22,000 ≤ 35,000	7 (6.0)
>35,000	10 (8.5)
Marital status (married)	41 (35.0)
Living arrangement (multiple answers)	
Living with husband or boyfriend	20 (17.1)
Living with child(ren)	69 (59.0)
Living with roommate	8 (6.8)
Living in a shelter	20 (17.1)

with higher income. The participants who had full- or part-time employment reported less psychological distress ($p < .01$), lower levels of depression ($p < .01$), and fewer oral health problems ($p < .05$) compared with the participants who did not report current employment.

Discussion

The aim of this study was to identify physical and mental health variables associated with IPV among women seeking help at a FJC, to understand unmet needs for planning intervention and prevention programs. We have three main findings. First, women who access services at the FJC experience low mental health functioning compared with the general population, as well as psychological distress and depression. Second, we found differences in health status by living situation. Third, regardless of living situation, social support is associated with better physical and mental health.

Although we found that physical health functioning for our study participants, as defined by the SF-12, was similar to the general population, mental health functioning was much lower. In addition, psychological distress and depression were significant problems among the participants. When the SF-12 scores

Table 2
Prevalence of Selected Demographic Variables by Living Situation (*n* = 117)

Demographic Variables	Shelter (<i>n</i> = 20), <i>n</i> (%)	Non-shelter (<i>n</i> = 97), <i>n</i> (%)
Hispanic		
Yes	6 (30.0)	30 (30.9)
No	14 (70.0)	64 (66.0)
Some college or more		
Yes	10 (50.0)	49 (50.5)
No	10 (50.0)	42 (43.3)
Employed		
Yes	1 (5.0)	33 (34.0)
No	18 (90.0)	59 (60.8)
Income >\$22,000		
Yes	1 (5.0)	16 (16.5)
No	17 (85.0)	72 (74.2)
Living with child(ren)		
Yes	3 (15.5)	58 (59.8)
No	17 (85.0)	31 (32.0)
Health insurance*		
Yes	5 (25.0)	47 (48.5)
No	12 (60.0)	33 (34.0)
Dental insurance		
Yes	3 (15.5)	26 (26.8)
No	17 (85.0)	63 (64.9)
Married		
Yes	11 (55.0)	30 (30.9)
No	9 (45.0)	60 (61.9)

Pearson chi-square * $p < .05$ (for cell size ≥ 5 only).

from the participants in our study were compared with females who experienced IPV and were seen in an emergency department or outpatient clinic, our participants had better physical health functioning, but worse or similar level of mental health functioning (McCloskey et al., 2006; Straus et al., 2009). For example, the patients seen in the emergency department who disclosed IPV victimization had an SF-12 PCS of 43.64 and MCS of 37.46, whereas participants in our study had SF-12 PCS of 48.1 and MCS of 33.7 (Straus et al., 2009). Our data were collected at a community organization, not at a health care facility. Clients who seek help for IPV at a community organization might not be suffering physical health problems, but are reporting low mental health functioning, compared with women who seek help in a health care setting.

Table 3
Physical and Mental Health and Social Support by Living Situation (*n* = 117)

Variable	M (SD)			<i>p</i>
	Total (<i>n</i> = 117)	Shelter (<i>n</i> = 20)	Non-shelter (<i>n</i> = 97)	
SF-12 (physical health and well-being)*				
Physical component score	48.1 (10.4)	42.7 (6.6)	49.2 (10.7)	<.01
Mental component score	33.7 (11.0)	39.9 (7.2)	32.3 (11.2)	<.05
GHQ-12 (psychological distress)†	7.7 (3.8)	7.9 (3.7)	7.7 (3.9)	NS
PHQ-9 (depression)‡	14.8 (6.7)	13.1 (5.2)	15.2 (7.0)	NS
MOHRQoL (oral health)§	2.2 (1.2)	1.9 (.8)	2.2 (1.3)	<.05
MOS-SSS (social support) overall	3.0 (1.1)	3.1 (1.0)	2.9 (1.2)	NS
Danger assessment¶	19.7 (6.8)	20.4 (5.6)	19.5 (7.1)	NS

Abbreviations: GHQ-12, General Health Questionnaire; MOHRQoL, Michigan Oral Health-related Quality of Life Scale; MOS-SSS, Medical Outcomes Study Social Support Survey; PHQ-9, Patient Health Questionnaire; SF-12, Short Form-12.

* Higher scores indicate better health functioning.

† Higher scores indicate worse psychological distress.

‡ Higher scores indicate more severe depression.

§ Higher scores indicate poorer oral health-related quality of life.

|| Higher scores indicate more social support.

¶ Higher scores indicate higher risk for intimate partner homicide.

Table 4
Predictors of Health Outcomes (*n* = 117)

Dependent Variables	PCS [†] (Physical)		MCS [‡] (Mental)		GHQ-12 [§] (Psychological)		PHQ-9 (Depression)		MOHRQoL [#] (Oral)	
	β	SE	β	SE	β	SE	β	SE	β	SE
Independent variables (Constant)	59.36**	5.58	12.07*	5.59	13.58**	1.96	25.32**	3.38	1.61*	0.59
Age	-0.32**	0.09	0.15	0.10	-0.00	0.03	-0.05	0.06	0.03**	0.01
Hispanic	-3.22	1.96	2.10	2.09	-0.37	0.69	0.66	1.19	-0.12	0.21
Low education	-4.53*	1.84	1.81	1.96	-1.09	0.64	-0.66	1.11	0.24	0.19
Employed	3.23	2.16	1.84	2.22	-2.19**	0.73	-4.37**	1.26	-0.38*	0.22
Health insurance	-0.79	2.14	-5.81*	2.28	0.71	0.75	4.74**	1.29	-0.02	0.22
Dental insurance	-5.01	2.60	1.02	2.77	1.49	0.91	-0.95	1.57	-0.24	0.27
Low income	-2.56	2.83	4.73	3.01	-1.14	0.99	-2.25	1.71	0.47*	0.30
Shelter	-5.93*	2.33	5.59*	2.49	-0.18	0.82	-1.59	1.41	-0.42	0.25
Social support	2.09*	0.84	4.29**	0.90	-1.56**	0.30	-2.63**	0.51	-0.18*	0.09
R ²	0.30		0.29		0.33		0.36		0.29	
F	5.15		4.94		5.73		6.66		4.91	
p	<.001		<.001		<.001		<.001		<.001	

Abbreviations: GHQ-12, General Health Questionnaire; MCS, mental component summary; MOHRQoL, Michigan Oral Health-related Quality of Life Scale; MOS-SSS, Medical Outcomes Study Social Support Survey; PCS, physical component summary; PHQ-9, Patient Health Questionnaire.

* $p < .05$, ** $p < .01$.

[†] Higher scores indicate better health functioning.

[‡] Higher scores indicate worse psychological distress.

[§] Higher scores indicate more severe depression.

^{||} Higher scores indicate poorer oral health-related quality of life.

[#] Higher scores indicate more social support.

We found that the participants who lived in a shelter reported better mental health functioning, but worse physical health functioning than those who did not live in a shelter. Given that women who have stayed in a shelter are more vulnerable than those who have never stayed (Grossman & Lundy, 2011) and usually have more mental health disorders (Helfrich, Fujiura, & Rutkowski-Kmitta, 2008), this result may be unexpected but not surprising. This probably reflects the community setting of our study. It is possible that women not living in the shelter are living with the perpetrator or in an unsafe environment, contributing to psychological distress and poorer mental health functioning compared with women living in the shelter. The benefits of living in a shelter include a feeling of safety and the resolution of the immediate danger from violence, while providing short-term support and access to services, which may have a positive impact on mental health. By acknowledging or disclosing the violence and moving into a shelter a woman may increase her self-care agency or ability to care for herself which was found to be a protective factor for depression in abused women (Campbell & Lewandowski, 1997). In addition, a recent study showed that having distance from an abuser makes abused women feel safe (Dichter & Gelles, 2012).

The FJC was not designed to offer long-term therapeutic support to clients, yet our study points to a potential need for such services, especially for women not living in a shelter. Although the FJC may not be able to offer these services on site, referral to mental health agencies may help women to improve their mental and psychological health and their ability to end IPV. For example, cognitive-behavioral therapy is effective in reducing posttraumatic stress disorder and depression symptoms among victims of interpersonal violence (Iverson et al., 2011). Alternatives to traditional mental health services should also be considered. A recent study conducted at a community-based domestic violence drop-in center found that a multifaceted depression care program improved depression severity for African-American women survivors of IPV (Nicolaidis et al., 2012).

Social support is associated with a better quality of life among women who have experienced IPV (Beeble, Bybee, Sullivan, & Adams, 2009; Liang, Goodman, Tummala-Narra, & Weintraub, 2005). We have similar findings showing that social support was associated with better physical and mental health, better oral health, and lower levels of psychological distress and depression. Social support has direct or buffering effects on health, and positively affects physical and mental health by preventing social isolation and moderating stressors on health (Berkman, Glass, Brissette, & Seeman, 2000). Improved physical and mental health is critical for women who experience IPV and want to reconstruct their lives without abuse (Alexander, Tracy, Radek, & Koverola, 2009; Hathaway et al., 2000). Information about how social support affects physical and mental health is essential to provide more comprehensive services to women who seek to end violence, particularly in non-shelter settings such as the FJC.

Study Limitations

Our study has several limitations. This was a cross-sectional study and we cannot determine the causal direction of the associations we found. It is possible that low mental health functioning and depression make women more vulnerable to IPV, or that women who experience IPV are more prone to mental health problems. Although we tried to recruit all eligible clients, clients who came to the FJC with an appointment for a specific service such as employment, immigration, or short-term, strength-based therapy sessions were sometimes excluded. In addition, only women who read and understood English were eligible to participate, so we cannot generalize our findings to women who are not English speaking. We are limited in understanding the impact of IPV severity on health since we were only able to obtain a Danger Assessment score for 60 out of 117 participants. We may have over- or underestimated the severity of IPV based on the availability of the Danger Assessments. Finally, this study was conducted in one FJC and is not generalizable to other FJCs located throughout the United States.

Further studies at other FJCs or similar non-shelter settings are warranted to confirm our findings.

Implications for Practice

To our knowledge, this is among the first studies of women who seek services at a community walk-in center to end IPV. We conducted our study in the first half of 2012 and the timeliness of the findings has implications to aid community organizations dedicated to helping women end violence in their lives. We found that social support is a particularly important factor for women's health and for women trying to end violence in their lives. Women who experience IPV may not necessarily discuss IPV experiences with their health care providers (Plichta, Duncan, & Plichta, 1996). Fewer than one half of the women in our study reported having health insurance and so may not have a health care provider with whom to discuss health issues, including IPV. Community walk-in organizations such as the FJC are integral to women's health and well-being by providing a supportive environment and access to services regardless of insurance status. The FJC where we conducted our study offers support groups that may improve women's connections and support while increasing their self-efficacy and ability to utilize community services to end the violence in their lives. Our data suggest that the support groups need to be continued and perhaps expanded. Many of the women who use the services at the FJC reported poor physical health and are probably experiencing health problems that cannot be treated at the FJC. Public and private organizations working together may be able to bridge this gap and provide free or low-cost health care for women as they seek to end abuse.

There is a need for traditional and nontraditional therapy for women who experience IPV, especially for women who may still be living in an abusive situation. Our findings show that the FJC staff members were right to be concerned about the mental health of their clients. FJCs were originally started to meet the acute needs of women who experience IPV and often reflect a criminal justice-related focus. Although criminal justice services will always be needed, the results of this study suggest that FJCs may want to consider expanding their advocacy services to meet the short and long-term mental health needs of their clients as part of the wrap around services that all FJC's offer. Currently, the FJC where we conducted our study is only able to provide short-term, strength-based therapy for clients; clearly, more long-term support is also necessary. The FJC staff members are reaching out to agencies that may be able to provide therapy on site or at alternative locations.

More information is needed to understand the needs of women who seek services at non-shelter settings. Although shelters are an important component of the response to IPV, some women are not ready or able to live in a shelter. In addition, shelters cannot serve all women, and are often limited in who can stay and for how long. Our study shows that women are choosing to make changes to end the violence in their lives using the services and support available in a community setting such as the FJC.

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