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Crime Victims' Institute
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Coordinated Justice: The Structure, Operations, and Impact of Domestic Violence Response Teams

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Domestic violence response teams (DVRTs) represent a multidisciplinary approach to addressing domestic violence (DV) and intimate partner violence (IPV). These programs, also referred to as domestic abuse response teams (DARTs), domestic violence enhanced response teams (DVERTs), and coordinated community response teams (CCRTs), generally involve collaboration among law enforcement, victim advocates, prosecutors, healthcare providers, and community organizations to provide a coordinated intervention that addresses the safety, legal, emotional, and social service needs of victim-survivors while increasing offender accountability (Bledsoe et al., 2006; Malik et al., 2008; McLaughlin et al., 2021). The rise of DVRTs reflects broader recognition that DV/IPV is a multifaceted problem requiring more than a traditional law enforcement response (Cox et al., 2025; White et al., 2005). Victim-survivors often interact simultaneously with police, courts, healthcare systems, shelters, and social service agencies, and fragmented systems can create barriers to safety and justice. Accordingly, DVRTs seek to streamline and improve those interactions by creating formalized partnerships among responding agencies (Clark et al., 2012; Johnson & Stylianou, 2022). The goal of this report is to provide an overview of the origins and development of DVRTs in the United States, including their operational structures and utilization, as well as empirical research on their functioning. This report will also discuss examples of contemporary DVRTs and review implementation recommendations based on existing research literature and practitioners' guidance.

Origins and Development of DVRTs

DVRTs emerged from the broader coordinated community response (CCR) movement that gained momentum in the 1980s and 1990s. Prior to this period, DV interventions were largely fragmented, where police often treated DV as a "private family matter" and victim-survivors were left to navigate criminal justice, social service, and healthcare systems independently (Whetstone, 2001). Advocates and policymakers increasingly recognized that isolated responses were insufficient because DV intersects with multiple systems and institutions. Accordingly, CCRs were developed to improve interagency communication, reduce systemic gaps, and create a unified strategy for addressing domestic violence (Boots et al., 2018). Early CCRs were strongly influenced by the Duluth Model (*see Figure 1*), which emphasized collaboration among police, courts, advocacy organizations, and community stakeholders (Shorey et al., 2014).

A key catalyst for DVRT expansion was the Violence Against Women Act (VAWA) of 1994, which provided federal funding for coordinated responses to domestic violence. Many communities used VAWA grant funding to develop multidisciplinary DV teams, task forces, and specialized intervention programs (Johnson et al., 2019; Johnson & Stylianou, 2022). A national review found that many coordinated response initiatives were established directly because of VAWA-related funding opportunities, which incentivized communities to formalize partnerships among agencies and institutions (Clark et al., 2012). With such funding opportunities, programs increasingly integrated victim advocates directly into police response models.

DVRTs also emerged in response to several well-documented limitations of traditional, police-centered DV interventions. Scholars have discussed how law enforcement officers often lacked the time, specialized training, or resources to address survivors' needs beyond the immediate criminal investigation, leaving

many victims without meaningful support (Whetstone, 2001). At the same time, victim services were frequently fragmented across systems, requiring survivors to independently navigate courts, shelters, counseling services, and healthcare providers during periods of acute trauma (Malik et al., 2008). Drawing on crisis theory, the literature has also recognized that victims may be particularly receptive to assistance during or immediately following a violent incident, highlighting the importance of rapid, on-scene intervention (Johnson et al., 2019). Moreover, proponents of coordinated responses posited that multidisciplinary collaboration could enhance offender accountability by improving evidence collection, case follow-through, and prosecution outcomes (Bledsoe et al., 2006). Collectively, these concerns motivated the development of DVRTs as a model to provide immediate advocacy and support to victim-survivors while simultaneously strengthening law enforcement and judicial responses.

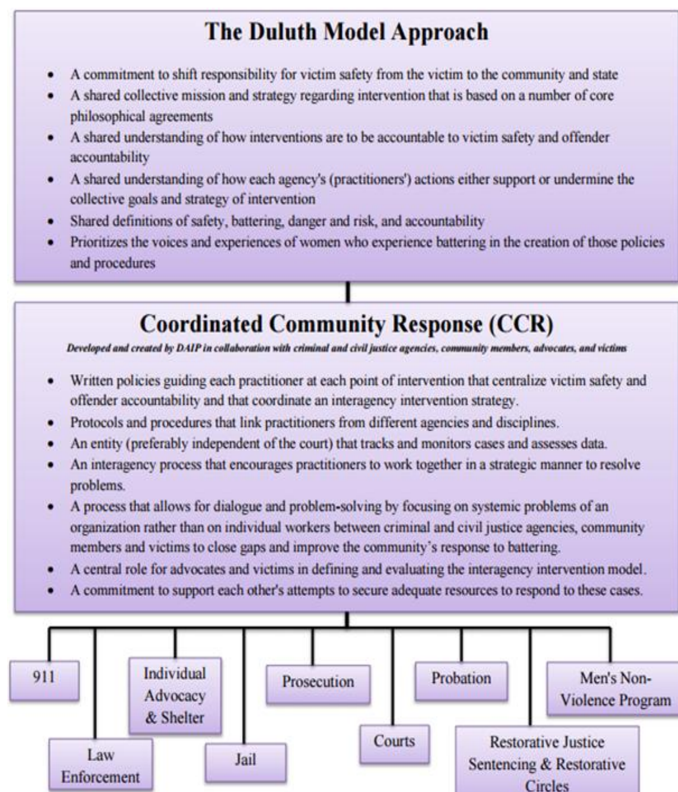

Figure 1: The Duluth Model (Domestic Abuse Intervention Programs).

Structure, Activation, and Utilization of DVRTs

Although models vary by jurisdiction, most DVRTs involve some combination of police, prosecutors, healthcare personnel, victim advocates/social workers, probation/parole staff, and community organizations (Shorey et al., 2014; Malik et al., 2008). The most common operational model pairs police officers with victim advocates either during the initial domestic violence response or shortly thereafter (Whetstone, 2001). In some jurisdictions, advocates respond directly to the scene with police, while in others they provide follow-up outreach after police intervention.

In terms of programmatic focus, DVRTs center on immediate crisis stabilization, safety planning, shelter placement, assistance with protective/restraining orders, court accompaniment, counseling referrals, and follow-up services (Rubenstein et al., 2021). For example, in Los Angeles, California, DART advocates may accompany officers to scenes, police stations, or victim-survivors' homes to provide crisis counseling, legal advocacy, shelter referrals, and assistance with protective orders (Peace Over Violence, n.d.). DVRTs are commonly funded through one or more of the following sources: VAWA grants, Victims of Crime Act (VOCA) funding, local municipal budgets, police department budgets, county or state appropriations, and/or private grants. The University of Colorado Denver's Center on Domestic Violence toolkit (2020) notes that the federal Office on Violence Against Women (OVW) grants remain one of the most common startup funding mechanisms for DVRT programs.

Furthermore, DVRTs are typically activated after DV arrests, high-risk DV calls, repeat domestic disturbance calls, or cases involving significant injury or lethality concerns. For instance, in Schaumburg, Illinois, its DVRT is activated for all domestic battery arrests and repeat domestic incidents involving three or more police calls within six months, and the team specifically monitors "domestic hot spots" for intervention (Hovey et al., 2023). In New Jersey, many DVRTs require the victim-survivor to be physically present with police before activation and often exclude dual-arrest or intoxication situations (Johnson et al., 2019).

Regarding utilization rates, there is no precise national data because DVRT implementation is decentralized. However, DV/IPV remains one of the most common police call categories nationwide, meaning many DVRTs respond frequently (Cox et al., 2025; Hovey et al., 2023). Whetstone's (2001) evaluation involved over 18,000 DV calls for service, with more than 4,000

confirmed IPV cases analyzed during the study period. Programs in urban jurisdictions often respond daily, while smaller suburban/rural jurisdictions may deploy less frequently depending on population size and staffing (Boots et al., 2018).

Examples of Contemporary DVRTs

- Cincinnati, Ohio: Cincinnati's DVERT program has become a notable example due to recent evaluation efforts (Wojcik et al., 2021). Created with funding from the Ohio Attorney General's Office, it combines law enforcement, prosecutors, and advocates from nonprofit Women Helping Women to provide enhanced services on scene to DV victim-survivors (Cincinnati Public Radio, 2017, 2022) (*See Figure 2*).

Figure 2: Cincinnati's Domestic Violence Enhanced Response Team (DVERT).

- Los Angeles, California: Los Angeles's model is among the most expansive nationally. All 22 Los Angeles Police Department divisions maintain DART teams, with advocates embedded alongside police. Services include crisis intervention, emergency protective order assistance, safety planning, and court accompaniment (Peace Over Violence, n.d.).

- Salem, Oregon: Salem's DART model includes specialized law enforcement and advocacy partnerships designed to provide follow-up victim support after police contact. The team's approach emphasizes prosecution support, offender accountability, and victim linkage to services (Bledsoe et al., 2006; Wojcik et al., 2021).

- Schaumburg, Illinois: Schaumburg's DVRT is highly structured and multidisciplinary, consisting of patrol officers, detectives, social workers, and a crime analyst. As previously mentioned, the program focuses heavily on repeat-call intervention and proactive monitoring of chronic DV households (Hovey et al., 2023).

- St. Louis, Missouri: St. Louis utilizes collaborative DVRTs that emphasize partnerships among law enforcement, prosecutors, and victim advocates, particularly in DV/IPV cases marked as high-risk and involving repeat offenders (Cox et al., 2025; Rubenstein et al., 2021).

- West Orange, New Jersey: New Jersey is one of the most robust statewide DVRT jurisdictions because state law requires law enforcement agencies to establish or participate in domestic crisis teams (Johnson et al., 2019). West Orange and other municipalities use volunteer advocate-based teams coordinated through county DV organizations.

Research Evidence on DVRTs

Empirical research on DVRTs and related coordinated community response (CCR) models suggests generally positive, yet mixed, outcomes across jurisdictions. For instance, Johnson and Stylianou's (2022) systematic review found that CCRs consistently improve interagency communication and increase victim access to services; however, the evidence for long-term reductions in repeat violence remains less conclusive. These findings reflect a broader trend in the literature showing that DVRTs are effective at improving system coordination and immediate responses, even as questions remain about sustained behavioral change among offenders. Some research also points to favorable criminal justice outcomes associated with coordinated DV/IPV interventions. For example, Whetstone (2001) found that jurisdictions employing specialized coordinated response teams experienced significantly higher arrest, prosecution, and conviction rates compared to control jurisdictions relying on

traditional responses. Such findings indicate that multidisciplinary coordination can strengthen case processing and accountability. Consistent with this conclusion, Bledsoe and colleagues (2006) reported that coordinated responses facilitate improved offender accountability by enhancing information sharing, case follow-through, and prosecutorial support.

Research examining victim-survivor experiences further indicates that DVRTs are generally viewed positively by victims. Corcoran and colleagues (2001) reported that victim-survivors involved in police-social work crisis intervention models expressed high levels of satisfaction, particularly valuing access to both legal assistance and emotional support at the point of crisis. Similarly, Malik and colleagues (2008) emphasized that coordinated response systems reduced barriers to service utilization by streamlining referrals and minimizing the burden on survivors of navigating complex, fragmented service networks on their own. Additionally, recent research demonstrates the adaptability of coordinated response models beyond traditional policing contexts. For instance, Kurbatfinski and colleagues (2024) evaluated a hospital-based DART operating in an emergency department, and found improvements in the identification of DV cases and the delivery of timely interventions within healthcare settings. Such results suggest that the principles underlying DVRTs can be successfully applied across institutional contexts.

Despite these promising findings, scholars have noted persistent challenges in defining and measuring program success. Evaluations conducted by scholars at Rutgers University (Johnson et al., 2019) highlight that advocates and law enforcement often prioritize different outcomes, such as survivor empowerment versus arrest and prosecution rates, which complicates efforts to develop consistent evaluation metrics. This tension is echoed in Hetzel-Riggin's (2023) research, which found significant differences in how stakeholder groups perceive CCR effectiveness, with advocates and criminal justice actors frequently emphasizing divergent goals and benchmarks.

Also, the formation and long-term viability of DVRTs may be hindered by uneven stakeholder "buy-in" and participation. For example, McLaughlin and colleagues (2021) found that the perceived effectiveness of collaborative DV/IPV responses was strongly influenced by the availability of resources and the degree to which participating agencies were meaningfully represented within decision-making structures. Accordingly, when key stakeholders lack adequate input or when partnerships are imbalanced, collaboration may be weakened. Similarly, studies of rural coordinated responses highlight structural barriers, such as limited funding, geographic isolation, and insufficient service infrastructure, which can hinder the development and sustainability of team efforts (Sudderth, 2004). Interorganizational tensions pose further challenges, particularly between police and victim advocates, who may operate from differing philosophical frameworks regarding victim autonomy, offender accountability, and the role of the criminal justice system. These tensions can create what Sudderth (2006) describes as an "uneasy alliance," complicating communication and coordination.

Moreover, while the empirical contributions thus far appear valuable, the literature on DVRTs remains limited in several important respects. Johnson and Stylianou (2022) conclude that the field is constrained by inconsistent outcome measures, a lack of randomized controlled trials, substantial variation in program structure, and a heavy reliance on descriptive or process-oriented evaluations. As a result, while existing research supports the value of DVRTs in improving coordination and short-term outcomes, further rigorous and standardized evaluation is needed to assess their long-term effectiveness.

Implementing DVRTs: Recommendations from Research and Practice

Jurisdictions seeking to establish such a multidisciplinary approach to address DV/IPV should begin by prioritizing the development of strong, collaborative interagency partnerships (Irwin, 2022; Shorey et al., 2014). The success of coordinated community responses depends heavily on the degree of trust, communication, and shared goals among participating agencies, including police, prosecutors, healthcare personnel, victim service providers, and advocacy organizations (Johnson & Stylianou, 2022). Having formal agreements in place, such as memoranda of understanding, can help clarify roles and responsibilities, establish referral pathways, and ensure consistency in service delivery (Clark et al., 2012; Iratzoqui & Leat, 2025). Without clearly defined

structures, collaboration may become fragmented, ultimately undermining the effectiveness of the coordinated response.

An essential component of effective DVRT implementation is the early and meaningful inclusion of victim advocates within the response framework. Research demonstrates that victim-survivors benefit from having access to emotional support, safety planning, and resource navigation at the earliest stages of intervention, particularly during or immediately following a crisis (Corcoran et al., 2001). Embedding advocates alongside law enforcement, either through co-response models or rapid follow-up, can significantly enhance victim-survivor engagement and improve access to services. This approach also reflects a trauma-informed framework that centers survivor autonomy and empowerment (DePrince et al., 2011).

Standardization of protocols is another important consideration. Jurisdictions should establish clear criteria for DVRT activation, as well as standardized procedures for documentation, communication, and follow-up services. Variability in implementation has been identified as a major challenge in evaluating coordinated community responses, making it difficult to assess program effectiveness across jurisdictions (Johnson et al., 2019). Developing structured, consistent procedures not only facilitates empirical evaluation but also ensures that victim-survivors receive equitable and reliable services regardless of the responding personnel or circumstances.

Training is equally important in preparing DVRT members to respond effectively to DV/IPV cases. All participating professionals should receive comprehensive, ongoing training in areas such as trauma-informed care, the dynamics of relationship violence, cultural competency, and risk/lethality assessment. Given the complexity of DV/IPV cases, interdisciplinary training can also foster mutual understanding across professions, helping to align goals and reduce potential tensions between criminal justice and advocacy perspectives (Johnson et al., 2021; McLaughlin, 2021; Sudderth, 2004, 2006).

In addition, jurisdictions should establish clear evaluation metrics at the outset of program implementation. These metrics may include indicators such as service utilization, victim-survivor satisfaction, repeat victimization rates, and related criminal justice outcomes, such as those focused on offender accountability. The existing literature highlights the importance of defining success in a multidimensional manner, recognizing that different stakeholders may prioritize different outcomes (Bledsoe et al., 2006; Hetzel-Riggin, 2023). Also, incorporating both quantitative and qualitative measures can provide a more comprehensive understanding of effectiveness.

Finally, sustainable funding is essential for long-term program viability. While many DVRTs are initially supported through federal grants, such as those provided under VAWA, reliance on short-term funding can threaten continuity. Jurisdictions should therefore seek to diversify funding sources, including state and local appropriations and partnerships with nonprofit organizations. Stable funding enables programs to maintain staffing levels, invest in training, and ensure consistent service delivery over time (Boots et al., 2018; Iratzoqui & Leat, 2025).

Relevance to Texas: The implementation and expansion of DVRTs are particularly relevant to Texas, given the state's geographic scale and large population, as well as the persistent challenges it, like many other states, faces when addressing DV/IPV. The DVRT model's strengths are well-suited to the state's densely populated urban centers, such as Austin, Dallas, Houston, and San Antonio, as well as its vast rural regions, where access to services may be limited. Particularly in areas characterized by significant disparities in service availability, implementing coordinated response models will help bridge gaps among law enforcement, advocacy organizations, and healthcare providers. In rural areas, victim-survivors have reported facing substantial barriers to accessing support services, including long travel distances, limited shelter capacity, and fewer specialized providers (Boots et al., 2018; Malik et al., 2008). Well-organized DVRTs offer a mechanism for extending services into underserved regions by integrating advocacy into law enforcement responses or by utilizing coordinated follow-up systems. Such models can help ensure that victim-survivors receive timely support in areas where standalone services are sparse.

Furthermore, in states like Texas that have large, varied populations, service providers will often encounter individuals who face additional structural and practical

barriers when seeking assistance, such as limited familiarity with available resources, communication challenges, or heightened concerns about engaging with formal systems (Cox et al., 2025; DePrince et al., 2011). Accordingly, coordinated response approaches that integrate advocates with appropriate language skills and community-specific knowledge are better equipped to address these challenges and foster trust during crisis intervention. Such models support broader access to services and enhance victim-survivor safety by ensuring teams are responsive to the distinct circumstances present at the point of contact.

Additionally, in sizeable jurisdictions similar to Texas, higher volumes of DV/IPV calls for service place considerable strain on law enforcement agencies. DVRTs can help alleviate this burden by distributing responsibilities across multiple agencies and ensuring that victim-survivors receive comprehensive support beyond the immediate law enforcement response. By integrating advocacy, legal assistance, and social services into a unified framework, well-planned and community-specific DVRTs have the potential to improve both efficiency and outcomes (Houston-Kolnik, 2026). For Texas jurisdictions, this suggests that DVRT models should be tailored to the unique demographic, cultural, and geographic characteristics of each community. For instance, urban areas may benefit from fully embedded co-response teams, while rural areas may require hybrid models incorporating remote advocacy or regional coordination.

Conclusion

DVRTs represent a vital evolution in how communities address DV/IPV, moving beyond fragmented, system-specific interventions toward coordinated, survivor-centered approaches. While the empirical evidence suggests that DVRTs improve interagency collaboration, increase access to services, and enhance elements of criminal justice processing, their greatest contribution may lie in reshaping how systems conceptualize responsibility for responding to DV/IPV (Clark et al., 2012; Johnson & Stylianou, 2022). Rather than placing the burden on victim-survivors to navigate complex and often disjointed systems, DVRTs redistribute that responsibility across organized networks of professionals. At the same time, the variability in program structure, implementation, and evaluation highlights the need for continued research and refinement. As jurisdictions expand or adopt DVRT models, attention must be given to relevant criminal justice outcomes, such as arrest and prosecution, as well as to survivor-defined measures of safety, autonomy, and overall well-being. Additionally, sustaining these programs requires investment in both team infrastructure and the training of frontline workers, whose roles are central to the success of coordinated responses. Looking forward, DVRTs appear to hold significant promise as part of a broader movement toward more holistic and equitable responses to DV/IPV. Their continued development and refinement will depend on the ability of jurisdictions to adapt these models to local needs, integrate emerging best practices, and maintain a commitment to multi-system, interdisciplinary collaboration. In doing so, DVRTs can serve as comprehensive frameworks that bring about large-scale improvements in the response to domestic violence in the United States.

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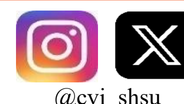

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