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Intimate Partner Violence : Institutional Responses

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ABSTRACT

This policy brief, the third in a three-part series on Intimate Partner Violence (IPV), reviews institutional and societal responses to IPV, focusing on Belgium's legal system, healthcare and mental health services, social work, and material support. It shows that Belgium has built a comprehensive legal framework since the 1990s, yet reporting to police remains low and enforcement of protection orders is limited, while IPV victims face multidimensional legal needs that extend well beyond criminal prosecution. Healthcare and mental health services are frequent points of contact but under-identify victims due to screening gaps, even though trauma-informed and advocacy-based interventions show measurable benefits. Social work and coordinated community responses improve outcomes when timely and empowerment-based, and material support, particularly shelter and housing, remains structurally insufficient relative to need. The brief concludes that legal aid, healthcare, and material support are complementary and that no single intervention is sufficient: sustainable exit from abusive relationships depends on their coordination, with substantial costs to society when services are inadequate, fragmented, or inaccessible to marginalised survivors.

KEY ELEMENTS

- ▶ In Brussels in 2024, less than 30% of physical-violence victims, 23% of sexual-violence victims, and 18% of psychological-violence victims reported the abuse to police, though this is well above the 3% reporting rate found in a 2010 survey. Still, less than half of the reported abuse ends in an officially recorded police file.
- ▶ Up to 89% of IPV victims have at least one other legal issue, next to the criminal case, aligned with evidence that vulnerable population in general is more exposed to legal issues and face dire consequences when such issues remain unresolved.
- ▶ IPV victims can greatly benefit from access to court to escape violence and debt; however, the court process can also be traumatic and produce secondary victimization.
- ▶ In a US study, 50% of IPV victims had 4 or more visits to the emergency department per year, yet only 23% of them were ever identified as IPV victims in their medical records.
- ▶ In Belgium in 2019, around 30% of social interventions by one of main the child protection were linked to children's exposure to IPV. In France, an estimated 11% of children in residential protection services are directly linked to IPV exposure.
- ▶ In France, an estimated 17% of IPV victims require shelter services for an average of nine months, with only one third of beds currently funded.

INTRODUCTION

This policy brief is the third in a series of three briefs dedicated to Intimate Partner Violence related to a broader research project covering the costs and benefits of legal aid for IPV victims. The first piece ([here](#)) focuses on the factors of victimisation and perpetration and on the prevalence rates. The second piece ([here](#)) presents a literature review of individual and societal consequences of IPV as well as the challenges associated with exiting violent households. The present piece focuses on the institutional and societal responses to IPV, with a focus on Belgium.

Public policies and programmes related to IPV belong to three types: primary interventions are concerned with preventing the onset of abuse, secondary interventions aim to prevent further abuse, and tertiary interventions deal with the consequences of abuse once the abuse has ceased (Ramsay et al., 2009). This policy brief reviews interventions related to the second and third categories, starting with a review of the Belgian legal system followed by the presentation of the response to IPV in the health and social sectors. The literature shows that it is the combination of effective legal interventions, access to housing and access to income that can significantly support victims in sustainably exiting abusive relationships.

LEGAL SYSTEM

Legal response to IPV operates at three levels: legislation criminalizing violence and establishing victims' rights (section "law" below); law enforcement responsible for receiving complaints and ensuring immediate safety (section "police" below); and the judicial system, including criminal, civil, and family courts (section "courts" below).

Laws

Belgium has progressively built a **comprehensive legal framework** aligned with international standards : criminalization of marital rape (1989), "Loi Lizin" establishing IPV as an aggravating circumstance (1997); recognition of psychological violence (1998); preferential attribution of the family home and temporary removal of the perpetrator (2003); strengthened protection orders and urgent measures, including for children (2012 & 2019), ratification of the Istanbul Convention (2016), successive National Action Plans (2015–2019; 2020–2024). Together, this legislative corpus recognizes domestic violence as an expression of power and domination within unequal gender relations (ACTIV, 2021; GAMS, 2019; GREVIO, 2025).

Police

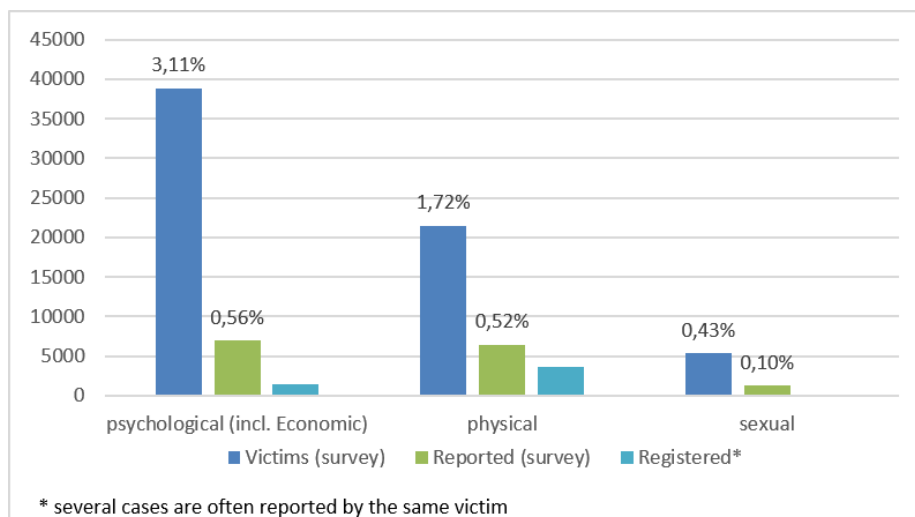
Police act primarily **as emergency responders and as gatekeepers to the criminal justice system**. To facilitate reporting by IPV victims, online complaints have been introduced, as well as the option to request a female officer, and trauma-informed response training for officers such as the EVA programme in Brussels (GREVIO, 2025). But still, in 2024 in Brussels, less than 30% of those who declared having been victim of intra-household physical violence¹ reported it to the police (23% for

¹ Statistics are not broken down between violence against the partner and violence against children or parents. Indicatively, in the officially recorded cases, two third of cases relate to violence against the partner.

victims of intra-household sexual violence and 18% for psychological violence, see Figure 1). This is aligned with international evidence that psychological violence is much less often reported (Duterte et al., 2008). These percentages are notably much higher than older statistics, with a 2010 survey reporting that only 3% of victims went to the police (Pieters et al., 2010).

Even when reported to the police, only a limited number of offenses are officially registered, as shown on Figure 1. Notably, for physical violence, twice as many victims declare having reported the violence to the police as the number of registered offenses, aligned with international evidence (Fagerlund et al., 2022; GREVIO, 2025; L. Johnson & Stylianou, 2022; Trépos, 2017). The figures are even lower for psychological violence. Reasons for this gap include the challenge to produce evidence and the lack of knowledge of victims of what legally constitute evidence².

Figure 1. Number of self-declared victims of IPV (and rate at population level, last 12 months), self-declared reporting of IPV to police (and rate at population level) and recorded IPV offenses for the Brussels region in 2024.



Social support and specialized responses can improve reporting. In the US, Coordinated Community Response (CCR) models, which support victims through the reporting process, are associated with higher arrest and conviction rates (6% vs. 1% conviction rate) and more positive victim experience of police interactions (L. Johnson & Stylianou, 2022). Community outreach further improves engagement with prosecution tasks (DePrince et al., 2012). Specialized IPV courts, as implemented in Spain, increased reporting by up to 28%, particularly for moderate offences, echoing evidence from women-only police stations in India or justice centres in Peru (García-Hombrados et al., 2024). Importantly, adequate responses of the police to disclosure can reduce mental health issues such as PTSD symptoms (Wright & Johnson, 2012), whereas inadequate or uninformed police reactions risk secondary victimization, lower reporting, and ultimately greater normalization of violence and lower state legitimacy (Gilley, 2009; Milliken & Krause, 2002; Rhode et al., 2018).

Marginalized women including migrants, ethnic minorities, and those with mental illness **face heightened barriers to report violence** and fear retaliation and institutional repercussions

² Based on interviews with specialised lawyers, confirmed in reports from Australia (Standing Committee on Social Policy and Legal Affairs, 2017) and the United Kingdom (Syposz, 2017).

(administrative status, deportation by border control police, custody of children³), resulting in lower access to protection. Marginalised survivors therefore endure an even larger burden of IPV. This phenomenon has also been documented in Belgium (GREVIO, 2025 and Vanneste et al., 2012).

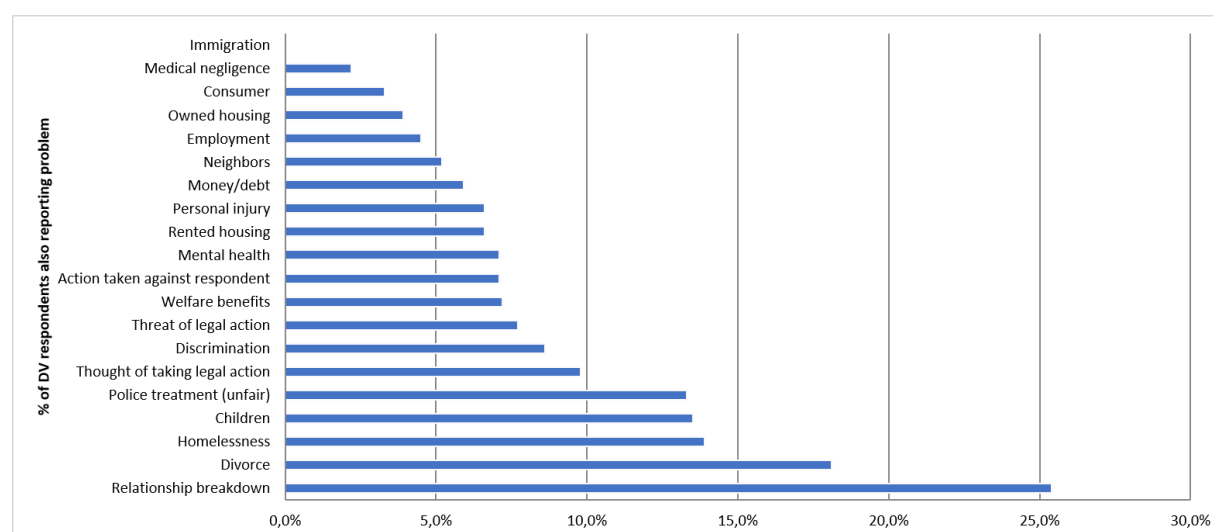
Courts

This section covers the legal needs encountered by IPV victims, the positive impact of adequate judicial response and of legal aid assistance, and the consequences of inadequate response.

IPV victims' multidimensional legal needs

IPV victims typically face complex and interrelated legal problems that extend far beyond criminal prosecution of IPV. Up to 89% of them report legal issues across multiple domains, including child custody, divorce, housing, employment, healthcare, property destruction, immigration status, and income maintenance⁴. Figure 2 presents the legal needs of IPV victims based on a comprehensive survey in the UK (Pleasence et al., 2004): the co-occurring frequencies reported in this population survey are much lower than the legal needs reported by users of legal aid services. It is unclear what the drivers are of these differences: different population sample, question phrasing or reporting norms could explain the differences.

Figure 2. Most frequent legal problems co-occurring with domestic violence among respondents reporting a domestic violence problem. Population survey in England and Wales, from Pleasence (2004).



More broadly, **vulnerable populations, to which IPV victims most often belong** (see Policy Brief [here](#) on the profile of IPV victims), **experience both a higher incidence of legal problems and more severe consequences when these problems remain unresolved** (Pleasence, 2013; Sandefur, 2016; Wetson, 2022). This phenomenon has been largely demonstrated in the area of health for instance, as illness and disability lead to legal problems (e.g. debt management following loss of job), while unresolved legal problems in turn worsen health outcomes (Granger et al., 2022). Belgian data confirm the

³ (Durfee, 2021; Orpinas et al., 2025; Standing Committee on Social Policy and Legal Affairs, 2017; Tutty et al., 2025)

⁴ (Fuentes & Bai, 2025; Lee & Backes, 2018; Logan et al., 2012; Pleasence et al., 2004)

phenomenon of “multiple problems” among legal aid beneficiaries: 11.6% had more than one case over a three-year period, with family law, criminal law, property law, social law, over-indebtedness, and immigration law most frequently involved (Dermine et al., 2019).

Positive impact of judicial intervention on IPV and its consequences

Effective access to courts, including through civil legal aid, can positively impact victims’ safety, health, and economic trajectories.

First and foremost, **legal processes aim at making effective the right to live free of violence**. In the US, forbidding the perpetrator from entering in contact with the victim is the most commonly sought remedy because it is more accessible than criminal convictions (Rosenberg & Grab, 2015). Evidence shows that it reduces physical, sexual, and psychological violence and is associated with reductions in post-traumatic stress and depression symptoms (T. P. Sullivan et al., 2021). In Belgium, such protection order exists in the law but it is seldom used in practice because of the lack of means to enforce it.

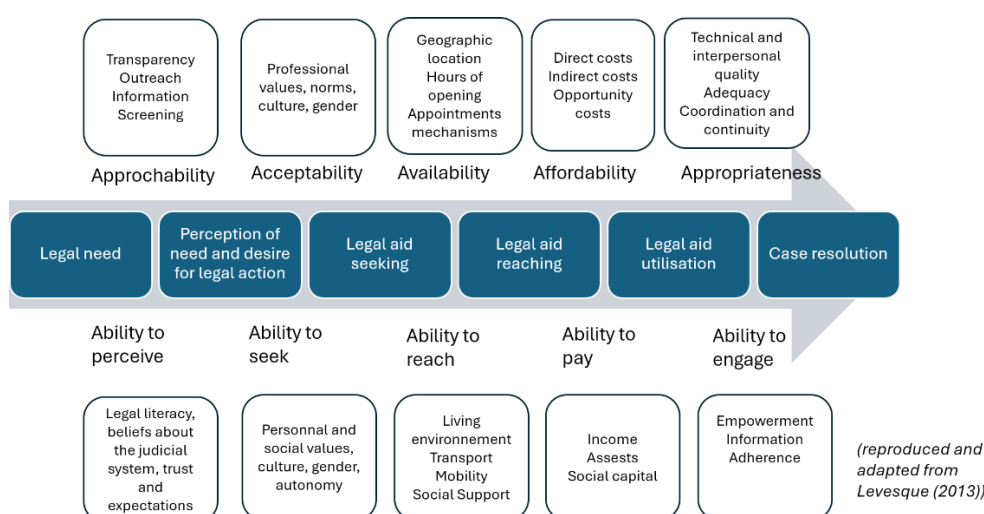
Legal intervention can also **improve material conditions** that are prerequisites for sustainable exit from violence. In a U.S. panel study of low-income women who experienced IPV, access to civil legal services increased monthly income by 19.5% and reduced reliance on food banks and utility assistance (Wetson, 2022). A US report also evidenced that effective access to justice reduced abuse incidence when addressing together custody, housing, immigration and financial vulnerabilities (Rosenberg & Grab, 2015). The same report also documents cost savings in health, justice, shelter use and child welfare involvement, as well as intangible gains in quality of life. Evidence outside the U.S. is scarce.

The court process itself, when perceived as fair, can **contribute to psychological recovery** (Tirone et al., 2021), a phenomenon not limited to IPV and coined therapeutic jurisprudence (Lynch, 2004). Importantly, for IPV victims and others, perceived procedural fairness matters more than winning the case in producing positive mental health effects (Heward-Belle et al., 2024) and the **coordination of legal and mental health approaches** is key to health symptom reduction ((Cerulli et al., 2011; Lynch, 2004).

Access to justice

Despite the benefits of access to courts, it remains challenged by the cost and other barriers to legal representation. Based on the model for healthcare take-up developed by Levesque et al. (2013), **access to justice can be conceptualized as legal needs being met in the legal system** and requires effort both on the victim and legal system sides, as illustrated in Figure 3. On the victim’s side, access to justice requires identification of one’s problem as legal problems, autonomy to seek legal assistance, ability to reach legal assistance, pay and engagement in the judicial process. All these conditions are affected as consequence of IPV (Wright & Johnson, 2012) with a key role of PTSD, prior experience with police and levels of social backing as predictor of seeking legal assistance. On the legal system side, access to justice requires transparent information, professional norms that make it acceptable to the victims, accessibility (location, appointment system, hours of opening), affordability and technical appropriateness to the needs of the victims, which in the case of IPV, includes trauma-informed responses. For instance, absence of training on IPV makes it difficult for lawyers to understand why their client may return to their abusers (Lee & Backes, 2018).

Figure 3. The access to health model adapted to justice.



Legal aid has been evidenced as a key element of access to justice for IPV victims through lowering the cost of legal representation. While legal aid has direct (lawyers' remuneration) and indirect costs (cost of Courts and legal apparatus), evidence emerged from Canada and the US that legal aid was overall a cost-reducing intervention from the public perspective (Moore & Farrow, 2019; Rosenberg & Grab, 2015). Women victims of IPV receiving legal aid have demonstrated **improved financial self-sufficiency, better mental health, and fewer incidents of subsequent violence** (Hartley & Renner, 2018; Lee & Backes, 2018). 17% of IPV victims with legal aid achieved complete resolution of their issues and 62% reported partial improvement (Logan et al., 2012). Legal aid has been shown to **reduce the proportion of children who enter foster care and reduce the duration of it** (Chiappetta, 2019). Legal representation also increases success rates substantially in the US, whether in immigration courts, family proceedings, or protection order hearings (Wetson, 2022). Additionally, increased access to civil justice may exert a preventive effect on domestic violence at the population level (Farmer & Tiefenthaler, 1997; Lee & Backes, 2018; Rosenberg & Grab, 2015).

It has been evidenced that **without legal representation in court, marginalised survivors are more likely to be further victimized by the court process and outcomes** (Lee & Backes, 2018; Logan et al., 2012). In the US, interdisciplinary approach combining legal assistance with social services dedicated to ethnic minorities and undocumented immigrants demonstrated significant improvement in self-sufficiency of IPV survivors regarding housing, social relations and child care (Fuentes & Bai, 2025). Furthermore, victim-focused, community-coordinated outreach programs improve survivors' engagement with prosecution and likelihood of case progression (vs. case being dismissed), particularly among marginalized women (DePrince et al., 2012).

Still, many survivors lack access to legal aid, due to resource constraints (Lee & Backes, 2018), with strong variation between areas. In the US, 80% of family law cases were declined, 70% of employment/consumer cases, and 56% of housing cases. In Belgium, where legal aid is state-funded, disadvantaged individuals often require more time-consuming support to address complex legal problems that public funding of legal aid does not compensate (Dermine et al., 2019).

Traumatic process and secondary victimization

The **court system can also reproduce harm**. Survivors frequently report negative experiences, including disbelief, gender bias, and inadequate understanding of coercive control among judicial actors (Heward-Belle et al., 2024), in turn exacerbating mental health burden (Cerulli et al., 2011; Reeves et al., 2025). Misconceptions about trauma and mental health can undermine credibility assessments, while forced disclosure of therapeutic records may damage recovery (Dodds et al., 2025). A review of legal proceedings in Belgium evidenced that in the case of sexual violence, defendants who are intimate partners received statistically shorter prison sentences than unrelated offenders (Bielen et al., 2022).

Legal processes may provide perpetrators opportunities to continue coercive control post-separation, inducing psychological violence, particularly during custody litigation (Douglas, 2018). Courts may prioritize maintaining contact with both parents, sometimes at the expense of victims' safety, leading to secondary victimization (Gutowski & Goodman, 2020; Khaw et al., 2021; Laing, 2017). Supervised visitation centres can function as protective mechanisms when properly implemented (Flory et al., 2001), yet skepticism toward mothers' claims and accusations of parental alienation remain common barriers.

Perpetrator processing, inequality, and recidivism

IPV defendants are disproportionately drawn from socioeconomically disadvantaged groups, which may influence prosecutorial decisions and sentencing patterns (Vanneste et al., 2017). Criminalization and incarceration entail significant costs, which were not reviewed as part of the present policy brief.

HEALTHCARE

Healthcare services constitute **a primary point of contact in response to IPV**. Victims are over-represented in health services, particularly primary care at general practitioners and emergency departments, yet this overutilization is rarely attributed to IPV because identification remains limited. In the U.S., Kothari & Rhodes (2006) traced back medical records and found that 788 (81.7%) victims generated a total of 4,456 Emergency Department visits. The median number of visits among all victims was 4 (ranging from 1 to 71). Only 23% of victims were identified as such in their medical records. Evidence from a Belgian study among pregnant women confirmed that women experiencing partner violence rarely disclose abuse to the health care services, unless they are directly asked about it (Roelens et al., 2008). Notably, victims tend to undervalue the severity of their symptoms or the link between their symptoms and abuse (Costa et al., 2019).

Screening practices are uneven. IPV is frequently under-detected, because health professionals perceive barriers in identification of IPV, report uncertainty about how to address disclosure, and discomfort in clarifying patients' needs, as identified in Belgium (Vergaert et al., 2023). Still, progress is being made such as guidelines in the context of child protection (Offermans, 2017).

Appropriate responses such as **trauma-informed care and co-located advocacy models** offering on-site needs assessment and safety planning are associated with greater **reductions in IPV exposure and depressive symptoms** compared to standard referral practices (Cho et al., 2025; Coker et al., 2012;

Rhodes et al., 2011; Wathen & Mantler, 2022). The positive effect of co-locating services for IPV victims follows the demonstrated value of integrated services for vulnerable people (OECD, 2015).

MENTAL HEALTH SERVICES

Mental health services are as central to the public response to IPV as physical health services, given the scale and persistence of psychological harm, yet identification of victims and delivery remain uneven. As in primary health care, **screening for IPV varies widely and professionals within mental health services report the same barriers to detection** (Baukaite et al., 2025). As a result, opportunities for intervention are frequently missed, and some survivors experience mental health services as insufficiently trauma-informed or even re-traumatizing (Oram et al., 2022). More inclusive, culturally competent, and trauma-informed approaches are therefore emphasized (Cho et al., 2025).

Where appropriately designed and delivered, psychosocial and psychotherapeutic interventions show **substantial effectiveness**. Meta-analytic evidence indicates large effect sizes for short-term psychological treatments tailored to IPV survivors, especially with cognitive-behavioural approaches (Arroyo et al., 2017), particularly when adopting a holistic view and trauma-informed approach (Paphitis et al., 2022). Randomized and controlled evaluations demonstrate clinically meaningful improvements in depression and psychological distress (Baranov et al., 2020; Ferrari et al., 2018), and broader reviews find that advocacy and CBT-based interventions significantly improve mental health, reduce re-abuse, and strengthen social outcomes (Jonker et al., 2015). Other studies nuanced the effectiveness of psychotherapy, for instance by showing that results held only in the short run but were undetectable in the longer run (Micklitz et al., 2024).

This aligns with evidence on the effectiveness of psychotherapy beyond the case of IPV. In Denmark, psychotherapy coverage by the social security has been shown to reduce psychiatric hospital contacts, physical healthcare use, and suicide attempts (Serena, 2025). Interestingly, while the programme did not appear to increase labour market outcomes, the cost of the programme was still offset by the **reduction in healthcare use**. The author computes that each euro invested in the reimbursement of psychotherapy reduced expenses of EUR 0.6 in other mental health care (mostly through a reduction of psychiatric hospital needs) and an additional EUR 1.5 reduction in physical healthcare expenditures. While the study is not specific to IPV, there is a priori no reason to exclude similar effects of psychotherapy on IPV victims.

Mental health is also supported through adequate response to disclosure from family, friends or colleagues. In a survey of Belgian employee (IEFH, 2020), half of IPV victims reported having discussed the situation at work. Among them, 28% reported having received **support or empathy**.

SOCIAL WORK

Social response to IPV encompasses a **wide spectrum of interventions** that vary across institutional contexts: community support groups, helplines, media campaigns and formal social work aimed at helping victims identify options, connect to resources, and take up available services. It can target the victim, the perpetrator and exposed children. In some settings, it includes providing victims with legal advice, however it does never include provision of legal representation in courts. These interventions can be described as **advocacy work, coordinated community responses (CCR), community-based**

services, or social work including parenting support and child protection case-workers (Ramsay et al., 2009; C. M. Sullivan & Goodman, 2019). In some contexts, general practitioners and other **primary care professionals** also largely contribute to these objectives, though such work is rarely formally recognized. Social response further includes informal and formal parent groups and **child protection services**. In France for instance, it was estimated that up to 11% of children referrals to child protection services were directly linked to IPV (Déroff & Potin, 2013). In Belgium in 2019, around 30% of social intervention by SOS Enfants were related to exposition to IPV⁵. **Family, friends, and colleagues** are the primary source approached by victims for informal and invaluable support (Meyer, 2016).

Empowerment-based, coordinated and timely approaches are particularly effective. Advocacy models that provide needs assessment, safety planning, education, and facilitated linkages to legal and community resources improve outcomes beyond emotional support alone (Coker et al., 2012; C. M. Sullivan & Goodman, 2019). Coordinated Community Responses (CCR, in the US) aim to mobilize community actors, enhance accountability, and reduce service fragmentation, with some evidence of increased child referrals to therapy and higher arrest rates (L. Johnson & Stylianou, 2022). Interdisciplinary models combining legal and social services appear especially beneficial for ethnic minority and undocumented survivors, who face compounded access barriers (Fuentes & Bai, 2025; Rhee & Silver, 2025; Sanhueza-Morales et al., 2025). In The Netherlands, social work during the critical period when the victims leave the emergency shelter has proven important in avoiding re-victimisation (Lako et al., 2018).

A large set of studies further illustrate the range of community-level strategies that can mitigate isolation, enhance empowerment, and facilitate sustainable exit from violence, like economic empowerment programs (Cardenas et al., 2022), role-model exposure promoting post-traumatic growth (Cobb et al., 2006), parent support groups (Renner et al., 2020), public awareness campaigns, helplines, and code-word systems to discreetly access services (Brink et al., 2021).

MATERIAL SUPPORT

Material support includes provision of in-kind services (mainly shelters and transitional housing) and income support.

Shelter provision is one option of protection for IPV victims among others (such as keeping the household housing, moving out on own resources, or housing in the social network), yet capacity remains structurally insufficient and there is documented evidence that IPV victims add up to the users of services dedicated to homeless individuals and families.

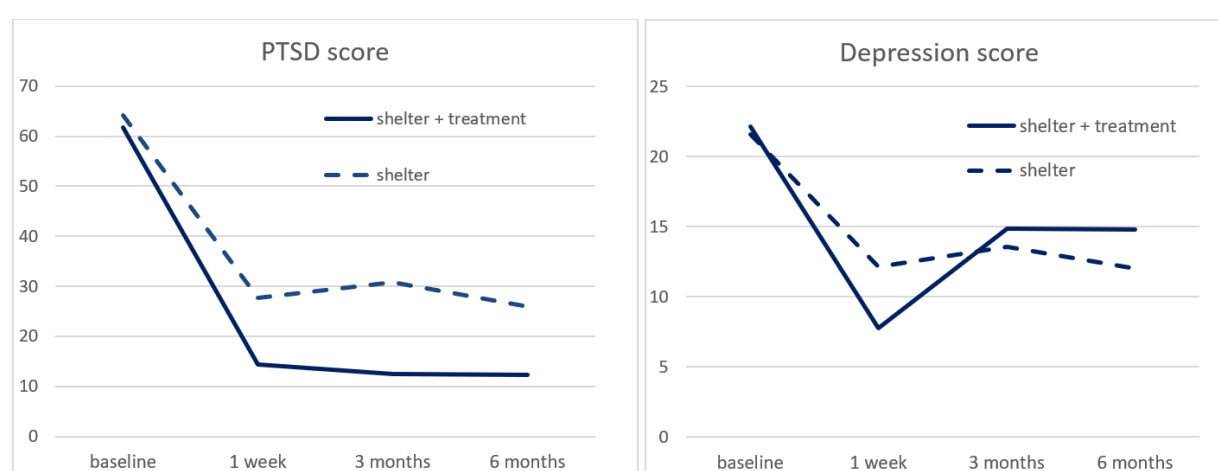
In France, 17% of IPV victims require shelter services for an average of nine months, implying an annual funding need of approximately 16,456 beds (vs. 4,456 specialized beds actually funded), forcing victims into general homeless facilities, with 35% of unspecialized homeless shelters accommodating IPV survivors (Conseil Economique, Social et Environnemental, 2018). In the US, 48,350 individuals use federally funded housing services dedicated to IPV victims on an average night, i.e. a population rate of 16 per 100 000 (Iyengar et al., 2008). Yet, 10% of daily requests go unmet due to resource constraints.

⁵ <https://www.one.be/public/violences-conjugales/>

Belgian evidence similarly illustrates structural pressure: the existing services dedicated to housing IPV victims and their children are saturated with reported waiting time of one year for families⁶. There is also a shortage of beds available in transitional housing⁷ (Bergé, 2025). In Brussels, IPV victims make up a significant share of 11.1% of homeless shelter users, and in particular of single parents with children (90% of them mothers) (Pierre, 2025). Also, 20% of all sheltered individuals in Brussels reported that relationship breakdown triggered homelessness.

Evidence nonetheless shows (see Figure 4) that access to shelters and longer-term housing significantly improves mental health, perceived safety, intent to leave abusive partners, and housing-related stress, particularly when combined with social work support (Allen et al., 2021; D. M. Johnson et al., 2016; Yakubovich et al., 2022).

Figure 4.. Evolution of PTSD and depression scores among beneficiaries of shelters with randomized access to psychotherapeutic treatment. Results from Johnson et al (2016).



As discussed in the first two policy briefs on IPV ([here](#)), employment is both a protective factor from IPV and its consequences, and at risk for IPV victims. In this context, interventions have been developed to **support victim's employment and broader economic empowerment**. Employer-focused initiatives, such as the CEASE network, aim to sensitize workplaces and facilitate supportive employment environments (ACTIV, 2021). For victims out of the labour market, programs such as ACTIV emphasize that victims must first self-identify as needing support, have their basic needs secured (safe housing, healthcare), and receive individual psychological support before group work, social reconnection, and ultimately employment assistance can yield durable results (ACTIV, 2021). For many survivors, particularly single mothers, labour market reintegration depends on access to affordable childcare and jobs compatible with school and daycare hours (Vivre Ensemble, 2025).

Beyond employment per se, broader **economic empowerment interventions have demonstrated measurable reductions in IPV**. A meta-analysis covering 44,772 participants finds that women's economic empowerment (through cash transfers, employment programs, microfinance, business training, childcare provision, savings accounts, and related measures) is associated with significant reductions in emotional, sexual, and physical IPV, particularly when combined with gender-

⁶ Reported by a general practitioner interviewed.

⁷ Transitional housing refers to housing solutions that are built for longer-term stay (several months) and aim at beneficiaries' autonomy upon exit.

sensitization components (Eggers Del Campo & Steinert, 2022). However, some studies report short-term increases in controlling behaviours following women-targeted cash transfers, suggesting potential backlash effects, in particular where masculinity norms are dominant (Baranov et al., 2021; Matavelli et al., 2026).

Figure 5. Evolution of the scores in quality of life and abuse among beneficiaries of an economic empowerment program. Data from Cardenas et al (2022). All differences between baseline and follow up are significant at 5% threshold.



CONCLUSIONS AND POLICY IMPLICATIONS

The policy brief examines the institutional responses to IPV, spanning legal interventions, healthcare, social services, housing support and employment programmes. Significant gaps remain in the provision of dedicated, trauma-informed, services, either because victims are not identified as such (for instance in healthcare settings), because of services are insufficiently available (such as shelters) or because staff is insufficiently trained to understand the dynamics of IPV (police and courts). Access to justice also remains a challenge, in particular for marginalised survivors. Hence, a measure of the funding of existing dedicated service would underestimate the cost of addressing IPV, as all survivors are not served or are served by programmes not associated with IPV response, such as homeless shelters. Still, for the victims served by appropriate services, it is easy to see that society as a whole bears a large cost from IPV, beyond the costs and suffering immediately borne by victims themselves.



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