

THE GUELPH-WELLINGTON SEXUAL ASSAULT
AND DOMESTIC VIOLENCE FIRST RESPONSE
PROTOCOL EVALUATION RESEARCH

Relationships are the Foundation



Mavis Morton, PhD
Linzy Bonham, MSW
Danielle Bader, BA
Melissa Horan, MPH
Sara Crann, MA

Acknowledgements

THE RESEARCH TEAM EXTENDS A SINCERE THANK YOU TO:

The women who participated and shared their stories of abuse
and their experiences with service providers.

The service providers who shared their experiences of working
with women and other service providers on SADV.

The Action Committee for their interest in and assistance with the research.

Participation and feedback from women, service providers and the Action Committee
was invaluable in helping to ensure the research was relevant and meaningful.

THE RESEARCH TEAM WOULD LIKE TO ACKNOWLEDGE THE CONTRIBUTIONS OF:

Ashley Murphy-Kilgar, University of Windsor

Sly Castaldi, Guelph-Wellington Women in Crisis

Anne Bergen, Shirley Shanahan, Linda Hawkins and Alida Allemanno,
Institute for Community Engaged Scholarship,
University of Guelph

Kellie Grace, Guelph-Wellington Women in Crisis

Leanna Ireland, University of Guelph

Siddharth Joshi, Wellington-Dufferin-Guelph Public Health

Laura Campbell, Wellington-Dufferin-Guelph Public Health

Mike Bernofsky, Chalutz Media Inc.

Table of Contents

ACKNOWLEDGEMENTS	2
EVALUATION RESEARCH SUMMARY	5
TENSION POINTS AND ACTION POINTS	7
INTRODUCTION	8
The Guelph-Wellington Action Committee on Sexual Assault and Domestic Violence	8
Experiencing SADV in Guelph-Wellington	10
The First Response Protocol	11
The Protocol Evaluation Research	11
The Protocol Evaluation Research Team	12
What Is In This Report?	12
METHODOLOGY	13
Study Purpose	13
Methods	14
Research Participants	14
Recruitment	14
Data Collection	15
Interviews with Women	15
Service Provider Online Survey and Focus Groups	15
Action Committee Agency Statistics	15
Data Analysis	16
Research Participant Input & Feedback	16
RESEARCH FINDINGS	17
Participant Demographics	17
Women	17
Service Providers	19
The Protocol – Training and Accessibility	20
Protocol Objectives of a Consistent and Caring Response	21
What is First Response and How Important Is It?	22
First Response and Privacy	23
Explaining Confidentiality	25
Risk Assessment	27
Safety Planning	29
Referring to “Experts” for Safety Planning	30
Effective Follow Up and Referrals	32
What is “Follow Up”?	32
Referrals	32
Bridging Services and Advocacy	34
Differential Response	35
Judgment from Service Providers	35
Not a “Cookie Cutter” Approach	36
Tangible Supports	36
Understanding and Empathy	38
Coordination and Collaboration	40
Action Committee Representatives	40

Collaboration Between Action Committee Agencies	43
Community Partner Consultations	43
The High Risk Team	45
Challenges and Barriers between Action Committee Agencies	47
Information and Communication Barriers	47
System/Institutional Barriers	51
Different Philosophies, Mandates and Agendas	52
Level of Value and Trust	54
Feedback and Suggestions for Improved Coordination/Collaboration	55
Beyond the Protocol	56
Larger Systemic Gaps in SADV Services	56
Public and Professional Knowledge about SADV	56
Overview	57
Gaps in Services	57
Issues with Court Systems	59
Restrictive Organizational Policies	59
ACTION AND TENSION POINTS	61
Action Points	61
Tension Points	64
CONNECTIONS BETWEEN OUR FINDINGS & PREVIOUS RESEARCH	66
Benefits of a Coordinated/Collaborative Approach: Relationships are Crucial	66
Challenges of working together	66
Shared power and decision making despite different mandates	67
Leadership and Active & Engaged Membership	67
Collaboration and coordination with accompaniment, support and advocacy	67
How services are delivered is key – positive and practical	68
Risk Assessment and Safety Planning	68
RESEARCH LIMITATIONS	69
CONCLUSION	70
APPENDIX A: Research Team Profiles	71
APPENDIX B: Agency Statistics on Domestic Violence and Sexual Assault	72
References	79

Evaluation Research Summary

The purpose of this report is to describe the process and findings from a community engaged research evaluation of the Guelph Wellington Sexual Assault and Domestic Violence First Response Protocol. The Guelph-Wellington Action Committee on Sexual Assault and Domestic Violence (the Action Committee) represents 27 organizations from various sectors across Guelph-Wellington, Ontario. These agencies offer services to women and children who have experienced sexual assault and/or domestic violence (SADV). Similar to Domestic Violence Community Coordinating Committees (DVCCCs) and Sexual Assault Response Teams (SARTs), the Action Committee functions as a vehicle to help facilitate a coordinated and collaborative response to domestic violence and sexual assault.

In 2003, the Action Committee developed a First Response Protocol (the Protocol) with funding from

the Ontario Ministry of the Attorney General. SADV protocols like this one have been developed and implemented in communities to clarify and formalize principles and practices for agencies to follow in an effort to enhance victim safety and offender accountability. The latest version of the Protocol was published in 2010 and outlines steps to a “consistent, caring and effective first response.”

Community engaged evaluation research was conducted through a community-university (CU) partnership between the Action Committee and the University of Guelph. The purpose of this research was to assess the implementation of the Protocol by hearing from women about their experiences with service providers, to hear from service providers about using the protocol, and to assess whether the protocol helped to facilitate coordination and collaboration among Action Committee agencies.

DATA COLLECTION AND ANALYSIS

Semi-structured interviews were conducted with 33 women who disclosed SADV to one or more Action Committee member agencies. The interviews asked women about their experiences with service providers and their use of the Protocol. Five focus groups were conducted with a total of 32 service providers. Ninety-eight service providers from various Action Committee agencies completed an online survey. Service providers were asked about their experiences using the Protocol (e.g. explaining

confidentiality and ensuring client privacy during disclosures) and about their work with other service providers who are part of the Action Committee.

Annual service delivery numbers and reported occurrences of sexual and domestic violence in Guelph-Wellington were compiled from available agency statistics. Quantitative data were analyzed using frequencies and other descriptive statistics. Qualitative data were analyzed collaboratively and systematically using thematic analysis.

FINDINGS

Is the First Response Protocol being implemented as written?

The majority of service providers (59%) agreed that their response to a disclosure of SADV fits with the Protocol. While some Protocol expectations are being implemented as written across agencies (e.g. explaining confidentiality), others, such as ensuring client privacy during disclosures, and providing a differential response to clients, are not implemented regularly or consistently.

To what extent are the objectives of the First Response Protocol being achieved?

Overall, while some objectives (e.g. explaining confidentiality, informed consent, asking preliminary questions about risk) are performed regularly across agencies, other objectives, such as safety planning, are only practiced regularly by some agencies. Providing a caring response is dependent on the individual worker and is not consistent within or across agencies. Additionally, agencies frequently provide referrals, but due to agency mandates or other constraints, follow-up beyond occasionally checking in at appointments does not often occur.

Do collaboration, co-ordination and planning between protocol member agencies facilitate the implementation of the First Response Protocol?

An essential ingredient for facilitating and sustaining cross-sector and cross-agency collaboration and coordination was the existence of individual positive relationships among service providers. Referring clients from one agency to another was the most common kind of collaboration. For example, a service provider might refer a woman to an agency like Women in Crisis because they are seen as an 'expert' in risk assessment and safety planning. Other types of interagency collaboration and coordination, such as case conferences, were infrequent.

To what extent does the First Response Protocol meet the needs of service providers in their work with individuals who have been impacted by sexual assault and/or domestic violence?

While the Protocol has been useful for service providers in some ways, a more accessible format and additional training would be helpful, particularly for those agencies whose main focus is not SADV. Cross-sectoral training was requested as a way to increase collaboration and help service providers more effectively support women and hold offenders accountable. A number of barriers, challenges (e.g., conflicting agency mandates, lack of trust) and benefits (e.g., time saver and efficient use of resources) to collaboration were identified.

To what extent are service users satisfied with their experiences of service providers as mandated by the First Response Protocol?

Women tended to focus on their overall impression or experience of service providers, rather than their first disclosure. The how of service delivery was paramount for women, which often came down to service provider personality and skill. Women felt supported when service providers were attentive, accommodating, compassionate, respectful, empathetic, non-judgmental, patient, understanding, and validating. Tangible and material supports, like providing bus tickets or clothing, were very important.

To what extent do the current protocol objectives meet the needs and issues facing women and children who experience sexual and/or domestic violence?

Overall, the Protocol is addressing and meeting some of the needs and issues facing women. However, women identified gaps in service delivery (e.g., parenting support, PetSafe program, detox program, accessibility for rural women), which impact safety and their ability to manage, cope and rebuild their lives. Additionally, women identified larger systems issues such as a lack of knowledge about SADV services, lack of offender accountability, restrictive organizational policies as well as economic security and housing. These issues impact their ability to access services and their experiences with service providers.

Based on the evaluation research findings, the researchers have created "action points" and "tension points" to highlight the key issues identified by women and service providers. Action points are key findings to consider for improving SADV service delivery. Action points include issues related to the Protocol as it is currently written (e.g., more clearly defining objectives and recognizing distinct service provider roles), and key messages from women about their experiences with service providers (e.g., the importance of tangible supports). Tension points reflect more complex issues both for women and service providers that require redress beyond Protocol changes. Tension points include larger systems' gaps, differing mandates and philosophies between agencies, and different understandings of concepts such as "high risk".

Action and Tension Points

Below is a summary of the Action and Tension Points identified by the current research findings.

It is beyond the scope of this research to examine if and how the Action Committee and the larger community addresses these Action and Tension Points.

Action Points Considerations for improving SADV service delivery. These represent key findings from women about their experiences with service providers and/or are suggestions from service providers.	Tension Points Differences identified by women and service providers in definitions/interpretation, service delivery styles, agency mandates, philosophies. Challenges, or tensions experienced at the Action Committee level.
<ul style="list-style-type: none"> • How service providers treat women is crucial • A woman's overall service delivery experience is memorable • Demonstrate non-judgment and acceptance • Bridge services through advocacy, accompaniment & support • Offer all clients privacy to facilitate a disclosure • Each service provider explain the limits of confidentiality to every woman • Provide basic safety planning to every woman experiencing violence • Revise safety planning expectations for historical occurrences of abuse • Develop and build a common safety planning tool • Revise risk assessment expectations & use a common risk assessment tool(s) • Increase availability of practical & tangible resources • Increase services & resources for specific populations • Define & explain "follow-up" • Increase accessibility of the Protocol • Provide cross-sectoral training to increase awareness and understanding of agencies' mandates, services & resources • Increase awareness of sexual assault & domestic violence services • Facilitate discussions on working collaboratively • Increase public education about violence 	<ul style="list-style-type: none"> • Balancing the duty to report and service providers' own values and approach • Disagreement about definitions of high risk & how to respond • Tension between trying to ensure women are connected with services and support, and ensuring women are able to freely choose which service providers to contact • Increased collaboration among service providers can have a negative impact on a woman's choice and agency • Different philosophies, mandates, and agendas • Illusion of entire agency implementing the Protocol • Communication • Trust issues between agencies • Lack of engagement & resources to facilitate collaborative work • Benefits vs. challenges of case conferences • Selective membership on the High Risk Team • Lack of personal relationships • Service providers' limited knowledge on violence • Limitations of the justice system related to charging • Women's frustration with the court system • Child welfare agency placing the onus on the mother to protect her children and failing to hold the abuser accountable

Introduction

THE GUELPH-WELLINGTON ACTION COMMITTEE ON SEXUAL ASSAULT AND DOMESTIC VIOLENCE

The Guelph-Wellington Action Committee on Sexual Assault and Domestic Violence (the Action Committee) is one of approximately 48 Domestic Violence Community Coordinating Committees in Ontario. Domestic Violence Community Coordinating Committees (DVCCCs), and Sexual Assault Response Teams (SARTs) are part of a larger community response to violence against women known as community coordinated responses (CCRs).

Historically, the community response to violence against women has been characterized by inadequate services and a lack of coordination across systems.ⁱ Since the 1980s, efforts to improve the response to violence against women have included bringing

relevant stakeholders together (e.g., criminal justice, social services, health, education, governments, religious organizations) to respond in a more coordinated and comprehensive manner. CCRs have become a one way to attempt to create a coordinated response and meet the collaboration requirement commonly attached to state funding.ⁱⁱ

In Guelph-Wellington, the Action Committee currently represents **27 local organizations** from various sectors that provide services to women and children who have experienced SADV¹ (Figure 1). The vision of the Action Committee is **“a community free of sexual and domestic violence and human trafficking.”**ⁱⁱ

There are 9 sectors that are represented on the Action Committee:

- Child Welfare
- Community
- Justice
- Education
- Government (Social Assistance)
- Health
- Mental Health
- Violence Against Women
- Faith

Each Action Committee agency sends a person from their agency to be their **Action Committee representative**. This person attends monthly meetings and their role is to represent their agency at the Action Committee table in discussions and decision-making processes, and to bring information from the Action Committee back to their agency. The Action Committee is **chaired by the Executive Director of the Guelph-Wellington Women in Crisis** and staffed by the **Action Committee Coordinator**.

¹ Sanguen, Parkwood Gardens Church, and Child Witness Centre joined the Action Committee after the start of the research and did not participate.



Demographic Snapshot of Guelph-Wellington^{iv 2}

Guelph-Wellington is made up of the City of Guelph, two towns, and five townships, and has approximately 200,000 residents.

In Guelph-Wellington, much like the rest of Ontario, there are approximately equal numbers of males and females and the population is aging. Approximately 60% of the population is married or common law. Cultural diversity is growing in Guelph-Wellington. Immigrants make up 17% of the population of Guelph-Wellington, and are most likely to settle in the City of Guelph.

More than half of the population (58%) has completed post-secondary education. The unemployment rate in Guelph-Wellington is 4.5%, which is below the provincial average (6%). Women (3.5%) are slightly more likely than men (2.5%) to be unemployed. The number of low-income residents in Guelph-Wellington (8.5%) is below the provincial average (14.7%). Similar to the rest of Ontario, women in Guelph-Wellington are more likely to be the lone parent in a household (9%) than men (2.5%). **Households with a lone female parent are significantly more likely to be low income (23%) than households with a lone male parent (12%).**

Social assistance (i.e. Ontario Works) caseloads have increased significantly in Guelph-Wellington since 2007. In 2007 there were approximately 275 social assistance cases in Wellington county and 900 social assistance cases in Guelph. In 2010 social assistance cases jumped to approximately 400 in Wellington county and 1500 in the city of Guelph. There has also been a 71% increase in the number of families on the wait-list for affordable housing in Guelph-Wellington since 2007.



EXPERIENCING SADV IN GUELPH-WELLINGTON

In Guelph-Wellington, as throughout Canada and the rest of the world, women and girls are at risk of victimization based on gender. The rates of sexual assault and domestic violence against women are high:

- Almost 40% of women in Canada have reported being sexually assaulted since the age of 16^v,
- Any given day in Canada, 3,300 women have to sleep in emergency shelters to escape domestic violence^{vi}, and
- On average, every 6 days a woman in Canada is murdered by her intimate partner^{vii}.

Aboriginal women, younger women and women with disabilities are especially at risk of violence, while immigrant women and women in rural communities face additional barriers in seeking services^{viii}.

Women often need and seek out a variety of supports during or after abuse by an intimate partner or sexual assault. There are a number of services and systems that women may come in contact with in Guelph-Wellington, either by seeking support for themselves and their children, or through involuntary contact with mandated services such as police or child welfare agencies.

In general, women may face a number of challenges accessing appropriate support for SADV. Women may not know what services are available in the community and/or they may have to re-tell their story to each new service provider they have contact with.^{ix} **Since women in Guelph-Wellington are less likely than men to be employed, and more likely to have low income and be the lone parent of a household, they may face additional barriers to accessing services (e.g. not having time to seek out or receive professional support).** Therefore, a coordinated and collaborative response to SADV can be an essential part of Guelph-Wellington's response to sexual assault and domestic violence.

² Percentages presented are an average of City of Guelph and Wellington County statistics.

THE FIRST RESPONSE PROTOCOL

The Action Committee developed a First Response Protocol (The Protocol) in 2003, with funding from the Ontario Ministry of the Attorney General, after recognizing the **need to increase service provider collaboration to better assist women who have experienced SADV in Guelph-Wellington.**

Protocols are often developed and implemented in communities to outline expectations, strategies, key issues, and goals for SADV service delivery^x.

The latest version of the Protocol was published in 2010 and outlines steps to a “consistent, caring and effective first response”. As part of their membership

on the Action Committee, all 27 agencies committed to using the Protocol in their work with women who experience SADV. This includes:

- receiving training on the Protocol,
- Providing service to women and children in a way that meets the objectives and goals of the Protocol, and;
- collaborating with other Action Committee agencies.

THE PROTOCOL EVALUATION RESEARCH

Discussions and questions about the effectiveness of the Protocol at the Action Committee table inspired the evaluation research. The Action Committee was particularly interested in hearing from women living in the community about their experiences with SADV service delivery in Guelph-Wellington. Therefore, the current evaluation had two main purposes:

1) To evaluate the implementation and effectiveness of the Protocol for women in the community using SADV services, and the agencies that provide those services and;

2) To examine the ongoing coordination and collaboration and related challenges experienced by Action Committee agencies in responding to SADV in Guelph-Wellington.



The Protocol Evaluation Research Team

This research study was conducted through a community-university (CU) partnership with the Action Committee, and the University of Guelph.

When the Action Committee first discussed their interest in doing evaluation research in 2012, a Health Promotion Specialist representing Wellington-Dufferin-Guelph (WDG) Public Health on the Action Committee offered to conduct the evaluation along with the Action Committee Coordinator. The Action Committee Chair also contacted a sociologist at the University of Guelph with expertise in violence against women and community engaged evaluation research. The Protocol Evaluation Research Team (Research Team) was created in 2012. The core research team was made up of:

- The Action Committee Coordinator,
- A sociologist from the University of Guelph,
- A Health Promotion Specialist from WDG Public Health, and member of the Action Committee,
- Two graduate students from the University of Guelph.

A Master's of Social Work (MSW) student from the University of Windsor, two additional students from the University of Guelph, the Knowledge Mobilization Coordinator from the Institute for Community Engaged Scholarship at the University of Guelph, and the Executive Assistant at Women in Crisis also supported the research at various stages. See Appendix A for research team profiles.

WHAT IS IN THIS REPORT?

This evaluation research report begins by identifying the Action Points and Tensions that came from the research findings. The report outlines the methodology used to conduct this research study, followed by a detailed discussion of the research findings, specifically related to the Protocol objectives, coordination and collaboration among service providers, as well as larger systemic issues beyond the Protocol. The findings include data collected from women who have accessed services about their satisfaction with service delivery as well as service providers' experiences implementing and using the Protocol to guide their work. Subsequently, limitations of this research study are presented.

The report concludes with connections between key findings of the current research study and previous academic research.

Women tended to focus on their overall impression or experience with service providers, but also discussed other relevant factors that shaped their service delivery experiences. Women and service providers often cited larger system issues beyond the scope of the Protocol, which are highlighted throughout and covered in the "Beyond the Protocol" section of this report.

Methodology

Evaluating collaborations is challenging because of their complexity and evolving nature, broad range of outcomes, and contextual issues. A community engaged research (CEnR) methodology was an obvious approach based on the members of our CU partnership and our mutual interest in evaluating the Protocol. A community engaged research approach involves **“collaboration between institutions of higher education and their larger communities (local, regional, national, global) for the mutually beneficial exchange of knowledge and resources in a context of partnership a context**

of partnership and reciprocity.”^{xi} It is the process of CU collaboration, rather than a rigid or specific methodology or set of methods, that is fundamental to a CEnR approach.^{xii} This evaluation research was guided by the principles of CEnR (e.g., building trust, shared power, fostering co-learning), but also fit with Community Based Research (CBR) and Participatory Action Research (PAR) methodologies, which informed the research and decision making processes while also ensuring a rigorous research design^{xiii}.

STUDY PURPOSE

The purpose of the current research was to assess whether or not the Protocol is working well according to service providers and women who use the services. The following research questions guided the current study:

1. a) **Is the First Response Protocol being implemented as written?**
 b) **To what extent are the objectives of the First Response Protocol being achieved?**

The objectives are:

- i) To provide a consistent and caring response, regardless of to which member agency an individual discloses abuse;
- ii) To explain confidentiality, the limits of that confidentiality and to obtain informed consent for service;
- iii) To offer safety planning and risk assessment; and
- iv) To provide coordinated, effective follow-up and support.

- c) **Do collaboration, co-ordination and planning between protocol member agencies facilitate the implementation of the First Response Protocol?**

2. **To what extent does the First Response Protocol meet the needs of service providers in their work with individuals who have been impacted by sexual assault and/or domestic violence?**
3. **To what extent are service users satisfied with their experiences of service providers as they are mandated by the First Response Protocol?**
4. **To what extent do the current protocol objectives meet the needs and issues facing women and children who experience sexual and/or domestic violence?**

METHODS

Research Participants

The current study collected data from two sources:

- **Women:** adult women who have experienced sexual assault and/or domestic violence and disclosed their experience to one or more Action Committee member agencies since the Protocol was implemented in 2006³.
- **Service providers:** front line workers and management that work at an Action Committee agency who may provide services and support to women and children who have experienced SADV⁴. (see page 7 for a diagram of agencies)

Recruitment

Women were recruited to participate in this research project across Guelph and Wellington via posters distributed in public locations (e.g., grocery stores, coffee shops, libraries, laundromats, employment centres, University of Guelph, and Action Committee agency locations). Recruitment advertisements were also circulated in the local newspaper, online classifieds (Kijiji and Craigslist) and social networking websites (Facebook).

Potential research participants were screened by an administrative assistant at Women in Crisis to determine their eligibility for this research study. In an effort to increase access to rural women in the research, the recruitment posters were revised to target women in Wellington county and posted in public locations. However, only three rural women participated in this research.

Service providers from all 27⁵ agencies with membership on the Action Committee, including Action Committee representatives, were invited to participate. Nineteen of the 27 Action Committee agencies participated in this research. Service providers were recruited from contact lists of agency staff given to the researchers by Action Committee Representatives. Using the contact lists, an email was sent to staff offering two ways to participate: by individually completing an online survey and/or participating in an agency-specific focus group. Focus groups were scheduled with agencies that had at least three staff that expressed interest. Since service providers are often overburdened, the support of the Action Committee Representatives and management was critical during this process because the staff associated the emails with this research, resulting in greater service provider participation.



³ We explicitly recruited women who had first contact with a service provider after 2006, however we did have one woman in the data set who only had experiences with services prior to 2006.

⁴ Data were collected and securely stored by the Action Committee Coordinator and the Principal Investigator from the University of Guelph and were only reviewed by members of the research team for the purpose of analysis. The study was approved by the Research Ethics Board at the University of Guelph.

⁵ At the time of the research, Abbeyfield Guelph Fund was a member of the Action Committee. Agencies that did not participate in this research study include the Crown Attorney's office, Guelph Community Health Centre, Canadian Mental Health Association (formerly Trellis Mental Health), Probation and Parole and the Upper Grand District School Board

DATA COLLECTION

Interviews with Women

Private face-to-face semi-structured interviews were conducted with **33 women** from December 2012 to May 2013. The interview questions were developed by the research team based on a review of the academic and grey literature as well as feedback from women and service providers. Women were given the choice of interview location, including: Women in Crisis, the University of Guelph and locations in the county. The interviews were audio recorded and later transcribed verbatim for analysis. The women received \$25 for participation and were compensated for transportation and childcare costs. Women were also provided with a list of community resources at the end of the interview.

Service Provider Online Survey and Focus Groups

The online survey and focus group questions were developed by the research team based on a review of the literature and with input from service providers. The purpose of the online survey and focus groups were to learn about service providers' experience using the Protocol, responding to women who have experienced SADV, and collaborating with other Action Committee agencies. A total of **94 online surveys** were completed between April 2013 and September 2013. Specifically, 15 of the 25 Action Committee Representatives participated in this research.

Five focus groups were conducted between May and October 2013 with the following agencies:

- Family Counselling & Support Services,
- John Howard Society,
- Marianne's Place (Women in Crisis shelter),
- Women in Crisis and;
- Family & Children's Services.

A total of **32 service providers** participated in the focus groups. Focus groups were audio recorded and transcribed verbatim for analysis. The focus groups took place at the participants' workplace and were 1 to 1.5 hours long. Service providers who participated in the online survey and/or focus groups were entered into a draw to win one of eight \$20 gift cards to Chapters Indigo.

The research findings were validated using multiple data collection tools, specifically online surveys, focus groups and interviews.

Action Committee Agency Statistics

Agency statistics were collected to give a snapshot of the **reported occurrences of sexual and domestic violence** in Guelph-Wellington county, as well as the services provided. An Internet search of available annual reports and relevant agency statistics were compiled and additional statistics were collected from Action Committee representatives. Agency statistics are presented in Appendix B and span 2010-2013, depending on availability.

DATA ANALYSIS

Aligned with the principles of CEnR, the research team **valued shared decision-making and a collaborative research process**. To begin the data analysis process, the research team met frequently as a group to develop a data analysis plan. Coding software⁶ was used to facilitate a team-based thematic analysis of the qualitative data. Thematic analysis is a method for identifying, analyzing, and reporting patterns, or themes^{xv}. The analytic approach included both theoretically-driven (deductive) and coding grounded in the data (inductive)^{xvi} to answer the research questions and identify additional emerging themes.

Initially, **coding was conducted as a team** to ensure consistency, increase rigor, and to ensure the research team members were familiar with the data, coding structure, and process. The remaining data were **coded individually by at least two researchers for reliability**. Data codes were then reviewed, discussed, collapsed, and reorganized collaboratively based on research team consensus. Once all of the coding had been reviewed and agreed upon, the various data components (e.g., service user interview data about the Protocol, service provider focus group data about collaboration) were **interpreted and analyzed for major themes by at least two researchers**. This research report

is interspersed with quotes from service providers as well as women who accessed services to provide evidence of the themes highlighted in the findings.

Research Participant Input & Feedback

Action Committee representatives, service providers and the women we interviewed were treated as important participants in the research design and this required ongoing and frequent communication. Aligned with CEnR principles, **members of the community participated in the research process not only as research subjects, but as valued research advisors and partners^{xvii}**. The research team obtained feedback from service providers and women on the development of questions for the online survey and interviews and we shared preliminary research findings with them. A **feedback focus group** was held with women who had been interviewed as a way to assess whether the research team's analysis of the interviews rang true to them. Similarly, **preliminary data results were presented at Action Committee meetings**. This was also a way for the research team to update the Action Committee on the progress of the research.

⁶ NVivo 10.

Research Findings

PARTICIPANT DEMOGRAPHICS

Women

The ages of the **33** women who were interviewed ranged from 18 to 74 years old (Figure 2). The majority of women identified as White ($n = 23$) (Figure 3) and spoke English as their first language ($n = 28$). Twenty-seven participants lived in the City of Guelph and all but two participants were born in Canada. There was a diverse range of education levels (Figure 4) and marital status (Figure 5) among the women. The majority of women had children ($n = 20$) and children's ages ranged from 7 months to 42 years old. Similarly, the majority of participants ($n = 20$) had a total annual income under \$20,000 (Figure 6).

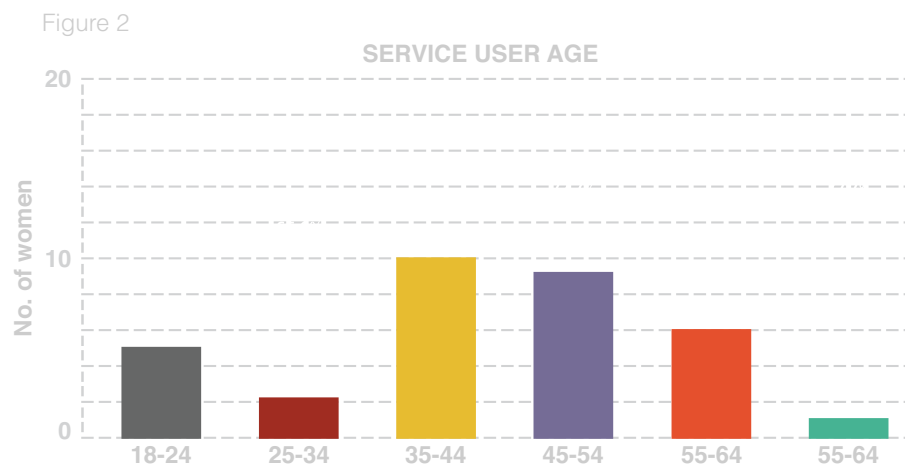


Figure 3

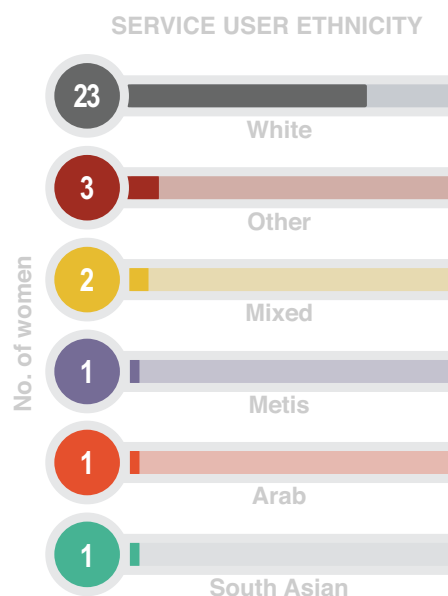


Figure 4

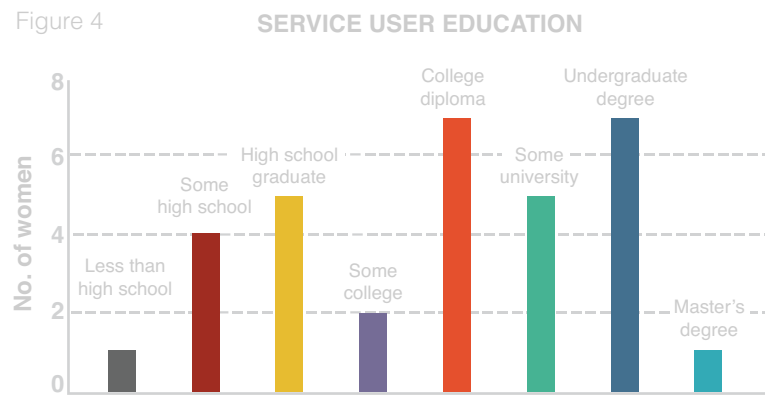


Figure 5

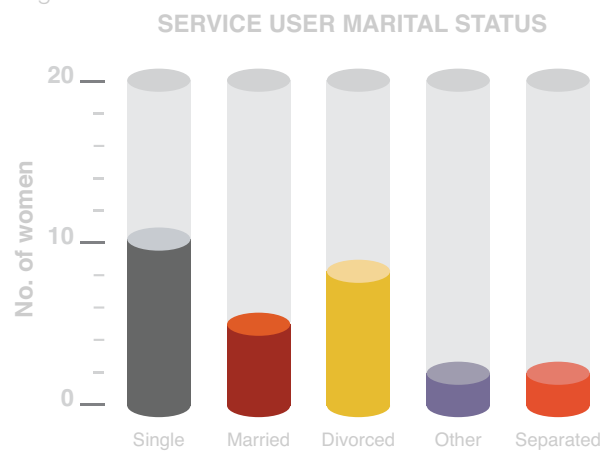
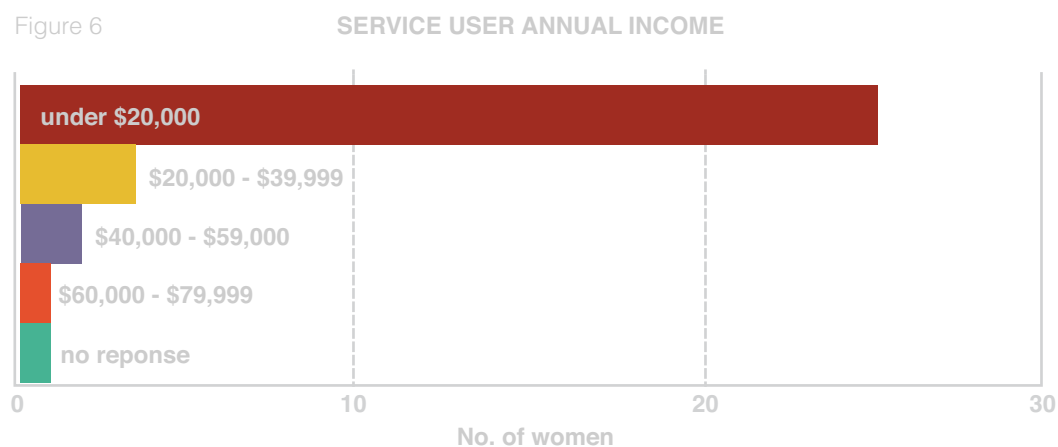


Figure 6



Service Providers

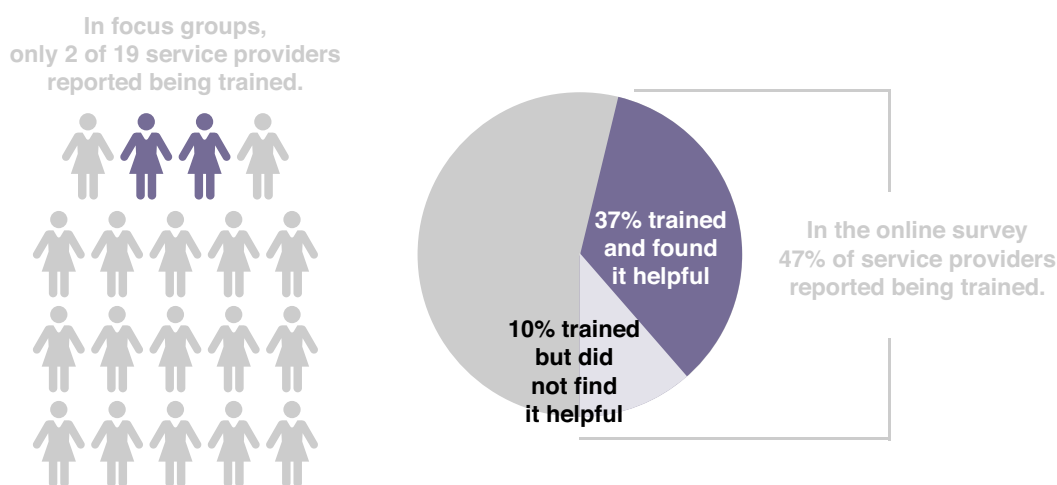
Out of the **98** service providers who filled out the online survey, they worked an average of 7.7 years in their position, ranging from 1 month to over 30 years. Service providers represented the following agencies and sectors:

Sector	Agency	No. of service providers per agency	Agency %	Sector %
Child Welfare (N = 7)	Family and Children's Services	7	7.4%	7.4%
Community (N = 13)	ARCH (HIV/AIDS Resources & Community Health)	8	8.5%	13.9
	Guelph Humane Society	1	1.1%	
	Immigrant Services Guelph-Wellington	1	1.1%	
	John Howard Society of Wellington-Waterloo	1	1.1%	
	Welcome In Drop-In Centre	2	2.1%	
Education (N=5)	University of Guelph	3	3.2%	5.3%
	Wellington-Catholic District School Board	2	2.1%	
Government (N=10)	County of Wellington – Housing Services	8	8.5%	10.6%
	Ontario Works	2	2.1%	
Justice (N=13)	Guelph Police Service	4	4.3%	13.9%
	Legal Aid Clinic	1	1.1%	
	Ontario Provincial Police	5	5.3%	
	Victim Services Wellington	1	1.1%	
	Victim/Witness Assistance Program	2	2.1%	
Medical Health (N=12)	Guelph General Hospital	8	8.5%	12.8%
	Wellington-Dufferin-Guelph Public Health	4	4.3%	
Mental Health (N=15)	Community Torchlight Distress Centre	2	2.1%	15.9%
	Family Counseling and Support Services	5	5.3%	
	Homewood Community Addictions Services	8	8.5%	
VAW (Violence Against Women) (N=18)	Guelph-Wellington Women in Crisis	18	19.1%	19.1%
			100%	100%

THE PROTOCOL – TRAINING AND ACCESSIBILITY

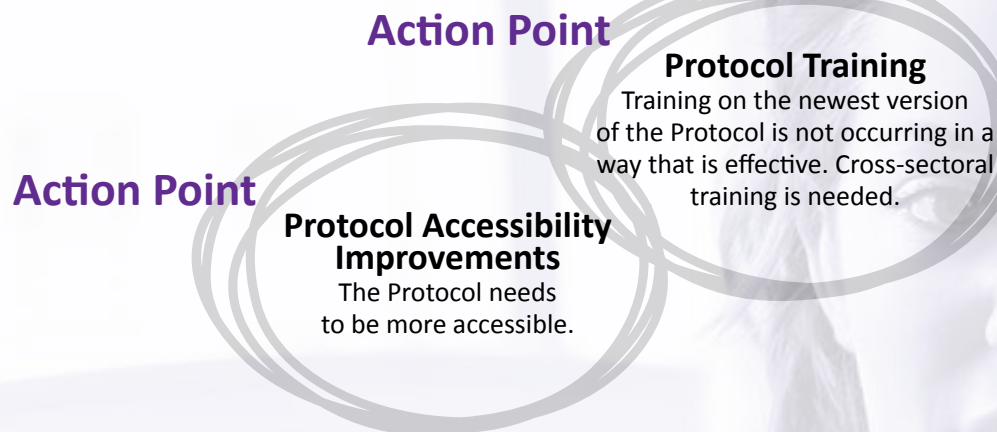
One of the research questions asked about the extent to which the Protocol meets the needs of service providers. The findings suggest that while it has been useful in some ways, **a more accessible format and additional training would be helpful**. Overall, 63% of service providers who completed the online survey and 84% of service providers that participated in a focus groups reported that they have read the Protocol. Service providers generally noted that the Protocol can be helpful in their work with women, but many reported not being very familiar with all of the content.

Training is described in the Protocol as “essential” in order for successful implementation. Service providers reported that this training has not occurred for the 2010 version of the Protocol. **Most service providers reported that they had not been trained on the Protocol**. Only 2 out of 19 service providers that participated in a focus group reported being trained. Additionally, less than half (47%) of service providers who completed the online survey reported being trained on the 2010 Protocol.



Service providers cited the importance of training and education. Of the 44 service providers who reported in the online survey that they were trained on the Protocol, 80% strongly agreed or agreed that the training prepared them to apply the Protocol to their work. Overall, this group only represents 37% of all service providers who completed the online survey, while the remaining 63% were either untrained or stated the training has not prepared them to apply the Protocol.

Cross-sectoral training is noted in the Protocol as **“enabling service providers to appreciate the role each service has in responding to sexual assault and domestic violence. This in turn will build stronger partnerships and working relationships and reduce barriers between agencies”** (pg. 22). The cross-sectoral training was also identified by service providers in focus groups as potentially valuable, but is not happening. Service providers noted that **being able to meet other service providers face to face is very helpful for them in building professional relationships that can help them support women**. Service providers requested trainings where they could increase their knowledge of the various systems and build relationships with other service providers.



PROTOCOL OBJECTIVES OF A CONSISTENT AND CARING RESPONSE

The research asked about whether the following Protocol objectives are being met: a consistent, caring and effective first response consists of three primary interventions:

1. Explaining confidentiality, the limits of that confidentiality, and obtaining informed consent
2. Offering safety planning and risk assessment
3. Making appropriate referrals and providing follow-up and support.

In this context service providers should: meet with women in a place that is safe and private; clearly describe services and what type of assistance the woman might find helpful; identify the potential implications of accepting their service; provide the opportunity to ask and have questions answered; listen to her story in a respectful and non-judgmental manner. (pg. 5)

In the online survey, 2/3 (59%) of service providers “strongly agreed” or “agreed” that their response to a disclosure of domestic violence would fit with the response outlined in the Protocol.

WHAT IS THE FIRST RESPONSE? HOW IMPORTANT IS IT?

The Protocol focuses on an effective “first response” to a disclosure of domestic violence or sexual assault. **No specific timeframe** defines “first response”. In most cases, although questions were asked about the first response, women answered based on their **overall contact with a service provider**, not only on what took place in the first session or interaction.

Women reported an **average of 4 contacts with different service providers**, with the number of service provider contacts ranging from 1 to 13. Women often shared that it was a **very stressful time in their lives** and that they had contact with multiple service providers during that time. They could not always clearly recall what had happened during their first interaction with a specific service provider. It was clear from the interviews that women’s experiences of ongoing service delivery created an **overall impression** of an agency and this is what mattered most to them.



Action Point

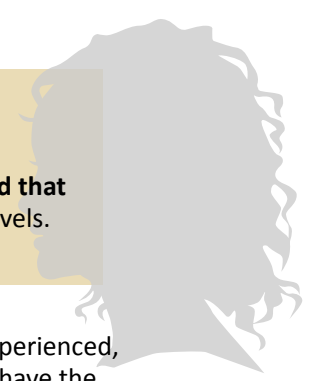
Overall Service Delivery

Women’s overall impressions of an agency’s service delivery mattered more to women than their first interaction with the agency.

FIRST RESPONSE AND PRIVACY

The Protocol asks service providers to “**meet with women in a place that is safe and private**”. (pg. 5) Women reported that their first disclosure to specific service providers took place in a variety of locations. Overall, women said that they disclosed experiencing SADV to a service provider in a private place 81% of the time. This means that **1 in 5 women disclosed in a place that they did not consider private**.


Sometimes these less private disclosures took place in waiting rooms, over the phone, in public locations, in public areas of agencies, or in their homes if the police were called. In some instances, like when the police are called to the house, **the person who was abusing them was within earshot of the conversation**. Many women who had been in these situations reported that they did not feel they were afforded the privacy they needed to feel comfortable or listened to.



Interviewer: *Did you have an opportunity to ask questions?*

W#5: Somewhat, but **[my husband and I] were still both in the house and that made it a little difficult**. A small two bedroom house you know sound travels. So some questions yes, other questions no.

Women shared that when they are ready to disclose the abuse or violence they have experienced, it is important that service providers let them know they are being heard and ensure they have the privacy needed to speak comfortably.



Interviewer: *Was there anything that was said or done that was supportive or is there a way that they could have been more supportive?*

W#1: Making me feel that I was being listened to would be nice. [...] Not like being so distracted with other things like you know. Like if somebody is talking to you, pay attention [...] **Maybe even just take them somewhere where they can talk privately or don't keep getting interrupted by people**. You know? People are standing around listening to you. [...] I just didn't like it at all.

What women perceive as their first disclosure to a specific service provider may not always happen in a private or clinical setting and **may not be recognized by service providers as a significant disclosure.** However, these disclosures can hold great weight and significance for women, regardless of where or how they take place. Women who felt that their first disclosure with an agency **was not private enough** for them to feel comfortable often reported this aspect of their contact **negatively. This first impression of a service could prevent them from further accessing this service.**

Action Point

Privacy is Important

Sexual assault/domestic violence disclosures for women are significant and may not look like service providers expect. A positive or negative experience during a disclosure can have a significant impact on women.

Tension Point

Privacy

What feels like “privacy” for service providers is not experienced as “privacy” by women, e.g. disclosures that occur in waiting rooms, over the phone, in older buildings where sound travels, or when the abusing partner is close by. This can impact whether the woman discloses and feels comfortable and/or heard.

EXPLAINING CONFIDENTIALITY

The research asked how much the Protocol objective of explaining confidentiality is being met. The Protocol states **“the limits of confidentiality – what can be held in confidence and what cannot – will be explained to every client.”** (pg. 6)

Of the primary interventions listed in the Protocol, **explaining confidentiality was reported by both women and service providers as the component most often completed.**

Almost 75% of service providers reported that they “always” explain confidentiality to clients, and 7.4% said they explain confidentiality “more than half of the time”. Reasons for not explaining confidentiality included it not being applicable in the service provider’s role (as they were not front line workers),

or confidentiality was already explained to the woman by someone else in the agency. Of the total number of contacts (n=143), women reported that 78% of service providers explained confidentiality and the limits thereof.



All of the agencies who participated in a focus group reported having a formalized informed consent process that included explaining confidentiality and having the woman review and sign a form. Some service providers noted there can be tension between adhering to the duty to report if a woman shares information that is outside of the limits of confidentiality (such as a disclosure that would need to be reported to Family & Children’s Services), and their own values and approach of “meeting a woman where they are at” while also trying to maintain a relationship with the client.

Women sometimes reported **confusion about their rights to confidentiality when they were being investigated** by Family & Children’s Services or the police. Family & Children’s Services workers noted in their focus group that when investigating a family, they obtain consent to get information from other service providers as a best practice, **but consent is not required by the Children and Family Services Act.** When a family is investigated by Family & Children’s Services or the police, women are often unclear about the limits of confidentiality with other service providers.

My Children's Aid worker was like ... calling in [to another agency] and wanted to talk to them or whatever. So I just remember them saying ... wanting me to sign a form for her to [release information]... and then I said well what if I don't want to sign it? Because they said if I sign it she can get all my files from whatever. And they said "if you don't sign it she could go to court and they could get all your files instead ... they could go back forever." **So I kind of felt like I was forced into signing something.** Because I feel like "well we're Children's Aid", right, because if you don't sign stuff [...] then they can force you to do it. So there is confidentiality but not really.

I just really wished [the Police] had of warned me when I came in...this sounds so silly but I didn't realize he'd be arrested...after everything kind of blew up I was scared that [abusive partner] was going to retaliate on me and then at the end after I was interviewed privately [by the police] [...] the officer said to me "well now we're going to arrest him" and I was like "oh my gosh", like I had no idea. So I think it would've helped. — W#18

The importance of explaining the limits of confidentiality was also highlighted by women who disclosed domestic violence to the police. **Women reported that not understanding the police's policy to arrest and charge abusing partners**

undermined their ability to make informed decisions. By being clearly informed of the limits of their confidentiality and choice, women can make informed choices about what information they do or do not share with service providers.

Action Point

Informed Decisions

Explain the limits of confidentiality to women to help ensure they make informed decisions about the information they share.

Action Point

Different Limits of Confidentiality

Not all services are voluntary or have the same level of confidentiality. These differences need to be more clearly explained to women by all service providers.

Tension Point

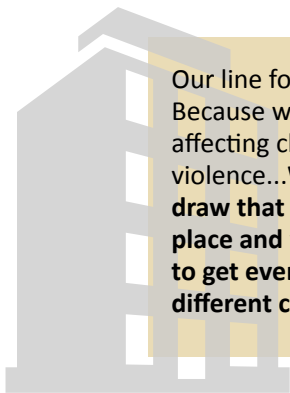
Duty to Report

Tension exists between adhering to the duty to report if a woman shared information that is outside of the limits of confidentiality and "meeting a woman where they're at," as well as maintaining the client relationship.

RISK ASSESSMENT

The Protocol states that “service providers should ask their client if they have previously completed a risk assessment and if so, check if the assessment needs to be updated to reflect changing circumstances.” (pg. 7) The Protocol **does not recommend a specific risk assessment** tool. The Protocol combines safety planning and risk assessment into one step, but the research team approached these components separately, understanding that safety planning naturally follows risk assessment, as risk assessment helps service providers to gain a fuller picture of the abuse women have experienced.

The Protocol includes a risk assessment tool, which was the most commonly used risk assessment tool cited by service providers. However, overall service providers noted that there is no prescribed tool to be used and there is disagreement within and between agencies about the definitions of abuse and “high risk”. In focus groups, most service providers reported **no formal procedures for completing risk assessments**, with the exception of the Women in Crisis focus groups.⁸



Our line for where we consider something violent should not have to be a charge was laid. Because what we see if we see emotional abuse, financial abuse, we see other things that are affecting children or patterns of behavior or communication style long before it's escalated to violence...**We even are inconsistent as workers, as supervisors, as an agency as to where we draw that line....**We kind of go back and forth on that still. **Women in Crisis want us in a certain place and we're not in that place, and criminal justice is in someplace else and it's really hard to get everybody on the same page because we do have different definitions, we do have different clientele.** – Family & Children's Services service provider

The online surveys revealed that 72% of service providers always ask questions to help determine how much risk a woman might be in and 9% said they do this more than half the time. Thirty-two percent (32%) of service providers always complete a risk assessment with clients and 14% said they do so more than half the time. Service providers said they would not complete a risk assessment if: they were referring the woman to another agency for a risk assessment; if it was not applicable to their role; or if they needed to build rapport with the woman first.

Women reported that they were aware service providers were asking them questions to determine how much danger they were in 59% of the time. **Only one quarter (26%) of women said they completed a formal risk assessment** with the service providers they were in contact with. Some women noted that when a formal risk assessment tool was used that it was educational for them by helping to connect different experiences and appropriately label them as abuse.

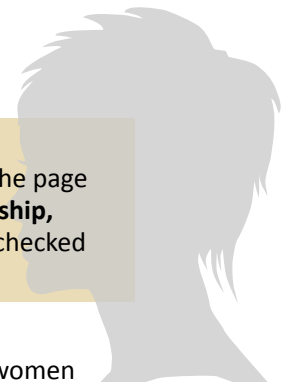
⁸ Women in Crisis and Marianne's Place Shelter.



72% of service providers reported that they always ask questions to help determine how much risk a woman might be in.

9% said they do this more than half the time.

Yeah, it's good to do that [complete a risk assessment] just even for yourself to look at the page and go "what?" Do you know what I mean, like **that's what made me leave my relationship, because I did an assessment** – a control assessment and I couldn't believe how many I checked off. — W#20



While some service providers said they refer to another agency for risk assessments, both women and service providers noted that **giving referrals does not guarantee that women will follow through on that referral.**

Action Point

Protocol Expectations for Risk Assessments

The "First Response" Protocol expectations suggest that *all* service providers can and should carry out the objectives in the same way. This does not recognize that different agencies play different roles.

Action Point

Risk Assessment Tools

Collectively deciding what risk assessment tools to use and how to interpret them could benefit both women and service providers.

Action Point

Risk Assessment Referrals

Referring women to other agencies for risk assessments and/or safety planning does not guarantee that the "first response" will be completed.

Tension Point

High Risk

There is disagreement within and between agencies about the definitions of abuse and "high risk."

SAFETY PLANNING

The Protocol states **“Safety resources will be reviewed with every woman who discloses woman abuse and where appropriate, sexual assault”** (pg. 7). The findings revealed that service providers were most reliant on referrals to other agencies for safety planning.

The online survey revealed that 62% of service providers “strongly agreed” or “agreed” that they felt confident developing a safety plan with a woman. Fifty-one (51%) percent said they “always” develop a safety plan with a woman experiencing domestic violence or sexual assault, and 16% said they do so “more than half of the time.” Overall, women reported that 57% of service providers talked to them about their safety, while 39% made clear safety plans with them. In these cases, women identified that safety planning, both ongoing safety planning and thorough safety planning checklists, were helpful.



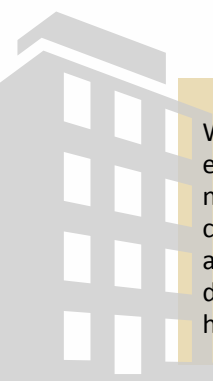
They gave me tons of paperwork. They gave me copies of the safety plan. They gave me a whole book on safety proofing your house. And they talked about putting in darker curtains and putting in alarms on the windows. **They were so thorough and so business-like about making sure that everything was done. And everything was signed and put through so that they knew that they didn't skip one thing.** — W# 9

One thing [...] that I enjoyed was that they did safety planning on a continuous basis, it wasn't just we do it once and then it's done. [...] I talked to the staff a lot about what was going on and how things were changing and different things and they would say “ok, well this little thing has changed [...] so we need to do another safety plan because we need to take that into account now.” So they're very good at helping you. **And once you start doing that on paper with somebody helping and guiding you through it [...] it teaches you how to do it in your head, so now I do safety planning everyday, but I don't need somebody sitting down to do it with me because I've been trained how to do it myself.** — W#17

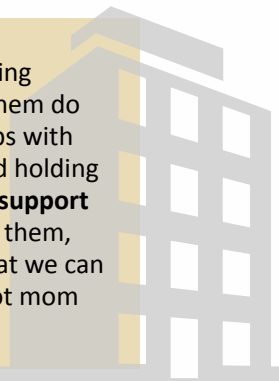
Some women reported that **safety planning was not necessary** in their situation because the abuse they disclosed was historical. This **distinction between current and historical abuse is not made in the Protocol**.

Referring to “Experts” for Safety Planning

There are Action Committee agencies that specialize in safety planning, and not surprisingly these agencies were identified as the most common referrals for safety planning. Service providers and women identified **Women in Crisis and Victim Services as “experts” in safety planning**. Service providers that participated in a focus group stated that they have **no formal expectations mandated by their agencies for safety planning** and they generally refer women to Women in Crisis.

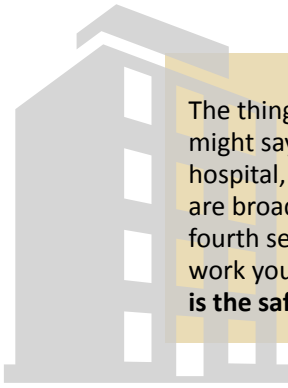


We don't really have [agency expectations for safety planning], again because honestly the experts on that would be Women in Crisis, [...] like I would not want the client to leave my office not knowing where they're going to or where their next stop is, and we have actually escorted clients directly to Women in Crisis because **we know they can do the safety plans**. But ourselves as an agency, as least for our job [...] we don't make any safety plans with our clients [...] we just do it informally, just making sure we take into account where are they going, where are they headed, who might be outside waiting for them. — John Howard Society service provider



If I hit the high-risk checklist and there's a lot of things there I'm worried about, I'm calling Women in Crisis. I'm booking an appointment, we're going in together and I'm letting them do the safety planning. They're the experts in that, they have the collaborative relationships with the Police. I'll do the basic stuff for them and the kids and give them ideas, but I'm hand holding and saying **“come, let's go talk to the people that this is their focus and they can help support you in this because that is all that they do.”** And that's where I'm going to try and help them, because they're **going to get more time and support through the VAW sector** than what we can give them. Our focus is those kids and not necessarily going to always be whether or not mom has a safety plan with her work. — Family & Children's Services service provider

Although safety planning is not necessarily something that all service providers focus on or have confidence doing, service providers from Women in Crisis talked about **safety planning being an “innate” part of their work**. They noted that **they have formal documents to refer to**, although **they are not formally trained** on safety planning.



The thing about safety planning is that it's always changing every time you meet a woman. She might say "I'm going to the hospital" and you might say "Oh, okay well how are you getting to the hospital, where does he live?" **It's always in relationship to the ex-partner.** So those questions are broad based questions but as workers you become – **it's just part of what you do.** Every fourth sentence it feels like you're checking in on some level around safety, because that's the work you do. And so, yeah it's...it just feels like **that's probably the most innate part of our work is the safety planning piece.** — Women in Crisis service provider

Overall, safety planning seemed to be understood as a **specialized service only to be performed by "experts"**. The problem is that **relying on other service providers for safety planning leaves potential gaps for women** if the woman does not follow through with the referral. As a result, the woman may not receive any safety planning at all.

Action Point

Protocol Expectations for Safety Planning

The Protocol does not recognize that safety planning may not always be necessary depending on the results of the risk assessment.

Action Point

Safety Planning Tools

Build and share a common safety planning checklist.

EFFECTIVE FOLLOW UP AND REFERRALS

The Protocol states **“Each woman will be informed of her choices and options for services based on her unique situation. Referrals to resources that will ensure support for a woman’s physical, medical and emotional needs should be offered to every client and service providers should offer assistance if needed”** (pg. 8). This paragraph emphasizes the importance of a differential response to domestic and/or sexual violence.

What is “Follow Up”?

The meaning of “follow up” is not clearly defined in the Protocol, but in many cases following up is in conflict with service agencies’ mandate or practice of giving women the choice about whether or not to engage with a service. Overall, many service providers said they follow up with women during scheduled appointments to see how they are doing and check-in about contact with referrals that were given. However, due to mandates and lack of time, service providers generally do not contact women outside of scheduled appointments.

Referrals

Women said they **often received referrals from service providers, but did not always follow through** because the referrals **did not seem relevant to them** or they **did not have the energy** to make contact with a new service provider. This was echoed in the service provider focus groups, which they emphasized that they can ask whether or not a woman has followed through on a referral and they can ask how those services are going, but accessing services or not is the woman’s choice.

I ask [women] if they want to come to group and...if they say no, then a few weeks later, “what do you think of group now” or, you know. It’s kind of ongoing and you **don’t force everything on people**, but you make sure **there’s a buffet there** and you kinda tell them, I ask them to advocate for themselves like **I don’t think you need to go to an appointment every day of the week, but maybe pick one or two that seem to fit for you.** — Family Counselling & Support Services service provider

Service providers were asked in the online survey to identify the top five referral agencies for SADV clients. The results revealed that Guelph-Wellington Women in Crisis was top referral agency for SADV clients (score = 68). This was followed by the Sexual Assault Care and Treatment Centre at Guelph General Hospital (score = 44) and the Guelph Police (score = 34). See Figure 7 for a visual of how local agencies scored as referral sources for SADV clients based on data from service providers.

⁹ Score indicates the count of the times an agency was mentioned as a referral source by SADV clients by service provider respondents.

Figure 7. Agencies SADV Clients are Most Frequently Referred to in Guelph-Wellington



Bridging Services and Advocacy

Accompaniment, support and advocacy were identified by service providers and women as a helpful way to “bridge services” and better connect a woman with new service providers when providing a referral. Women reported that they felt supported and got better results when service providers made the phone call with them to set up an appointment with the new agency, attended the first appointment and/or were in communication with other service providers on their behalves.

Women noted that they especially appreciated accompaniment when going through the legal system and interacting with police and the court systems. They also appreciated accompaniment during their encounters with Family & Children’s Services. Women reported **that these agencies were intimidating due to their power and authority.**

So I do think like, you know, that they do have a hard job or whatever [...] but I feel like you know, **if someone’s telling you they’re scared to go to the Police Station and they’re saying “go to the Police Station” [...] Would you not go with them?** Or send somebody with them? I know they have those services but I was unable to advocate for myself and say “look, you guys need to help me.” I couldn’t do that at the time. — W#2

Some women reported that **they did not receive the support needed unless they were accompanied to their appointment or another service provider advocated on their behalf.**

...When my [other worker] came, **she [current worker] was attentive...** I felt that it was more **[detailed] when my [other worker] came with me...** I found it way more helpful when there’s all three of us sitting down... [other worker] knows what kinda questions to ask, I’ve never been through this... — W#18

Action Point

Bridging Services

Accompaniment, support, and advocacy are significant ways to “bridge services” and can effectively and efficiently connect a woman with new service providers.

Action Point

Defining Follow Up

The Protocol does not clearly define follow-up. The definition should be clarified and needs to be more clearly explained to women by all service providers.

Tension Point

Connecting but not Pressuring Women

Tension exists between service providers trying to ensure women are connected with the support they need, while wanting women to freely choose services without feeling pressured.

DIFFERENTIAL RESPONSE

Under Effective Follow-Up & Support, the Protocol also notes the importance of a differential response, stating: **“A differential response to domestic violence recognizes the unique characteristics and dynamics of each situation require an individualized response. A differential response examines each situation in its context from a holistic and strength-based approach”** (pg. 8).

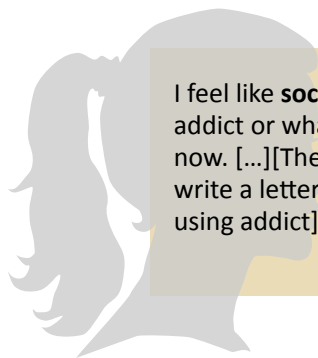
This response in the Protocol is highlighted in reference to women making their own choices about staying in or leaving an abusive relationship. In the research, “differential response” was also taken by the researchers to include identity factors that will shape each unique situation such as income, race/ethnicity, ability, sexual orientation and English as a second language.

Judgment from Service Providers

In some instances, women reported that they were not believed, and were judged. As a result they were denied services based on:

- appearance,
- addictions,
- low income,
- employment status,
- mental health, and
- abusive partners influencing service providers’ perceptions of the woman.

These women reported that they sometimes **needed another service provider to advocate on their behalf in order to access basic quality services.**



I feel like **society let me down at that time.** What I feel like now, because I’m not like a using addict or whatever, I would be treated different. And plus, I know how to stand up for myself now. [...] [The agency] wouldn’t help me [...] then I go to the Legal Clinic and they help me to write a letter and then they call back two hours later and help. Where before [when I was a using addict] they said no, they can’t [help me]. — W#2

Not a “Cookie Cutter” Approach


Many service providers shared that they **try to ensure access and quality service for all women by assessing women’s individual needs and then identifying barriers and appropriate referrals.** This could include advocacy with other service providers, arranging for language interpreters, meeting a woman in the community or over the phone and working closely with other support workers. Some service providers cited a purposeful differential response of **“meeting women where they’re at”.**

If it were a cookie cutter approach, we would lose our clients. That’s part of why women come here – I believe. And so yeah, sometimes it’s not appropriate when a woman’s frightened and she’s making a disclosure about an abuser to ask what he looks like...you just know that and that would be our agenda because we feel we have to do it. And so you have to gauge that with each individual, because **you could lose a client or it could shut down the conversation. So it’s fine to put those expectations in place, but they don’t always play out like that** and they can’t and if they did, we would be a cookie cutter organization and no one would want to come. – Women in Crisis service provider

This approach of recognizing and responding to different needs and factors was contrasted with service providers who stated that they **try to ensure access and quality service by using consistent procedures and treating all clients the same.**

Tangible Supports

Women reported that practical and tangible assistance and resources were one of the most helpful things they received from service providers. Service providers also recognized that these resources were helpful and necessary for women in the process of managing and rebuilding their lives.



I got into Housing before I left the shelter. You know they made sure like within a few days... when I was in the shelter they gave me spending money because I didn't have any....they gave me money to start me off so I could get around by bus... If I had come and they didn't have room for me I don't know what I would have done. — W#11

My apartment got fully furnished from the community...because I had nothing but the clothes Sister Christine gave me. — W#33

Action Point

Judgment/Not Believed

Some women reported feeling not believed and judged based on socio-economic and employment status, mental health or addictions, or due to their abusive partners influencing the service providers' perceptions of the woman.

Action Point

Practical and Tangible Resources

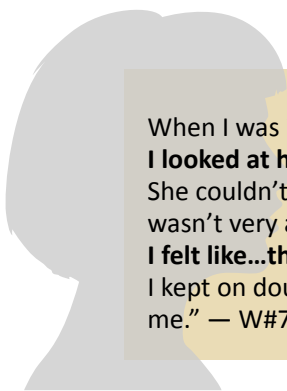
These are important as ways to help meet women's specific needs (e.g., bus tickets, vouchers and food and clothing, child care services, emergency alarms, pamphlets).

UNDERSTANDING AND EMPATHY

The final section of the Protocol reads: **[The Protocol] cannot replace the most important quality we can all bring to our work – our understanding and empathy. It is not only what we say or do that will be remembered, but also how we make a person feel when he or she comes to us for help that will be remembered (based on the quote by Carl W. Buechner). By providing a consistent, caring, and respectful first response as well as coordinated, effective follow-up and support to those who experience domestic violence and sexual assault, we can help make this community safer for all. It is our firm belief that there should “no wrong door” for any one to come to, when seeking assistance in dealing with domestic violence and/or sexual assault” (2003, 23).**

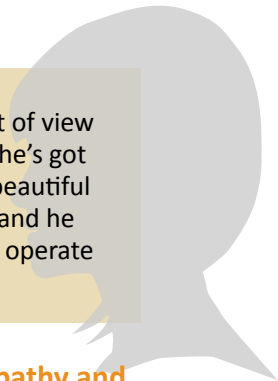
The importance of understanding and empathy was echoed throughout the interviews with all of the women. They reported **how service is delivered is equally as important as the content of the service.** Women reported positive experiences with service providers if they demonstrated **attentiveness, accommodation, care, compassion, respect, empathy, non-judgment, patience, understanding, and validation.** Service providers mentioned similar qualities when asked how they make a woman feel supported. Service providers also added helping women to maintain some control with the small amount of power they might have in the situation, being sensitive to religious and cultural values, and using a differential approach with every woman as ways they make a woman feel supported.

The how of service delivery was paramount for women and often came down to a service provider’s personality as well as skill. Women reported feeling unsupported when service providers did not demonstrate caring qualities. In fact, sometimes women identified **feeling further victimized as a result of treatment they received by a service provider.** Some women even reported feeling victimized by programs that are specifically designed to meet the needs of women that have experienced violence.



When I was in her office, it was not the most calming experience...**I remember every time I looked at her and I could see the look on her face changing even more to a frustration level.** She couldn't get me to stop crying enough to answer her questions. I wasn't able to, and she wasn't very accepting of that...In the meantime I felt like I was going into the black hole. **I felt like...this woman is not getting what I'm trying to say to her.** Is it really my imagination? I kept on doubting myself from the look on her face and the tone of voice she was using with me." — W#7

Experiences with service providers who were supportive and empathetic were very positively remembered by the women.



I just feel like this [police officer] gets it...he's so helpful, he listens to the woman's point of view and doesn't take anything outside of that... You feel like **"oh, finally someone gets it"**...he's got a sense of humour, but he's very strict too, like he's the kinda person who's got such a beautiful balance – you know very strong and firm, but also human. He's just so great, he listens and he understands the male mentality, the controlling abusive mentality...he knows how they operate right, and you know it's just second nature to him. — W#20

While the Protocol outlines steps to a consistent and caring first response, the **value of empathy and understanding** in this response should not be underestimated. As the interviews reveal, the way women are treated when disclosing abuse and during their ongoing interactions with service providers was revealed to be the most important aspect of their experience.

Action Point

The *How* of Service Delivery

How a service is delivered is equally as important as the content of the service being delivered. Service providers' personality and skills play a large part in determining whether a woman's experience accessing and receiving services is positive or negative.

Action Point

Increased Awareness of Services

Increased awareness of the services that agencies offer can greatly impact women's service provision experience.

COORDINATION AND COLLABORATION

“Collaboration takes time, effort and creativity - sometimes the “status quo” is easier” – service provider

The first research question asked about coordinated, effective follow-up and support and whether collaboration, coordination and planning between Action Committee agencies helped service providers use the Protocol and work more effectively together. Collaboration and coordination were examined both between Action Committee Representatives and Action Committee agencies, specifically through community partner consultations and the High Risk Team.

Overall, **both women and service providers suggested there was room for improvement when it came to coordination and collaboration.** In fact, women largely shared experiences of isolated service delivery. This section mainly focuses on the barriers/challenges of coordination and collaboration experienced between service providers. Despite the limited coordination and collaboration happening, comments were made about the benefits of coordination and collaboration, resulting in improved service delivery. Women also noted multiple benefits to service provider collaboration.

I think the main thing with all of them [service providers] is **that there is a disconnect** – a complete disconnect of communication between them...they don't communicate with each other to be able to be effective. — W#17

... I have had this **circle going and they all knew what was happening** with the [ex-partner] so they would be able to communicate what they needed to...know. — W#20

Action Committee Representatives

Action Committee Representatives who participated in the online survey were asked about collaboration at the Action Committee table. Service providers who are not Action Committee Representatives also commented about the Action Committee. For example, one service provider said they did not understand the role of the Action Committee, “I don't even know what they do! I don't know the purpose of the Action Committee! Other than the Protocol I have no idea. Are they holding agencies accountable for their actions? If I don't know what they do then I don't know how to tie accountability into that”.

I think one of the advantages of the Action Committee has been that there's a **heightened sensitivity among stakeholders about what each agency does and how they operate...**
– Family & Children's Services service provider

The majority of Action Committee representatives (75%) attributed collaboration barriers to working under different agency philosophies, mandates, and agendas.


Different mandates can sometimes feel like 'who is most important' and turn into a competition instead of a collaboration. — Action Committee representative

Agency representation at the Action Committee table was identified as a specific challenge to coordination and collaboration. For larger agencies, an Action Committee representative from one service or program may be present at the table, yet there is an appearance that the entire agency is on board. This has specific implications for the Protocol, meaning training may not be occurring agency-wide, even though it appears that the agency is a signatory to the Protocol.

... Some people at the agency have no idea what the Protocol is, so how can you say that an entire institution takes it on when there are very few places that have access to the resources and access to the training? — service provider

Varying levels of trust and feeling valued at the table was raised by Action Committee Representatives. Tension between representatives over “turfism”, conflict, and poor communication were noted as barriers to collaboration.


**75% attributed collaboration barriers
to working under different agency
philosophies, mandates, and agendas.**



I have good relationships with everyone at the table but I have heard participants make comments to me privately that indicates a **lack of trust at best and anger, conflict, poor listening skills at worst. Some just show up and want to do their part, others have high expectations and/or don't think the other 'gets it'.** — Action Committee representative

Dismissive attitudes towards other member's knowledge and experience around the issue of violence against women. **WIC postures as if only their staff actually understand the issue,** and so they are the only 'experts' at the table. — Action Committee representative

Another barrier to coordination and collaboration includes a **lack of engagement, commitment and/or involvement** between agencies or between agencies and the Action Committee. The lack of representation of some agencies at the Action Committee table and/or the lack of full involvement was reported. In some cases this was perceived by other Action Committee Representatives as a lack of commitment, but some service providers explained that it is due to a lack of resources.



...I'm stretched to sit at many tables and sometimes **when I can't commit to everything at the Action Committee, it feels like some might think I'm not 'on board'.** I am totally committed, want to influence systems to better respond to violence against women, and am trying to push staff at my agency – but **these things take time and we do our best...**but for sure we can always do better. — Action Committee representative.

...Different agencies have different number of staffing so not always able to attend. Which is unfortunate however a reality, **if unable to attend being made to feel guilty is not the right approach.** — Action Committee representative

Tension Point

Different Mandates

Different philosophies, mandates, and agendas reduce collaboration.

Tension Point

Illusion of Full Agency Participation

The appearance vs. reality of Action Committee membership and the resulting impacts on involvement and Protocol implementation.

Tension Point

Communication and Trust Issues

Varying levels of trust and feeling valued, “turfism”, conflict, and poor communication.

Tension Point

Lack of Engagement and Resources


Perceived lack of engagement, commitment or involvement. Some agencies lack resources to put towards Action Committee tasks or other collaborative work.

COLLABORATION BETWEEN ACTION COMMITTEE AGENCIES

Community Partner Consultations

Community Partner Consultations are commonly referred to as “case conferences”, and are highlighted in the Protocol as a communication strategy to assist with coordination and collaboration. The Protocol states: **Case conferences may be initiated by any community partner or service provider to review cases and share information for ongoing high risk situations, to advocate for a client and assist her in taking control of her life whenever possible, and to support her efforts to protect herself and her children. Case conferences may also be used to identify and advocate for strategies that hold the offender accountable and to review and evaluate the intervention and outcomes”** (pg. 9).

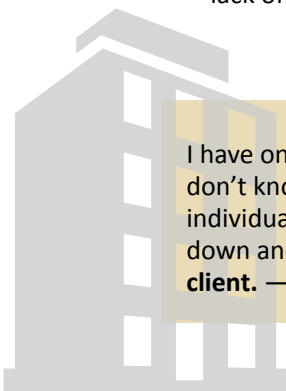
Although the majority of the women who were interviewed did not participate in a case conference, they felt that it would have been helpful. **Three out of 33 service users who were interviewed participated in a community partner consultation.**



[A case conference] would have been fantastic because then I would've had this opportunity that someone in the community felt "yeah this is an issue...and **let's acknowledge that instead of [participant] running from this building, to this agency to this agency you know and doing it all by herself.** — W#22

Service providers reported benefits and challenges to case conferences. Challenges included the time it takes to coordinate schedules and sort out who the appropriate contact is, especially when working within a context of high volume workloads. Other challenges included:

- inaccurate understanding of other agencies' roles,
- different agencies' approaches/mandates/agendas,
- limits to sharing information and confidentiality,
- not having a woman's consent to hold a case conference,
- lack of realistic action plans.



I have one comment just about case conferences...I don't know that they're working. And I don't know that they [accomplish]... Sometimes I think more happens with the one-to-one individual counsellor peer support person who's taking on those pieces and just it's too watered down and **sometimes I feel the client is secondary, it's more about the optics than it is about a client.** — Women in Crisis service provider

Some of the issues mentioned by service providers as challenges to case conferences (e.g., the time it takes to set one up) were also mentioned as potential strengths (e.g., time saved since everyone is at the table). The **potential for increased coordination, consistency, and efficiency** was mentioned as something that would benefit both women and service providers. This also reduces the number of times a woman has to share her story. The shared discussion space can also provide an opportunity to clarify roles and expectations between agencies.

While different mandates and perspectives were generally perceived to be a disadvantage (e.g. philosophically for some agencies such as Women in Crisis, a case conference would not be held in a woman's absence); in other ways, **difference was recognized as an opportunity to hear about and incorporate more ideas and possibly better solutions.** It was suggested that these potential benefits could result in better support for women, especially in high-risk cases or cases with special circumstances. It also has the potential to increase accountability across service providers and agencies.

Tension Point

Benefits vs. Challenges of Case Conferences

Benefits and challenges for case conferences can be one and the same.

The High Risk Team

The Protocol states that a High Risk Team would be developed “to review cases where there is an identified high risk” along with “a commitment to formalizing the link between the High Risk Team, Community Partner Consultations and DVERS¹⁰ for the purpose of ensuring safety of all women and children in high-risk situations regardless of whether they are before the courts or not” (pg. 10).


Feedback from service providers said there were two main problems with the current High Risk Team model:

- lack of clarity on criteria and process for high risk cases, and;
- lack of information sharing and trust for service providers outside of the High Risk Team.

Service providers stated that the criteria and process for dealing with high risk cases need to be reviewed, clarified and updated for all agencies. Feedback suggested that the criteria might be too narrow and therefore limit the potential for the police to be involved in cases where no physical assault has occurred.


Lack of Clarity on Criteria and Process for High Risk Cases

Service providers suggested “more communication around high risk clients and the Mobile Emergency Response System (MERS) program is needed and clear details about the referral process would be helpful”.



High risk criteria is **based on charges** and less on risk and danger. — Family & Children’s Services service provider


Cases that fall outside the justice system are not covered well. Extenuating circumstances are not covered well. — Women in Crisis service provider



¹⁰ As of 2013 the DVERS (Domestic Violence Emergency Response System) program is no longer running and has been replaced by MERS (Mobile Emergency Response System).


Lack of Information Sharing & Trust for Service Providers Outside of the High Risk Team

The potential for coordination and collaboration **can be impeded by a lack of information sharing**, which has been associated with a **lack of trust** between certain agencies. Some service providers who are not part of the justice sector (e.g., Women in Crisis) feel locked out of the high risk process. In particular, lack of involvement in the High Risk Team was perceived to be related to a lack of trust and being less valued than other agencies. There is concern that this exclusion of some service providers creates barriers for women.



I believe [the High Risk Team] meetings are case conferences and they are extremely effective. **I would like to see us be able to include other agencies at these meetings for specific cases they are involved with already.** — service provider

There is a disconnect between [Women in Crisis] and the high risk committee. I feel **there is mistrust on their part of the DVHR as a whole.** Some of this is due to the lack of ability to share information. — service provider



Tension Point

High Risk Team Membership

Membership or lack of membership on High Risk Team.

CHALLENGES AND BARRIERS BETWEEN ACTION COMMITTEE AGENCIES

The following challenges were identified as barriers to coordination and collaboration between Action Committee agencies:

- Information & communication barriers (including community partner consultations)
- System and institutional barriers
- Diverse mandates and philosophies
- Level of value and trust

Information and Communication Barriers

There are many agencies in Guelph who offer great services, however, I am **not clear about what services they all offer**, so therefore links and referrals may not always get made. - service provider

Service providers were asked whether they were aware of services offered by other agencies related to SADV. The **majority of service providers said they were knowledgeable about other SADV services offered in the community**. Services offered by Women in Crisis (95% of respondents) and Family and Children Services (92% of respondents) were best known by other agencies, while service providers were least familiar with services offered by the Crown Attorney (58% of respondents) and ARCH (53%). Table 2 displays service providers' awareness of SADV services by agency:

Sector	Agency	No. of service providers who agreed they were aware of agency's services
Child Welfare	Family and Children's Services	92%
Community	ARCH (HIV/AIDS Resources & Community Health)	53%
	Guelph Humane Society	76%
	Immigrant Services Guelph-Wellington	67%
	John Howard Society of Wellington-Waterloo	57%
	Welcome In Drop-In Centre	59%
Education	University of Guelph	66%
	Wellington-Catholic District School Board	60%
	Upper Grand District School Board	68%
Government	County of Wellington – Housing Services	79%
	Ontario Works	(asked on online survey as County and Wellington Social Services)
Justice	Guelph Police Service	86%
	Legal Aid Clinic	70%
	Ontario Provincial Police	85%
	Victim Services Wellington	80%
	Victim Witness Assistance Program	61%
	Crown Attorney	58%
	Probation and Parole	70%
Health	Guelph General Hospital	80%
	Wellington-Dufferin-Guelph Public Health	71%
Mental Health	Family Counseling and Support Services	86%
	Homewood Community Addictions Services	86%
	Canadian Mental Health Association	83%
VAW	Guelph-Wellington Women in Crisis	96%

Awareness of available services and resources facilitates coordination and collaboration, specifically referrals between agencies. Alternatively, when service providers **lack knowledge about other agencies and available services, it can reduce women's access to needed resources**. Poor visibility and service providers' lack of knowledge about the Guelph-Wellington Care & Treatment Centre for Sexual Assault & Domestic Violence at the Guelph General Hospital (e.g., no signs, other staff not being aware) was identified as a significant barrier to accessing this service by women and service providers. Women reported that they often rely on service providers they are connected with to share information about the range of services offered by other agencies.

They were very knowledgeable. They had answers to a different realm of things, not just you know one area. They knew legal, financial, all kinds. Like they were just great. — W#5

I felt that there were **services that were available that I didn't know about**, that I was never made aware of. Things that I could've put to good use ... **and they weren't offered to me.** — W#17

Lack of communication was specifically identified as a challenge to coordination and collaboration. **Fourteen service providers indicated that they experienced either a lack of communication or had difficulties communicating with other service provider agencies.** In a few cases, service providers said that they were not able to communicate with another service provider because:

- their call was not answered,
- their call was not returned quickly, or they played telephone tag before speaking to one another, and/or
- they did not know who to contact from a particular organization.

Who to contact? Do I know someone there?

Service providers reported that it was important to know who to contact at another agency, but also have **a positive relationship or experience** with that person. For example, only 15-20% of service providers said they were able to identify someone at an agency in the community sector¹¹ that they had an established personal relationship with and would feel comfortable contacting. However, the majority of service providers said this would increase coordination/ collaboration. Comments such as, so and so **"has been helpful in the past"**, or **"I know her personally"** or **"I have a good working relationship and [she/he] has been at the agency for a long time"** were given as reasons service providers were more likely to communicate with another agency.

¹¹ ARCH, Humane Society, Immigrant Services, John Howard Society of Waterloo-Wellington, Welcome In Drop-In Centre

Action Point

Increasing Awareness of Mandates

Greater awareness/understanding of agencies' mandates, services and resources between agencies can facilitate referrals and improve access to services for women.

Action Point

Working with Differences

Further discussions on how to work together in spite of differences could be beneficial.

Tension Point

Personal Relationships

Lack of communication and personal relationships between agencies makes coordination and collaboration among agencies a challenge.

SYSTEM/INSTITUTIONAL BARRIERS

System and institutional barriers were identified as impeding coordination and collaboration between service providers. The **disconnect between family and criminal courts** was identified as an ongoing systems issue. Other examples include: **confidentiality, eligibility criteria for specific services, wait times and high caseloads, lack of resources, funding constraints, and administrative structures**. These are institutional and systems barriers because they are related to the organizational structure as well as policies/practices of the organizations rather than personnel issues.

Perceived or actual confidentiality constraints are another example of an institutional barrier. Service providers stated that agency referral processes can also be barriers, especially if they have not established relationships with other agencies.


...Another big problem is that sometimes the information can't be transferred; sometimes... you know Guelph Police has a **police report that they're not allowed to release to anybody**, so everybody else is sitting over here going "we need to know what happened so we know how to help this girl". The Guelph Police aren't allowed to give out the police report because of confidentiality, well I mean... come on...you need to give that to Children's Aid so they know how to protect the baby, right! — W#17

The referral process is not friendly. I have encountered that if you do not know someone there it is very difficult to get connected with someone to help our clients. — service provider

The Guelph Police and the OPP were highlighted as examples of agencies whose **different reporting systems** make it difficult to share information with other service providers. For example, not all police services collect and report statistics in a way that makes it easy to compare¹². Another reporting example is that the University of Guelph Campus Police has its own internal process for reporting sexual assaults. One service provider stated **"You're publishing that you only know of 1 or 2 sexual assaults a year, but you know damn well that's not the case"**. These discrepancies in reporting process/system leads other service providers to question the extent to which real collaboration occurs.

High caseloads were another institutional/system issue commonly reported. Service providers noted the lack of resources/funding and the impact this has especially for rural populations. Size of caseloads was also identified as increasing inconsistencies in service provision. Women identified that long wait times for specific services are an issue, especially mental health services.


¹² i.e. a "domestic violence incident" can refer to one or more related criminal code offences and so depending on how this information is identified, collected, reported and communicated, it can be hard to compare across different police services.



Size of caseloads often creates **barriers for being able to talk to workers in a timely way**. There are workers who have more training/knowledge about DV/SA, which does present **inconsistencies of services provided**. — service provider

The final systems barriers identified by women were the challenges and complexity of their involvement with agencies/systems. A few women reflected on their experiences as **overwhelming and time consuming**.

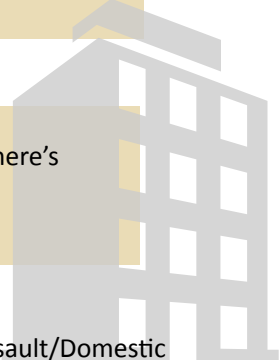
Different Philosophies, Mandates and Agendas




Some service providers suggested that the potential for “collaboration” as they understand it, between agencies with different mandates and philosophies is minimal. Some service providers specifically mentioned that the lack of a common feminist/anti-racist perspective increased challenges to collaborating.

If all agencies had a **more aligned vision**, it would be easier to collaborate successfully. — service provider

More education is needed around understanding what women – why they stay – and there’s **a lot of women blaming** still right, mother blaming. [other participants in agreement]
— Marianne’s Place Shelter service provider



Alternatively, positive working relationships and greater coordination between the Sexual Assault/Domestic Violence Care and Treatment Centre and Women in Crisis were attributed to working with the same philosophy.



That’s it – the women [at the SADV Care & Treatment Centre] are amazing. For me, it’s **they get it** – right. I don’t have to explain why I’m advocating and struggling so hard to try to connect a woman to a family doctor for medication because she’s got night terrors, I don’t have to explain any of it, they get it, as soon as someone from here is calling there’s no questions... **[The nurses] are compassionate, they’re funny and the feedback from women is amazing, they feel supported, they feel heard**. — Women in Crisis service provider

Comments about differences in mandates/philosophies surfaced most often when talking about **whether an agency's mandate is to "support" or "investigate" a woman**. This came up most often in reference to the police and child welfare. Family & Children's Services workers expressed feeling that other service providers do not understand the organizational limitations they work under. Child welfare agencies are often at odds with violence against women agencies or similar agencies that prioritize the "best interests of the woman" because of conflicting philosophies/mandates, creating tension that cannot be reconciled.

It seems to me that some **staff do not understand the limitations of the work of Family & Children Services**. I have a sense that challenges can arise between Family & Children's Services and Women in Crisis due to 'best interest of the child' vs. 'best interest of the parent', which may be competing interests. — Family & Children's Services service provider



Another service provider offered a similar perspective about conflicting mandates and suggested, "the mandate conflicts in a way that presents as **who is more 'important' the woman or the child** – which impedes a collaborative approach – but that depends on the worker". One service provider explained "... if you know that disclosing [to F&CS] is going to impact your relationship with your client, you are going to be cautious about collaborating".

In fact, the feedback from service providers suggests that the very definition and interpretation of "collaboration" may require further discussion, examination and critical thinking. For example, some service providers expressed concern about the way in which women can experience a systems' approach in that **all Action Committee agencies are understood to be mandated services**. For instance, mandated counselling by Family & Children's Services can have a negative impact on women's choice and agency. It was also noted that **some women may not want multiple service providers speaking about her**. A coordinated and collaborative model could also **lead women to have unrealistic expectations** about what they could expect because of the appearance of full system coordination and integration.

Tension Point

Differences

Different philosophies, mandates, and agendas reduce collaboration.

Tension Point


Downsides of Collaboration

In some cases, increased collaboration may negatively impact a woman's choice and agency.


Level of Value and Trust

The perception that some agencies are not as valued or trusted as others was highlighted by service providers. This was identified above in feedback related to different mandates/philosophies as well as agencies' relationship to the Action Committee representatives, case conferences, the High Risk Team and general interactions between service providers.

However, in addition to issues that arose around different mandates, there was also feedback by service providers about the extent or value in working with others and together. For example one service provider said they felt marginalized as an agency because they are not considered "clinical".



Some agencies don't seem to trust that other agencies are doing their jobs or don't do it as well as they do. — service provider



A small number of workers can begin working relationships with [F&CS] with **extensive mistrust and make assumptions about who we are and what we do** – I get it, but it can be tiresome when I'm busy. — Family & Children's Services service provider

Feedback and Suggestions for Improved Coordination/Collaboration

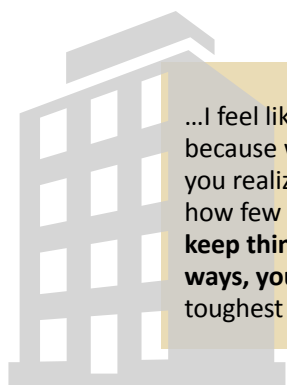
Service providers were specifically asked for ideas and suggestions about how to address coordination and collaboration challenges (Table 3).

Ideas/Suggestions to Improve Collaboration	Number of Service Providers
Education/Training/Forums	16
Increased communication	14
Shared website/portal	4
Meetings between front-line workers	3
More funding	3
First point of contact at each agency	3
More staff	3
Prioritize collaboration and plan for it	3

Table 3. Service provider suggestions on how to increase coordination and collaboration between agencies.

One service provider suggested moving toward a **more formal collaboration format**, such as having violence against women workers working out of Family & Children's Services.

Recognition that **all agencies are pressed for time** would go a long way in developing and maintaining positive relationships. Within a context of tightening budgets, strategies to address fiscal and resource constraints was supported. Finally, there was recognition that this is difficult work and service providers working with women and children who have experienced violence need more emotional support.



...I feel like it needs to be acknowledged **how tough this work is**...that's part of the frustration because when you know in your head how widespread it is and then when you start to do it and you realize, it's nauseating how much this is in our society, how many people are affected by it, how few people feel they can come forward and make some changes – it's exhausting! And **you keep thinking your diggin' away and you see that you're not really getting anywhere, in some ways, you are with individuals, but the problem is still there** and I think that that's one of the toughest things to deal with in this work. — Family Counseling & Support Services service provider

BEYOND THE PROTOCOL

Larger Systemic Gaps in SADV Services

Both women and service providers identified **larger systemic gaps and challenges** that affect SADV service delivery and women's experiences with Action Committee agencies, but extend beyond the limits the Protocol. Many of these gaps and challenges refer to the larger context in which women and children live. As a result, it is difficult for women to access services needed to cope and rebuild their lives. In some cases it is difficult for specific populations to access services and support.

Public and Professional Knowledge about SADV

Both women and service providers reported that they lack knowledge about SADV. Women often did not identify their experience as abuse, particularly if it was not physical violence.

...You know what, even at that point [initial contact with a service provider] I didn't understand it as violence, I understood as his addiction and I understood it as his problem and I hadn't fully been able to even look at where it had taken me in my life. — W# 21

Similarly, the lack of professional education for service providers was also identified. Some service providers reported that they lack knowledge on these issues. This impacts service provider's ability to help women who have experienced violence, especially those agencies whose main focus is not SADV.

Service providers were asked how the Action Committee could help improve the response to SADV in the community. They expressed a need for increased public education for the larger community, not just victims of SADV, specifically through ad campaigns and public speakers.

Action Point

Public Education

Increase public's access to information/education about abuse and recognizing the signs of being in an abusive relationship.

Tension Point

Public SADV Knowledge

A lack of public knowledge about SADV continues to exist and reduces ability for people to get assistance.

Tension Point

Service Provider SADV Knowledge

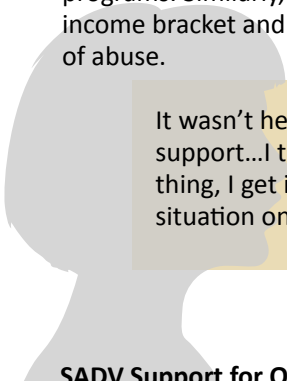
A lack of knowledge on SADV issues can impede service providers' ability to assist women.

OVERVIEW

Gaps in Services

Support Related to Children

Women and service providers highlighted the lack of services available in the community for children who have witnessed violence or been a victim of violence. Parenting support was also identified as a gap in services. One service provider from Family & Children's Services commented that the ministry does not fund parenting programs. Similarly, women identified a need for financial assistance with child care since many were in a low income bracket and cannot afford to pay for a child care provider, making it difficult to deal with the aftermath of abuse.



It wasn't helpful to have what felt like little support, I mean I don't have a whole lot of family support...I think there needs to be more support you know with parenting. I mean this is a basic thing, I get it, but I mean people need help with parenting and then put them through this situation on top of it and you're asking, you're almost asking for a disaster. — W#17

SADV Support for Other Vulnerable Populations

Service providers highlighted that there are **limited services available in the community for male victims of SADV**, as well as other vulnerable populations including **elderly men, trans-identified individuals and women in rural communities**. Some service providers discussed how they have made efforts to adapt their services to serve these individuals, recognizing that these services are lacking in the community. In some cases service providers will meet a woman at her home in the county and in other cases service providers will adapt the gendered language of the Protocol to assess the level of risk for a male victim of violence.

Offender Accountability and Effective Services for Offenders

Service providers and women both commented on the **lack of offender accountability**. Service providers discussed the perceived ineffective programming for perpetrators, specifically the Partner Assault Response (PAR) program. For example, service providers at Family & Children's Services stated that PAR does not work for chronic offenders and that there was no expectation for abusing individuals to actively participate in the program or apply the learning in their lives. It was also suggested that there is a disconnect between the PAR program and offender accountability more generally. The criminal courts are not notified about an offender's counseling/PAR history, meaning that there is no system in place to effectively track offenders. In addition service providers at John Howard Society **noted the lack of services for youth who commit sexual crimes**.

I've discussed the ongoing issues...I still discuss them today [...] we [women] have to completely change, you know **[we] continue to work on ourselves although we're not really the issue** [...] Something has to give though, especially when children are involved [...] my daughter and I are both continually doing counseling [...] when the culprit [is the problem][...] where's their accountability? — W#21

Service providers at Marianne's Place, the Women in Crisis shelter commented that **women and children are most often uprooted from their homes** when the police respond to a domestic violence call, rather than the abusing partner. Services and supports available in the community are geared for female victims (e.g., the shelter), as opposed to abusing individuals. This is a systems challenge that places the burden on women to leave.

Lack of Other Services: PetSafe and Detox

Service providers at Marianne's Place identified the **absence of a PetSafe program**, which would offer women temporary housing for their pets. The limited housing options for pets can restrict women's ability to leave an abusive relationship.

Limited access to a detox program was also identified as a gap. Women are required to travel to Kitchener if she requires detox services. This can be especially challenging if a woman does not have access to transportation.

Action Point

Recommended Services/Resources

- Effective services (e.g. holding offenders accountable) for people who are abusive are needed.
- Longer-term shelters for pets for women fleeing violence are needed.
- Detox programs needed.
- Supports for children, males, trans-identified individuals, women in rural areas, youth sexual offenders.

Issues with Court Systems

Some women expressed frustration with the criminal and family court systems. The criminal court system may not be able to directly address SADV because **non-physical violence (e.g. emotional or verbal) is not chargeable**. However, non-physical forms of violence can have a large impact on women's lives. Additionally, some justice professionals may not understand the complexity of domestic violence, leaving women feeling like it is another avenue in which the abusive partner continues to abuse her.



I've really gotten the feeling from everything [...] unless there's semen in the vagina and it's proved to whoever, or a broken arm and there's a witness that's not your family member or your friend you know who probably would be around [...] **there really isn't much you can do** and that's what were living with. — W#21

Tension Point

Charges

Limitations of the justice system to charge non-physical violence.

Tension Point

Court Systems

Frustration of women with court systems. Court as being another avenue where abuse from the abusive partner can take place.

Restrictive Organizational Policies

Women and service providers acknowledged that **women might feel systemically abused** due to policies at various agencies. It was noted by women and service providers that Family & Children's Services puts the onus on women to protect her children and make changes in their lives, without holding the abusing partner accountable in a meaningful way.

A lot of the women we work [with] feel systemically further abused. First of all, the files are open in the woman's name, never in the perpetrators name, so that's an issue I think that hopefully we're going to try to grapple...there is an onus on mom to keep her children safe and the feedback that I often get is "why are you focusing on me?" — Family & Children's Services service provider



Finally, Housing policies for Special Priority requiring proof of cohabitation with the abusing partner. This was identified by some service providers as a barrier for women escaping an abusive relationship. Staff at Marianne's Place shared that this policy can be unrealistic because women in abusive relationships are often unable to provide proof of cohabitation when they have been financially abused or have had to leave in a hurry. Furthermore, housing assessments, which are conducted after women move into housing can be experienced as ongoing monitoring and assessment.

Tension Point

Onus on Women

Family & Children's Services puts the onus on women to protect her children, without holding the abusing partner accountable.

Tension Point

Restrictive Policies

Special Priority Housing policies that require proof of cohabitation with the abusing partner can impede a woman escaping an abusive relationship

Action and Tension Points

Below is a more detailed summary of the Action and Tension Points identified in the research findings.

Action Points are specific considerations for improving SADV service delivery. Some Action Points are a result of key findings from women about their experiences with service providers. Other Action Points are suggestions, which have come from service providers, about needed Protocol changes.

Tension Points reflect differences that both women and service providers identified in definitions/ interpretation, service delivery styles, agency mandates, philosophies and challenges, or tensions experienced at the Action Committee level.

Whether and how these Action and Tension Points are examined and/or addressed by the Action Committee and the larger community is beyond the parameters of the research. Nevertheless, they are listed below in an order that is consistent with their significance.

ACTION POINTS

SERVICE DELIVERY

The *How* of Service Delivery: *How* a service is delivered is equally as important as the content of the service. Service provider personality and skills play a large part in determining whether a woman's experience is positive or negative

Awareness of Services: Increased awareness of the services that agencies offer can greatly impact women's service provision.

Bridging Services

Bridging Services: Accompaniment, support, and advocacy are significant ways to "bridge services" and can effectively and efficiently connect a woman with new service providers.

Practical and Tangible resources: Practical and Tangible Resources. These are important as ways to help meet women's specific needs. e.g. bus tickets, vouchers and food and clothing, child care services, emergency alarms, pamphlets.

Judgment/Not Believed

Some women reported feeling not believed and judged based on:

- income and employment status,
- mental health or addictions status or
- due to their abusive partners influencing the service providers' perceptions of the woman.

FIRST RESPONSE

Overall Service Delivery: Women's overall impressions of an agencies' service delivery mattered more than their first interaction with the agency.

Privacy

Privacy is Important: Sexual assault/domestic violence disclosures for women are significant and may not look like service providers expect. Privacy during a disclosure is important and a positive or negative experience during a disclosure can have a large impact on women.

Limits of Confidentiality

Informed Decisions: Explain the limits of confidentiality to women to help ensure they make informed decisions about the information they share.

Different Limits of Confidentiality: Confidentiality limits differ by agency: not all services are voluntary or have the same level of confidentiality. For example:

- the Police and Family & Children Services investigate women without consent.
- women's safety can be compromised if they disclose physical abuse without understanding the implications of mandatory charging,
- the Crown cannot offer confidentiality at all.

These differences need to be more clearly explained to women by all service providers.

Risk Assessment

Protocol Risk Assessment Expectations: The "First Response" Protocol expectations suggest that *all* service providers can and should carry out the objectives in the same way. This does not recognize that different agencies play different roles and the first response may not be possible or appropriate in every service provider situation. Risk assessment is an example of this expectation not being realistic.

Risk Assessment Tools: Collectively deciding what risk assessment tools to use and how to interpret them could benefit both women and service providers.

Risk Assessment Referrals: Some service providers reported referring women to other agencies for risk assessments and/or safety planning. However, making a referral does not guarantee that the "first response" will be completed. Doing some risk assessment and safety planning is better than none.

Safety Planning

Protocol Expectations for Safety Planning: The Protocol does not recognize that safety planning may not always be necessary depending on the results of the risk assessment. For example, historical abuse may not require a safety plan.

Safety Planning Tools: Build and share a common safety planning checklist.

Follow Up

Defining Follow Up: The Protocol does not clearly define follow-up and the definition should be clarified. Follow up may be contrary to an agency's mandate and a service provider's respect for a woman's self-determination.

COORDINATION/COLLABORATION

Increasing Awareness of Mandates: Greater awareness/understanding of agencies' mandates and services and resources between agencies can facilitate referrals and improve access to services.

Working with Differences: Further discussions on how to work together in spite of differences could be beneficial.

Protocol Accessibility Improvements

The Protocol needs to be more accessible: Service providers suggested ways the following ways that can happen:

- shorten the document and/or provide one page handouts;
- make Protocol publicly available and searchable online;
- improve readability of the document by using plain language;
- revise the risk assessment tool to make it more sensitive to subtle abuse and not gender or relationship specific;
- create a risk assessment tool app for mobile service providers;
- include information on working with children or people who are abusive;
- create documents that could be used by the general public or women experiencing violence.

Protocol Training:

Cross-sectoral training: Training on the newest version of the Protocol is not occurring in a way that is effective. Cross-sectoral training is needed to build professional relationships to help service providers more effectively support women.

BEYOND THE PROTOCOL

Public Education: Increase public's access to information/education about abuse and recognizing the signs of being in an abusive relationship.

Recommended Services/Resources:

- Effective services (e.g. holding offenders accountable) for people who are abusive are needed.
- Shelters for pets for women fleeing violence are needed.
- Detox programs are needed.
- Supports for children, males, trans-identified individuals, women in rural areas.

TENSION POINTS

Privacy

Privacy: What feels like “privacy” for service providers is not experienced as “privacy” by women, e.g. disclosures that occur in waiting rooms, over the phone, in older buildings where sound travels, or when the abusing partner is close by. This can impact whether the woman discloses and feels comfortable and/or heard.

Confidentiality

Duty to Report: Tension exists between adhering to the duty to report if a woman shared information that is outside of the limits of confidentiality (such as a disclosure that would need to be reported to Family and Children’s Services) and their own values and approach of “meeting a woman where they’re at,” as well as maintaining the relationship with the woman.

Risk Assessment

High Risk: There is disagreement within and between agencies about the definitions of abuse and “high risk” and therefore how to respond.

Follow Up

Connecting but not Pressuring Women: Tension exists between service providers trying to ensure women are connected with the support they need on the one hand while wanting women to freely choose services without feeling pressured to respond in a particular way.

Coordination/Collaboration

Different Mandates: Different philosophies, mandates, and agendas reduce collaboration.

Illusion of Full Agency Participation: The appearance vs. reality of Action Committee membership, involvement and Protocol implementation. Status as a Protocol signatory may give the false impression that entire agencies implement the “first response” outlined in the document. In reality, an Action Committee member may only represent a small department in a large agency. A specific department aligning with the Protocol does not mean that the entire agency is aware of and implements the steps of the Protocol.

Communication and Trust Issues: Varying levels of trust and feeling valued; “turfism;” conflict; and poor communication.

Lack of Engagement and Resources: Perceived lack of engagement, commitment or involvement and the lack of resources that some agencies have to put towards Action Committee tasks or other collaborative work exists.

Benefits vs. Challenges of Case Conferences: Benefits and challenges can be one and the same. For example, the time required to set-up a case conference is a challenge; however, it can also save time for agencies involved.

High Risk Team Membership: Membership or lack of membership on High Risk Team.

Personal Relationships: Lack of communication and personal relationships between agencies presents a challenge to coordination and collaboration

Downsides of Collaboration: In some cases, more collaboration may negatively impact a woman's choice and agency.

BEYOND THE PROTOCOL

Public SADV Knowledge: A lack of public knowledge about SADV continues to exist and reduces the ability for people to get assistance.

Service Provider SADV Knowledge: A lack of knowledge on SADV issues can impede service providers' ability to assist women.

Charges: Limitations of the justice system to charge non-physical violence.

Court Systems: Frustration of women with court systems. Court as being another avenue where abuse from the abusive partner can take place.

Onus on Women: Family & Children's Services puts the onus on women to protect her children, without holding the abusing partner accountable.

Restrictive Policies: Special Priority Housing policies that require proof of cohabitation with the abusing partner can impede a woman escaping an abusive relationship

Connections Between Our Findings & Previous Research

Below is a brief review of the connections that exist between our evaluation research findings and previous research on community coordinated responses to sexual assault and domestic violence. Identifying and comparing our findings with other research can help the Action Committee and the broader community think about, assess, and make decisions about possible next steps. Connecting our findings with other relevant peer reviewed research lends support and credibility to the findings of this research.

BENEFITS OF A COORDINATED/COLLABORATIVE APPROACH: RELATIONSHIPS ARE CRUCIAL

Previous research has mainly sought feedback from service providers in evaluating a coordinated and collaborative response. Our research addresses this important critique^{xxii} by including feedback from women who have accessed services. The inclusion of women was critically important to this research study because valuable data about the effectiveness of a program or initiative is derived from those using the services, and not only from those providing the services^{xix}.

Evaluation research on CCRs and their “success” is lacking. The limited research that has been done suggest that CCRs are not uniformly effective^{xx}. CCRs are well positioned to increase knowledge, cooperation and communication across systems^{xxi}; improve

institutional changes such as new policies and practices^{xxii} and increase public awareness and interest in responding to violence against women^{xxiii}. Specifically our findings suggests that developing and enhancing relationships play an important role in “bridging social ties,” and forming relationships across sectors which positively impacts institutional change^{xxiv}. Greeson and Campbell found that “... when relationships between systems are poor, opportunities to work together and create improvements are missed”^{xxv}. Current research by Allen et al.^{xxvi} suggests that the development of new relationships and increased knowledge among stakeholders as a result of collaborative activities and greater access to influential leaders leads to a kind of “synergy” that facilitates systems change.

CHALLENGES OF WORKING TOGETHER

Our research supports previous research about the challenges in working together. A finding of our research, and one commonly found in previous research, was that service providers from one system lack knowledge of what and how other systems respond to survivors^{xxvii}. Additionally, we found that sharing information was sometimes challenging,

especially because of confidentiality and the high risk nature of some cases, which is heightened if the environment is characterized by a lack of trust among service providers^{xxviii}. Lack of information sharing among agencies can lead to survivors feeling overwhelmed, tired and frustrated and therefore less likely to report and seek help^{xxix}.

SHARED POWER AND DECISION MAKING DESPITE DIFFERENT MANDATES

We found that survivors of violence and service providers had great insights about changes that are required to improve SADV service delivery, both within their own organization as well as other systems. However, other research suggests that unless shared power and influence in decision making between agencies and systems is supported at the CCR, their input may not affect change^{xxx}. Greeson and Campbell found that “turf wars” were common. Researchers concluded that “service providers often have different agendas and styles of interacting with victims and each wanted to claim their approach as ‘right’ and their time with victims as more important”^{xxxi}. Giacomazzi and Smithey note that turf issues remain a stumbling block for true collaboration^{xxxii}.

Our findings are consistent with a prevalent theme in previous research that revealed tension between

child welfare and violence against women agencies responding to families affected by SADV^{xxxiii}. Specifically, we heard that women express fear of child welfare investigation and the potential loss of access to their child/children^{xxxiiii}. Other research argues^{xxxv} that supporting non-abusive mothers to be safe is the most promising approach to reconciling the ongoing tension that exists between child welfare and violence against women agencies.

Despite different mandates and agendas there is support in the literature for an understanding of gender and power differences as fundamental to the work. In fact, it is argued that without an understanding of the gendered dynamics of abuse, women’s services are likely to be under-resourced and marginalized as more powerful agencies take over^{xxxvi}.

LEADERSHIP AND ACTIVE & ENGAGED MEMBERSHIP

The challenges we identified in working together was consistent with previous research that found developing an “inclusive climate” (i.e. shared power in decision making, the presence of a shared mission and active participation from a broad array of key stakeholders) is needed to affect change^{xxxvii}. In addition, quality of leadership (i.e., attending to process by including and managing diverse viewpoints and action) is a critical predictor of the

committee’s ability to meet their goals^{xxxviii}. Similar to our findings, previous research provides evidence that disparities between official and active membership in coordinating committees is common. Further, active membership was found to be a key ingredient to accomplishing committee goals and therefore is a good reminder that promoting active participation of those that are empowered to influence change is crucial^{xxxix}.

COLLABORATION AND COORDINATION WITH ACCOMPANIMENT, SUPPORT AND ADVOCACY

Survivors of SADV have diverse needs that require a wide variety of community resources^{xl} that are typically difficult to access^{xli}. Therefore, comprehensive advocacy services are essential

to helping women cope and rebuild their lives^{xlii}. Our research confirms this and argues that accompaniment, support and advocacy are needed for any effective coordinated responsive model.

HOW SERVICES ARE DELIVERED IS KEY – POSITIVE AND PRACTICAL

The results of our research contribute to the body of knowledge about how domestic violence and sexual assault services should be delivered^{xliii}. In fact our research confirms that how service providers interact with women is more important than whether the Protocol objectives are met (i.e. the First Response Protocol requirements (i.e. confidentiality, safety planning, risk assessment, follow up, etc.). Women who are treated more positively find services more useful and effective^{xliiv}. We found that care, understanding, listening and empathy were what women wanted. “Support for abused women and the development of an empowering woman-centered focus underlies all the work done”^{xliv}.

In a study by Postmus and Hahn^{xlvi}, women suggested that service providers should be attentive to their situation in an effort to break the cycle of dependency on the system and on abusers in women’s lives by empowering them, rather than further victimizing them through service delivery.

Further, Zweig & Burt found that when women have a greater sense of control while working with agencies, they find services more helpful and effective^{xlvii}. Similarly, a broad agenda of empowerment of women and children and using a strengths perspective^{xlviii} carried out in direct, down-to-earth practical ways was essential^{xli}.

We also heard that practical/tangible supports were most helpful to women. Understanding the importance of material resources must be understood within the larger context within which women live. “... The current focus on individual women does not address or even begin to eliminate the institutional structures in society that support intimate violence against women particularly barriers to women’s economic security”^l. In fact they argue that women’s economic security is a necessity and must be part of any community coordinated response to intimate partner violence^{li}.

RISK ASSESSMENT AND SAFETY PLANNING

Our finding about the interconnection between risk assessment and safety planning are consistent with previous research. A risk assessment is often a precursor to devising a safety plan and informs appropriate strategies to keep women and their children safe^{lii}. Davies et al. assert “a thorough and accurate risk analysis is an essential component of safety planning”^{liiii}. Additionally, safety planning is integral to SADV service delivery^{liv}, yet many service providers in the current study perceived safety planning to be a specialized skill requiring extensive training. While it might be the case that comprehensive safety planning should be done with someone experienced with SADV, service providers whose primary focus is not SADV can still effectively do some safety planning with women^{lv}. Davies et al.,

note that one of the inherent limitations of safety planning is that “no one can know everything about every risk or reduce every risk”. This is important for service providers working with individuals who have experienced SADV to consider. This supports our assertion that some safety planning is better than none.

Despite the challenges and critiques of CCRs, many researchers, service providers and other advocates agree that nothing short of systems and community change has any chance of making a significant long-term difference in reducing, let alone ending violence against women^{lvi}.

Research Limitations

A major strength of this evaluation research was the participatory community-engaged approach. While another strength is the use of multiple sources of data, much of this data relies on self-report and from relatively small samples. There are, however, several limitations of the research that should be acknowledged.

- **Small Number of Focus Groups:** A relatively large number of service providers completed the online survey, but we had a small sample of focus groups (n=5) with a total of 32 participants. While we had anticipated more focus groups, overall interest in focus groups was low. The low response rate was likely due to the amount of time required to participate and the difficulty coordinating a mutually agreeable time. While the findings from the focus groups are not generalizable to all service providers, many of the same themes were also found in the online survey.
- **Low Representation from the County:** Although we tried to recruit women from the county by posting ads on social media/Kijiji and posting recruitment flyers in community spaces, we had a small sample of women from the county that had experience with county-based services.
- **More Domestic Violence Focused:** The majority of the women we interviewed had sought services for experiences of domestic violence, which may have encompassed sexual assault. There were only a small number of women who participated in the research who used Action Committee agency services for sexual assault. Both the small sample of women from the county and women seeking sexual assault services may have influenced the types of experiences women reported with SADV agencies.
- **Limited Systems Knowledge of Interviewers:** The graduate students who conducted the interviews had not worked in the SADV service community in Guelph-Wellington. Therefore, the graduate students were not as familiar with the various systems and other non-Action Committee services available in Guelph-Wellington as someone who worked within the system may have been. This may have influenced the interviewers' ability to ask appropriate follow-up questions or respond to participant's questions about the broader service provision system. However, it was important that the interviewers were seen by women to be impartial and separate from the Action Committee and the Action Committee agencies

Conclusion

The results of the evaluation research suggest that the Protocol is being implemented as written across agencies to varying degrees. Some objectives (e.g. explaining confidentiality) were met most of the time, while other objectives (e.g. safety planning) are often assumed to be addressed by other agencies through referrals. Service providers reported that there has not been adequate training on the 2010 Protocol and that the document itself can be made more accessible.

Positive individual relationships were found to be crucial to both SADV service delivery and collaboration between Action Committee agencies and representatives. Women reported that how services are delivered creates a positive overall impression of a service, particularly when the service provider displayed empathy and understanding. Similarly, service providers reported that having a positive relationship with service providers at other agencies increased the likelihood of coordination and collaboration.

This research has identified several Action Points, which ask for the attention and consideration of the Action Committee, the broader SADV services system and the Guelph-Wellington community. This research has also identified larger systems issues beyond the reach of the Protocol. Many of these are noted as Tension Points and can negatively impact collaboration and women receiving the support and resources they need.

Many of the findings of this research align with the findings of other research on SADV services and community coordinated responses. Based on this and other research, considerations for future research include examining the definition and role of coordination and collaboration among SADV agencies and the impact of this collaboration (or lack thereof) on

both women's experiences of services and their overall well-being. In particular, the tensions between child welfare and violence against women services should be further explored.

There is some evidence that the extent to which coordinating committees achieve their desired goals are influenced by the context in which they operate. As a result, future research could further examine the climate of agencies to assess how supportive they are implementing change. Committee effectiveness should also be evaluated within the unique context in which that committee operates.

Given the importance of systems and community change in ending violence against women, future research should also focus on understanding SADV in the context of broader organizational, social and political systems. This research should identify the ways in which the larger context impacts the extent to which a coordinated and collaborative community response to violence against women can address the needs and issues facing women who have experienced abuse and people who are abusive.

This report has identified the importance of positive individual relationships between women and service providers as well as among service providers, ensuring an effective response to SADV. These relationships facilitate a systemic response to SADV that has a large positive impact. It should be noted that this response cannot prevent SADV. Continuing to improve systemic responses to SADV through efforts such as the Protocol creates the possibility for positive change for individual women. However, broader social change, in the form of equity and social justice, continues to be a vision for the future.

Appendix A: Research Team Profiles

CORE RESEARCH TEAM:

Danielle Bader

Danielle is an M.A. candidate in the Criminology and Criminal Justice Policy program at the University of Guelph. She completed her B.A. with a major in Criminology at York University in 2009. Broadly, her research interests include violence against women, community based research, community engaged evaluation research and participatory action research.

Linzy Bonham

Linzy has been the Coordinator of the Action Committee since June 2011. She has a Masters of Social Work and is a registered clinical social worker specializing in sexual assault, domestic violence and trauma counselling. Linzy has an extensive history in community organizing around social justice and feminist issues and is passionate about working for change on both the individual and community level.

Sara Crann

Sara is a Ph.D. Candidate in the Department of Psychology at the University of Guelph. Her research focuses on women's health and wellbeing using qualitative and community-engaged approaches. She is a Project Manager at the Research Shop/Institute for Community Engaged Scholarship at the University of Guelph.

Melissa Horan

Melissa is a Health Promotion Specialist at Wellington-Dufferin-Guelph Public Health and represents her agency at the Action Committee table. She has provided evaluation expertise, including design, data collection, analysis, and report writing, for multiple public health initiatives.

Mavis Morton

Mavis is an Assistant Professor in the Department of Sociology and Anthropology at the University of Guelph. She is a community engaged scholar focusing on violence against women, justice and social policy, community based and evaluation research and community engaged learning. Mavis has worked with rural and urban community partners (advocates, community coordinating committees, criminal justice and social service organizations and government) on community based research, education, protocol development, advocacy, service coordination and evaluation on issues related to violence against women and their children and other social justice issues for over 25 years.

With contributions from:

Ashley Murphy-Kilgar

Ashley is a registered community social worker. Ashley is a recent graduate from the University of Windsor where she obtained a Masters of Social Work. She is passionate about community social work, feminist issues, and advocating for individuals with a developmental disability.

Appendix B: Agency Statistics on Domestic Violence and Sexual Assault

Some of the agencies have available secondary statistics about domestic violence and sexual assault, this section presents those statistics in order to give context to domestic violence and sexual assault since 2010¹³ in the Guelph-Wellington area.

VIOLENCE AGAINST WOMEN

Guelph Wellington Women in Crisis

Guelph Wellington Women in Crisis (WIC) provides support to women and children affected by domestic violence and sexual assault. WIC's programs are: the Transitional and Housing Support Program, the Rural Women's Support Program, the Crisis Line, Marianne's Place (i.e., shelter), and the Sexual Assault Centre. The following information is retrieved from their annual report for the 2010/2011^{lvii} and 2011/2012^{lviii} fiscal years (April 1 to March 31).

The Transitional and Housing Support Program (THSP) had a 109 percent increase of women using individual support and/or group programming services from 2010/2011 to 2011/2012. In 2010/2011, THSP accompanied 63 women to court and/or

appointments, assisted in 106 housing applications, and constructed 542 safety or transition plans. In 2010/2011, THSP provided a total of 5,933 direct service hours to supporting women and children. In 2011/2012, there was 15 percent increase in safety plans from the previous reported year.

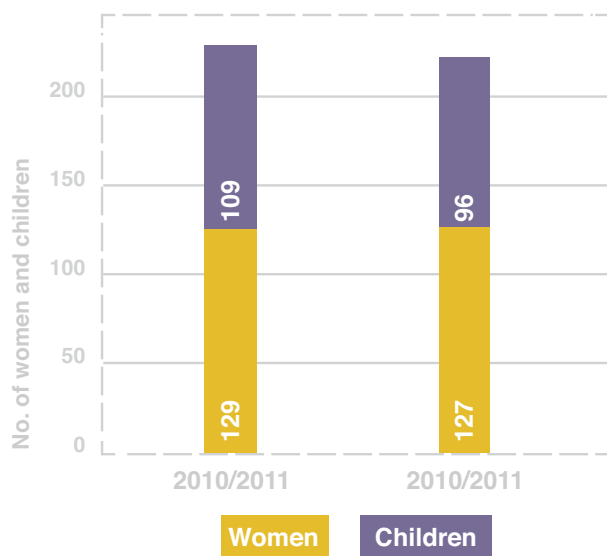
The Rural Women's Support Program (RWSP) provided support to 310 women in 2010/2011 and 279 women in 2011/2012. In 2010/2011, RWSP accompanied 46 women to appointments, and took 124 crisis calls at the country offices. RWSP provided a total of 3,655 direct service hours to women across Wellington County.

The Crisis Line received 3,600 calls in 2010/2011.

Marianne's Place had approximately a seven percent decrease of women and children from 2010/2011 to 2011/2012. The shelter had 238 (129 women and 109 children) in 2010/2011, and 223 people (127 women and 96 children) in 2011/2012.

The Sexual Assault Centre supported 130 women through individual counselling and 74 women through groups and workshops in 2010/2011. The Sexual Assault Centre supported 499 women in 2011/2012 through individual counseling, groups, workshops, and public education events.

Chart 1. WIC Transitional & Housing Support Program



¹³ Please note that the timeframe for individual agencies' statistics vary slightly because agency statistics for certain years were unavailable.

Table 1. WIC Transitional & Housing Support Program

	2010/2011	2011/2012
# of women for individual support and/or group programming	522	1089
Safety plans created with women and children	542	625

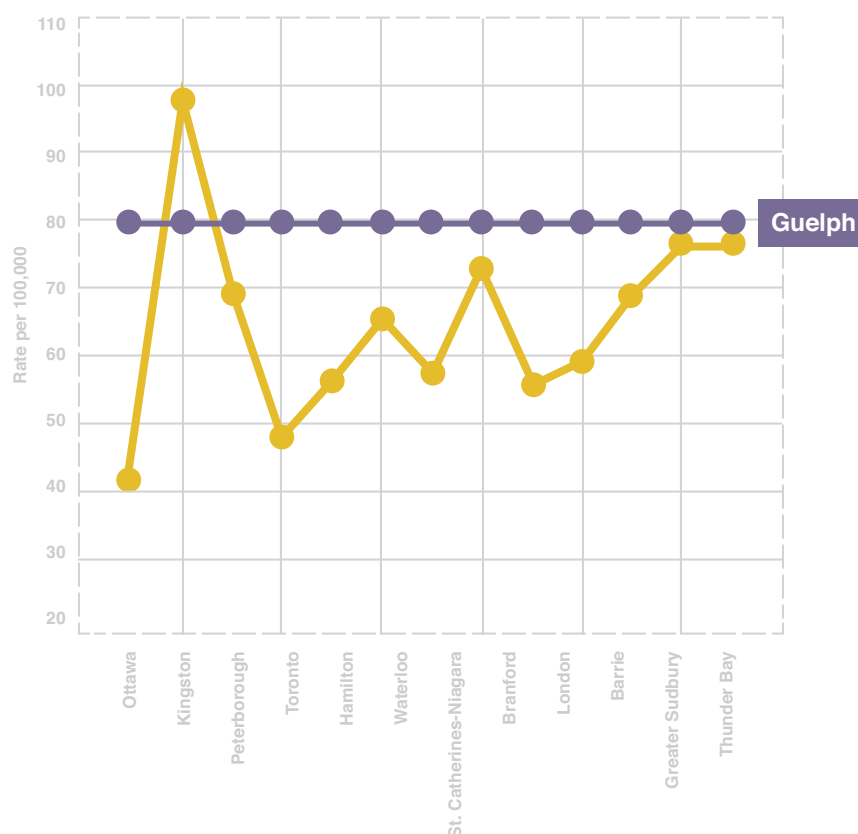
JUSTICE

Victim Reporting to Criminal Justice System

Police reported data provides information on incidents that come to the attention of the police. This data includes the number of domestic violence and sexual assault victims seeking support from the police. The Canadian legal system refers to sexual assault as any forced or attempted forced sexual activity or any unwanted sexual touching, grabbing,

kissing or fondling^{liv}. Sexual assault is legally classified by the physical harm or trauma to the victim: sexual assault with minor or no physical injuries (i.e. level one), sexual assault with a weapon, threat, and bodily harm (i.e. level two), and sexual assault with wounding, maiming, disfiguring or endangering the victim (i.e. aggravated sexual assault or level three). Reported sexual assault data includes spouses charged with sexual assault.

Chart 2. Police reported Sexual Assault Level 1, 2 and 3, by census metropolitan area, 2012



The police reported data is limited to criminal offenses that are reported to the police. Self-reported surveys about victimization supplement the police data in order to fully represent both reported and unreported incidents to the police.

Research has shown that sexual assault and domestic violence are among the most underreported crimes in Canada. According to the 2009 Canadian General Social Survey, about 30% of female victims and 13% of male victims reported domestic violence to the police^{lxv}, and approximately 12% of victims reported sexual assault to the police^{lxv}. In the post-secondary setting, research shows that less than five percent of sexual assaults are reported to post-secondary authorities.^{lxvii}

Based on the Uniform Crime Reporting Survey, a survey on police-reported statistics, in 2012, Guelph had the second highest rate of reported sexual assaults (level 1, 2 and 3) for census metropolitan areas in Ontario⁶³. The rate of sexual assaults for Guelph was 79 per 100, 000 people; the national rate was 63 per 100, 000 people.

The high rate of reported sexual assaults could indicate a higher prevalence of sexual assault in the Guelph-Wellington area, although it could also indicate a higher amount of sexual assault victims that feel comfortable reporting to Police. One of the most common reasons reported by victims for hesitation in reporting sexual assault is the lack of confidence in the criminal justice system.^{lxviii} Research indicates that reporting of sexual assault is more likely to occur if there are positive attitudes to and relationships with

policing authorities, and if there are accessible victim services.^{lxv}

Police Services in the Guelph-Wellington Area

There are three police services in the Guelph-Wellington area: Ontario Provincial Police (OPP), Guelph Police Service, and the University of Guelph Campus Community Police. The Guelph Police Service primarily police the City of Guelph, the OPP provides policing services to the Wellington area, and the Campus Community Police exclusively police the campuses of the University of Guelph, which is located in the City of Guelph.

Guelph Police Service

Reported occurrences of sexual assault to the Guelph Police Service are steadily increasing. The Guelph Police Service had an increase of 11.5 percent from 2011 to 2012 in reported occurrences of sexual assault. In 2011, there were 87 reported occurrences of sexual assaults, a rate of 37 per population of 100,000. In 2012, there were 97 reported occurrences of sexual assault, a rate of 76 per 100,000.

The number of domestic dispute calls, from 2010 to 2012, has steadily decreased. The number of domestic (other relative) violence service calls present as relatively stable.

The statistics for the Guelph Police were retrieved from their Annual Reports.^{lxvi}

Table 2. Guelph Police Occurance Data (2010-2012)

	2010	2011	2012
# of actual sexual assault occurrences	62	87	97
# of domestic dispute service calls	1315	1305	1287
# of domestic (other relative) service calls	627	576	643

Ontario Provincial Police

The Wellington County Ontario Provincial Police detachment had a 65.6 percent increase in reported occurrences of sexual assault from 2011 to 2012. Based on primary Uniform Crime Reporting (UCR) offence level counts, there were 29 actual occurrences in 2011 and 48 actual occurrences in 2012. In 2010, there were 26 actual occurrence of sexual assault reported.

The statistics for the Wellington County OPP detachment are retrieved from the detachments' 2011-2013 business plan^{lxvii}, which is based on primary UCR offence level counts. The statistics are actual reported occurrences of SA, which differ from projected estimates of annual occurrences.

University of Guelph Campus Community Police

There was one domestic disturbance reported to Campus Community Police in 2010/11 (May 1- April 30) and three in 2011/12. Two occurrences of sexual assaults were reported in 2010/11, and three occurrences of sexual assaults were reported in 2011/12.

The statistics for the University of Guelph Campus Community Police were retrieved from their Annual Reports.^{lxviii}

Victim Services in Guelph-Wellington

There are two victim services located in Guelph-Wellington that assist and support victims through various stages of the criminal justice system: Victims Services Wellington and the Victim/Witness Assistance Program. Victims Services Wellington provides assistance to victims immediately after victimization. Victim/Witness Assistance Program provides assistance to victims after the police have laid charges, and continues its support until the conclusion of the court case.

Chart 3. University of Guelph Occurance Data (2009/2010 - 2011/2012)



The number of sexual assault victims who contacted or used the victim services in Guelph-Wellington has slightly increased according to the services reported fiscal years. The number of domestic violence victims supported remains relatively consistent.

Victim Services Wellington (VSW) supported 244 victims of domestic violence and 51 victims of sexual assault in 2012/13 (April 11 – March 31). In 2013/14 VSW assisted 231 victims of domestic violence and 58 victims of sexual assault.

Victim Witness Assistance Program (VWAP) assisted 350 victims of domestic violence and 20 victims of sexual assault in 2011, and assisted 375 victims of domestic violence and 29 victims of sexual assault in 2012. The number of domestic violence victims seeking VWAP services is relatively stable. There was a sharp increase in sexual assault victims in 2012, a 45 percent increase, from 2010 and from 2011.

The statistics for the victim services are retrieved from the agencies' databases.

Chart 4. Victim Services Wellington (2010 - 2012)

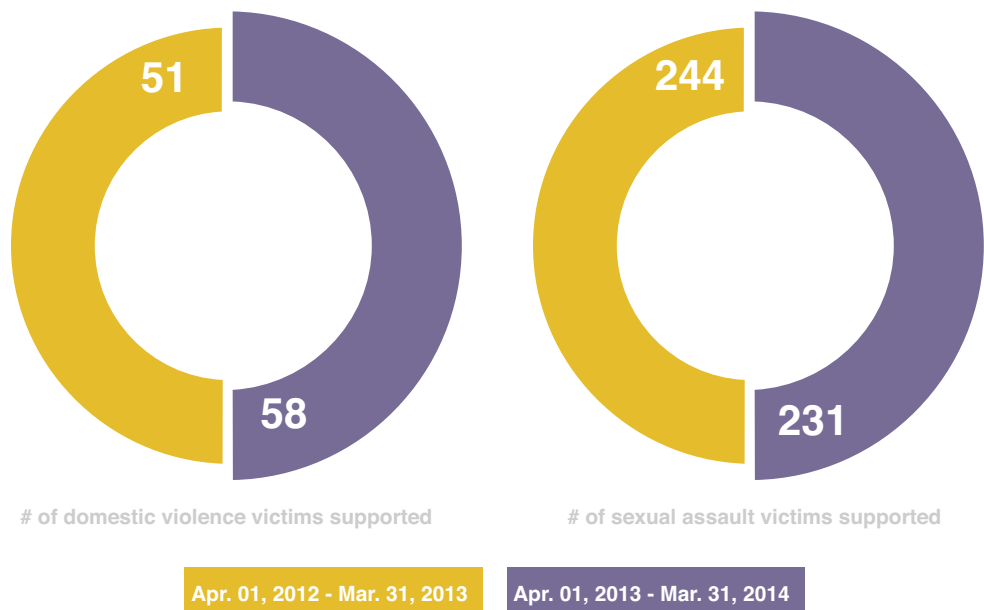


Chart 5. Guelph-Wellington Care & Treatment Centre for Sexual Assault & Domestic Violence

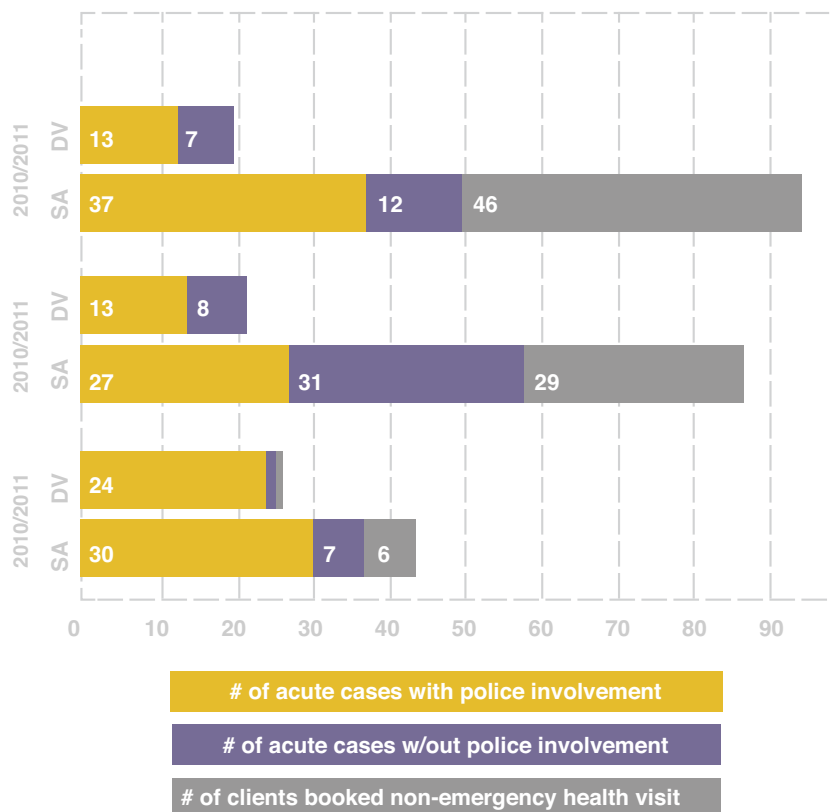
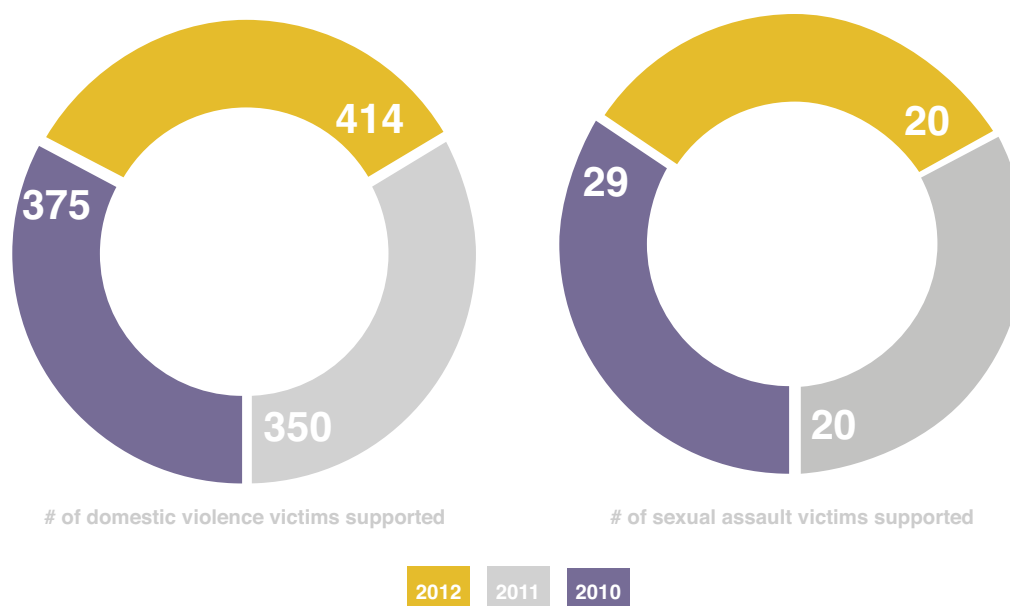


Chart 6. Victim/Witness Assistance Program (2010-2012)



HEALTH

Guelph Wellington Sexual Assault and Domestic Violence Care and Treatment Centre at Guelph General Hospital

The Guelph Wellington Sexual Assault and Domestic Violence Care and Treatment Centre at Guelph General Hospital provides victims of domestic violence and sexual assault medical care, including but not limited to physical examination(s), crisis counselling, treatment of injuries, and the option of having a Sexual Assault Evidence Kit completed.

Acute (i.e., emergency) cases of domestic violence seen by the Centre remain relatively consistent over the last two reported periods. Acute cases are clients who have been assaulted within 72 hours of arriving at the Centre. Of the total acute cases, with and without police involvement, all domestic violence cases were

female victims. The Centre did not have any non-emergency health visits from either male or female victims in 2011/12 and in 2012/13. The Centre's fiscal year represents April 01- March 31.

There was an increase in acute cases of sexual assault with police involvement and a decline in acute cases of sexual assault without police involvement

from 2011/12 to 2012/13. Of the total number of acute emergency sexual assault cases, approximately 98 percent of cases were female in both 2011/12 and 2012/13, with one male client in 2011/12 and 2012/13.

Men and women in booked non-emergency health visits for sexual assault has steadily increased in the last three reporting periods. In 2011/12, 27 women and two men were seen for a booked non-emergency health visit. There were 43 women and three men seen for a booked non-emergency health visit in 2012/13.

There has been a steady decline of calls to domestic violence and sexual assault victims, who were not seen in the emergency or follow-up clinic, for phone support or crisis intervention.

The number of follow-up calls and health visits for acute and non-acute sexual assault clients have increased dramatically in 2012/13 from the previous reported periods (76% increase from 2011/12).

Follow-up calls for health visits of acute and non- acute sexual assault clients increased by 47 percent from 2011/12 to 2012/13.

Counselling services provided to female and male sexual assault victims increased from 72 women and no men in 2011/12 to 125 women and five men in 2012/13.

There was a dramatic increase in counselling services provided to domestic violence and sexual assault victims by the Guelph Wellington Sexual Assault and Domestic Violence Care and Treatment Centre at Guelph General Hospital between 2011/12 to 2012/13.

The statistics for the Guelph Wellington Sexual Assault and Domestic Violence Care and Treatment Centre were retrieved from the agency. The statistics were compiled from their 2010/11^{lxix}, 2011/12^{lxx}, and 2012/13^{lxxxi} 'Quarterly Statistical Form Domestic Violence for Clients 16 and older', and from their 2010/11^{lxxii}, 2011/12^{lxxiii}, and 2012/13^{lxxiv} 'Quarterly Statistical Form Sexual Assault for Clients 16 and older'.^{lxxv}

Table 3. Guelph-Wellington Care & Treatment Centre for Sexual Assault & Domestic Violence

	2010/2011		2011/2012		2012/2013	
	DV	SA	DV	SA	DV	SA
# of calls for clients who have received phone support or crisis intervention	10	7	4	5	0	9
# of follow-up calls for acute/non-acute clients	22	37	3	62	15	109
# of follow-up health visits for acute/non-acute clients	7	57	2	55	6	81
# of clients using counselling services	20	44	20	72	50	130

References

- ⁱ Allen, N. E. (2006). An examination of the effectiveness of domestic violence coordinating councils. *Violence Against Women*, 12, 46-67.
- ⁱⁱ Allen, N. E. (2006). An examination of the effectiveness of domestic violence coordinating councils. *Violence Against Women*, 12, 46-67.
- ⁱⁱⁱ The Action Committee (2014). *Vision and guiding principles*. Retrieved from: www.theactioncommittee.ca/who-we-are/vision-and-guiding-principles/.
- ^{iv} Wellington-Dufferin-Guelph Public Health. (2012). *Community Picture: Health Status of Wellington-Dufferin-Guelph (Report)*. Guelph, ON.
- ^v Johnson, H. (2006). *Measuring violence against women: Statistical trends*. Statistics Canada Catalogue no. 85-570-XIE.
- ^{vi} Burczycka, M., & Cotter, A. (2011). *Shelters for Abuse Women in Canada, 2010*. Statistics Canada Catalogue no. 85-002-X.
- ^{vii} Perreault, S. (2011). *Homicide in Canada, 2011*. Statistics Canada Catalogue no. 85-002-X.
- ^{viii} Canadian Women's Foundation. (n.d.). *The facts about violence*. Retrieved from: <http://www.canadianwomen.org/facts-about-violence#4>.
- ^{ix} Brown, A. W. (2001). *Obstacles to women accessing forensic medical exams in case of sexual violence*. World Health Organization Background Paper. Retrieved from: <http://www.hrw.org/reports/2001/06/25/obstacles-women-accessing-forensic-medical-exams-cases-sexual-violence>.
- ^x National Sexual Violence Resource Center (NSVRC). (2011). *An evaluation of the sexual assault response team victim advocate program*. Enola, PA: Author; Pence, E. & McDonnell, C. (1999). Developing policies and protocols. In M. Shepherd & E. Pence (Eds.), *Coordinating community responses to domestic violence: Lessons from Duluth and beyond*, 41-65. Thousand Oaks, CA: Sage Publications, Inc.
- ^{xi} Carnegie Foundation for the Advancement of Teaching. (2010). *Community engagement elective classification*. Retrieved from: <http://www.carnegiefoundation.org/>.
- ^{xii} Calleson, D., Kauper-Brown, J., & Seifer S. D. (2005). *Community-Engaged Scholarship Toolkit*. Seattle: Community- Campus Partnerships for Health. Retrieved from: <http://www.communityengagedscholarship.info>; Minkler, M. (2005). *Community organizing and community building for health*, Rutgers University Press, Piscataway: NJ.
- ^{xiii} Shalowitz, M. U., Isacco, A., Barquin, N., Clark-Kauffman, E., Delger, P., Nelson, D., Quinn, A. & Wagenaar, K. A. (2009). Community-based participatory research: A review of the literature with strategies for community engagement. *Journal of Developmental & Behavioral Pediatrics*, 30, 350-361.
- ^{xiv} Greeson, M. R., & Campbell, R. (2013) Sexual assault response teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation., *Violence & Abuse*, 14(2), 83-95.
- ^{xv} Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.

- ^{xvi} Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.
- ^{xvii} Furco, A. (2010). The engaged campus: Toward a comprehensive approach to public engagement. *British Journal of Educational Studies*, 58, 375-390.
- ^{xviii} Allen, N. E. (2006). An examination of the effectiveness of domestic violence coordinating councils. *Violence Against Women*, 12, 46-67.; Allen, N. E., Watt, K. A., & Hess, J. Z. (2008). A qualitative study of the activities and outcomes of domestic violence coordinating councils. *American Journal of Community Psychology*, 41(1-2), 63-73; Greeson, M. R., & Campbell, R. (2013) Sexual assault response teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation. , *Violence & Abuse*, 14(2), 83-95; Hague, G. and Bridge, S. (2008). Inching forward on domestic violence: The co-ordinated community response and putting it in practice in Cheshire. *Journal of Gender Studies*, 17(3), 185-199; Zweig, J. M. and Burt, M. R. (2007). Predicting women's perceptions of domestic violence and sexual assault agency helpfulness: What matters to program clients? *Violence Against Women*, 13(11), 1149-1178.
- ^{xix} Allen, N. E. (2006). An examination of the effectiveness of domestic violence coordinating councils. *Violence Against Women*, 12, 46-67.; Sullivan, C. M. (2011). Evaluating domestic violence support service programs: Waste of time, necessary evil, or opportunity for growth? *Aggression and Violent Behavior*, 16(4), 354-360.
- ^{xx} Allen, N. E. (2006). An examination of the effectiveness of domestic violence coordinating councils. *Violence Against Women*, 12, 46-67.; Malik, N., Ward, K., & Janczewski, C. (2008). Coordinated community response to family violence. *Journal of Interpersonal Violence*, 23(7), 933-955.
- ^{xxi} Allen, N. E. (2006). An examination of the effectiveness of domestic violence coordinating councils. *Violence Against Women*, 12, 46-67.
- ^{xxii} Allen, N. E. (2006). An examination of the effectiveness of domestic violence coordinating councils. *Violence Against Women*, 12, 46-67.; Allen, N. E., Watt, K. A., & Hess, J. Z. (2008). A qualitative study of the activities and outcomes of domestic violence coordinating councils. *American Journal of Community Psychology*, 41(1-2), 63-73; Greeson, M. R., & Campbell, R. (2013) Sexual assault response teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation. *Trauma, Violence & Abuse*, 14(2), 83-95.
- ^{xxiii} Allen, N. E. (2006). An examination of the effectiveness of domestic violence coordinating councils. *Violence Against Women*, 12, 46-67.; Allen, N. E., Watt, K. A., & Hess, J. Z. (2008). A qualitative study of the activities and outcomes of domestic violence coordinating councils. *American Journal of Community Psychology*, 41(1-2), 63-73.
- ^{xxiv} Allen, N. E., Watt, K. A., & Hess, J. Z. (2008). A qualitative study of the activities and outcomes of domestic violence coordinating councils. *American Journal of Community Psychology*, 41(1-2), 63-73.
- ^{xxv} Greeson, M. R., & Campbell, R. (2013). Sexual assault response teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation. *Trauma, Violence & Abuse*, 14(2), 83-95.
- ^{xxvi} Allen, N., Todd, N., Anderson, C., Davis, S., Javdani, S., Bruehler, V., et al. (2013). Council-based approaches to intimate partner violence: Evidence for distal change in the system response. *American Journal of Community Psychology*, 52(1-2), 1-12.
- ^{xxvii} Allen, N. E., Watt, K. A., & Hess, J. Z. (2008). A qualitative study of the activities and outcomes of domestic violence coordinating councils. *American Journal of Community Psychology*, 41(1-2), 63-73.
- ^{xxviii} Campbell, R., Patterson, D. & Bybee, D. (2011). Using mixed methods to evaluate a community intervention for sexual assault survivors: A methodological tale (case study). *Violence Against Women*, 17(2), 376-388.
- ^{xxix} Allen, N. E., Watt, K. A., & Hess, J. Z. (2008). A qualitative study of the activities and outcomes of domestic violence coordinating councils. *American Journal of Community Psychology*, 41(1-2), 63-73; Robinson, A. L. (2006). Reducing repeat victimization among high-risk victims of domestic violence: The benefits of a coordinated community response in Cardiff, Wales. *Violence Against Women*, 12(8), 761-788.
- ^{xxx} Allen, N. E. (2006). An examination of the effectiveness of domestic violence coordinating councils. *Violence Against Women*, 12, 62; Sullivan, C. M. (2011). Evaluating domestic violence support service programs: Waste of time, necessary evil, or opportunity for growth? *Aggression and Violent Behavior*, 16, 354-360.

- ^{xxxi} Greeson, M. R., & Campbell, R. (2013) Sexual assault response teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation. *Trauma, Violence & Abuse*, 14(2), 83-95.
- ^{xxxii} Giacomazzi, A. L. & Smithey, M. (2001). Community policing and family violence against women: Lessons learned from a multi-agency collaborative. *Police Quarterly*, 44(1), 99-122.
- ^{xxxiii} Fleck-Henderson, A. (2000). Domestic violence in the child protection system: Seeing double. *Children and Youth Services Review*, 22, 333-354; Hester, M. (2007). Making an impact children and domestic violence: A reader (2nd ed.). London: J. Kingsley Publishers; Moles, K. (2008). Bridging the divide between child welfare and domestic violence services: Deconstructing the change process. *Children and Youth Services Review*, 30(6), 647-688; Schechter, S. & Edleson, J. (1994). *In the best interest of women and children: A call for collaboration between child welfare and domestic violence constituencies*. Paper presented at the Conference on Domestic Violence and Child Welfare: Integrating Policy and Practice for Families, Racine, WI. Paper retrieved from: <http://www.mincava.umn.edu/documents/wingsp/wingsp.html>
- ^{xxxiv} Rose, D. Trevillion, K., Woodall, A., Morgan, C., Feder G, & Howard, L. (2011). Barriers and disclosures of domestic violence by mental health service users: Qualitative study. *British Journal of Psychiatry*, 198, 189-194; The Coalition to End Violence Against Women. (2012). *The Niagara region domestic violence report card 2011/2012: The system matters*. Niagara, ON: Ian DeGeer; Schechter, S. & Edleson, J. (1994). *In the best interest of women and children: A call for collaboration between child welfare and domestic violence constituencies*. Paper presented at the Conference on Domestic Violence and Child Welfare: Integrating Policy and Practice for Families, Racine, WI. Paper retrieved from: <http://www.mincava.umn.edu/documents/wingsp/wingsp.html>
- ^{xxxv} Fleck-Henderson, A. (2000). Domestic violence in the child protection system: Seeing double. *Children and Youth Services Review*, 22(5), 333-354. Hester et. al. Hester, M. (2007). Making an impact children and domestic violence: A reader (2nd ed.). London: J. Kingsley Publishers.
- ^{xxxvi} Hague, G. and Bridge, S. (2008). Inching forward on domestic violence: The co-ordinated community response and putting it in practice in Cheshire. *Journal of Gender Studies*, 17(3), 188.
- ^{xxxvii} Allen, N. E. (2006). An examination of the effectiveness of domestic violence coordinating councils. *Violence Against Women*, 12, 46-67.; Furco, A. (2010). The engaged campus: Toward a comprehensive approach to public engagement. *British Journal of Educational Studies*, 58, 375-390; Greeson, M. R., & Campbell, R. (2013) Sexual assault response teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation. *Trauma, Violence, & Abuse*, 14(2), 83-95.
- ^{xxxviii} Butterfoss, F., Goodman, R., & Wandersman, A. (1993). Community coalitions for prevention and health promotion. *Health Education Research*, 8(3), 315-330; Foster-Fishman, P. G., Berkowitz, S. L., Lounsbury, D. W., Jacobson, S., & Allen, N. A. (2001). Building collaborative capacity in community coalitions: A review and integrative framework. *American Journal of Community Psychology*, 29(2), 241-261; Furco, A. (2010). The engaged campus: Toward a comprehensive approach to public engagement. *British Journal of Educational Studies*, 58, 375-390; Greeson, M. R., & Campbell, R. (2013) Sexual assault response teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation. *Trauma, Violence & Abuse*, 14(2), 83-95.
- ^{xxxix} Allen, N. E. (2006). An examination of the effectiveness of domestic violence coordinating councils. *Violence Against Women*, 12, 64; Allen, N. E., Watt, K. A., & Hess, J. Z. (2008). A qualitative study of the activities and outcomes of domestic violence coordinating councils. *American Journal of Community Psychology*, 41(1-2), 63-73; Greeson, M. R., & Campbell, R. (2013) Sexual assault response teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation. *Trauma, Violence & Abuse*, 14(2), 83-95.
- ^{xl} Greeson, M. R., & Campbell, R. (2013) Sexual assault response teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation. *Trauma, Violence & Abuse*, 14(2), 83-95.
- ^{xli} Allen, N. E. (2006). An examination of the effectiveness of domestic violence coordinating councils. *Violence Against Women*, 12, 61; Allen, N. E., Bybee, D. I. & Sullivan, C. M. (2004). Battered women's multitude of needs: Evidence supporting the need for comprehensive advocacy. *Violence Against Women*, 10(9), 1015-1035; Sullivan, C. M., & Bybee, D. I. (1999). Reducing violence using community-based advocacy for women with abusive partners. *Journal of Consulting and Clinical Psychology*, 67, 43-53.
- ^{xlii} Foster-Fishman, P. G., Berkowitz, S. L., Lounsbury, D. W., Jacobson, S., & Allen, N. A. (2001). Building collaborative capacity in community coalitions: A review and integrative framework. *American Journal of Community Psychology*, 29(2), 241-261; Moles, K.

(2008). Bridging the divide between child welfare and domestic violence services: Deconstructing the change process. *Children and Youth Services Review*, 30(6), 647-688.

^{xliii} Grasley, C., Wolfe, D. A. & Wekerle, C. (1999). Empowering youth to end relationship violence. *Children's Services*, 2(4), 209-223; Greeson, M. R., & Campbell, R. (2013) Sexual assault response teams (SARTs): An empirical review of their effectiveness and challenges to successful implementation. *Trauma, Violence & Abuse*, 14(2), 83-95; Kulkarni, S. J., Bell, H., Rhodes, D. M., Kulkarni, S. J., Bell, H., & Rhodes, D. M. Back to basics. *Violence Against Women*, 18(1), 85-101.

^{xliv} Zweig, J. M. & Burt, M. R. (2007). Predicting women's perceptions of domestic violence and sexual assault agency helpfulness: What matters to program clients? *Violence Against Women*, 13(11), 1172.

^{xlv} Hague, G. & Bridge, S. (2008). Inching forward on domestic violence: The co-ordinated community response and putting it in practice in Cheshire. *Journal of Gender Studies*, 17(3), 196

^{xlvi} Postmus, J. L. & Hahn, S. A. (2007) The Collaboration between welfare and advocacy organizations: Learning from the experiences of domestic violence survivors. *Families in Society – The Journal of Contemporary Social Services*, 88(3), 475-484.

^{xlvii} Zweig, J. M. and Burt, M. R. (2007). Predicting women's perceptions of domestic violence and sexual assault agency helpfulness: What matters to program clients? *Violence Against Women*, 13(11), 1172.

ⁱ Pennington-Zoellner, K. (2009). Expanding 'Community' in the community response to intimate partner violence. *Journal of Family Violence*, 24(8), 539-545.

ⁱⁱ Hague, G. & Bridge, S. (2008). Inching forward on domestic violence: The co-ordinated community response and putting it in practice in Cheshire. *Journal of Gender Studies*, 17(3), 197

ⁱ Pennington-Zoellner, K. (2009). Expanding 'Community' in the community response to intimate partner violence. *Journal of Family Violence*, 24(8), 542.

ⁱⁱ Postmus, J. L. & Hahn, S. A. (2007) The Collaboration between welfare and advocacy organizations: Learning from the experiences of domestic violence survivors. *Families in Society – The Journal of Contemporary Social Services*, 88(3), 475-484.

ⁱⁱⁱ Campbell, M., Cross, P., Jaffe, P. & MacQuarrie, B. (2010). *Threat assessment and risk management in domestic violence cases: An overview of Ontario justice and community collaboration for 2010 and future directions*. London, ON: Centre for Research and Education on Violence Against Women.; Ontario Women's Directorate. (2009). *Transforming our communities: Report from the Domestic Violence Advisory Council for the Minister Responsible for Women's Issues*. Toronto, ON: Author.

ⁱⁱⁱⁱ Davies, J., Lyon, E., & Monti-Catania, D. (1998). *Safety planning with battered women: Complex lives/difficult choices*. Thousand Oaks, CA: Sage Publications, Inc.

^{liv} Goodkind, J., Sullivan, C. & Bybee, D. (2004). A contextual analysis of battered women's safety planning. *Violence Against Women*, 10(5), 514-533.

^{lv} Ministry of Public Safety and Solicitor General, Victim Services and Crime Prevention Division. (2010). *Domestic Violence Response: A Community Framework for Maximizing Women's Safety*. Retrieved from: <http://www.pssg.gov.bc.ca/victimservices/shareddocs/pubs/domestic-violence-response.pdf>

^{lvi} Salazar, L. F., Emshoff, J. G., Baker, C. K., & Crowley, T. (2007). Examining the behavior of a system: An outcome evaluation of a coordinated community response to domestic violence. *Journal of Family Violence*, 22(7), 631-641.

^{lvii} Guelph-Wellington Women in Crisis. (2011). *2010-2011 Annual Report of Guelph-Wellington Women in Crisis*. Retrieved from: <http://www.gwwomenincrisis.org/wp-content/uploads/2010/12/AGM-Report-2010-2011.pdf>

^{lviii} Guelph-Wellington Women in Crisis. (2012). *2011-2012 Annual Report of Guelph-Wellington Women in Crisis*. Retrieved from: <http://www.gwwomenincrisis.org/wp-content/uploads/2010/12/G-W-Women-in-Crisis-Annual-Report-2011-12.pdf>

^{lx} Perreault, S., & Brennan, S. (2010). Criminal victimization in Canada, 2009. Statistics Canada Catalogue no. 85-002-X.

- ^{lxi} Mahony, T. H. (2011). Women and the criminal justice system. *Women in Canada: A Gender-Based Statistical Report*. Statistics Canada Catalogue no. 89-503-X
- ^{lxii} Perreault, S., & Brennan, S. (2010). *Criminal victimization in Canada, 2009*. Statistics Canada Catalogue no. 85-002-X.
- ^{lxiii} Karjane, H., Fisher B., & Cullen, F. (2005). *Sexual assault on Campus: What colleges and universities are doing about it*. Washington, D.C.:U.S. Department of Justice, National Institute of Justice.
- ^{lxiiii} Perreault, S. (2013). *Police-reported crime statistics in Canada, 2012*. Statistics Canada Catalogue no. 85-002-X
- ^{lxv} Hattem, T. (2000). Survey of sexual assault survivors (Report No. 2000-4e). Ottawa: Department of Justice Canada.
- ^{lxvi} Karjane, H., Fisher B., & Cullen, F. (2005). *Sexual assault on Campus: What colleges and universities are doing about it*. Washington, D.C.:U.S. Department of Justice, National Institute of Justice; Rosenbaum, D., Schuck, A., Costello, S., Hawkins, D., & Ring, M. (2005). Attitudes towards the police: The effects of direct and vicarious experience. *Police Quarterly*, 8(3), 343-365.
- ^{lxvii} Guelph Police. (2010). *2010 Annual report of the Guelph Police*. Retrieved from: <http://www.guelphpolice.com/assets/Website-PDF-AR-2010.pdf>; Guelph Police (2011). *2011 Annual report of the Guelph Police*. Retrieved from: http://www.guelphpolice.com/assets/Site_PDFs/2011AnnualReport.pdf
- ^{lxviii} Wellington County Ontario Provincial Police. (2013). *Business plan for Wellington County OPP detachment 2011- 2013*. Ontario Provincial Police. Retrieved from: http://www.wellington.ca/en/resources/Wellington_County_Detachment_Plan_2013_WEB.pdf
- ^{lxix} University of Guelph Campus Community Police. (2010). Annual report of *University of Guelph Campus Community Police 2009/2010*. Retrieved from: <https://www.uoguelph.ca/police/sites/uoguelph.ca.police/files/ANNUAL%20REPORT%202009-2010.pdf>; University of Guelph Campus Community Police. (2011). Annual report of *University of Guelph Campus Community Police 2010/2011*. Retrieved from: <https://www.uoguelph.ca/police/sites/uoguelph.ca.police/files/images/users/emcmilla/Annual%20Report%202010-2011.pdf>; University of Guelph Campus Community Police. (2012). Annual report of *University of Guelph Campus Community Police 2011/2012*. Retrieved from: <https://www.uoguelph.ca/police/sites/uoguelph.ca.police/files/images/users/emcmilla/Annual%20Report%202011-2012%20final.pdf>
- ^{lxx} Guelph/ Wellington Sexual Assault & Domestic Violence Care & Treatment Centre. (2011). *2010/2011 Ministry of Health Quarterly Statistical Form Domestic Violence for Clients 16 and Over*.
- ^{lxxi} Guelph/ Wellington Sexual Assault & Domestic Violence Care & Treatment Centre. (2012). *2011/2012 Ministry of Health Quarterly Statistical Form Domestic Violence for Clients 16 and Over*.
- ^{lxxii} Guelph/ Wellington Sexual Assault & Domestic Violence Care & Treatment Centre. (2013). *2012/2013 Ministry of Health Quarterly Statistical Form Domestic Violence for Clients 16 and Over*.
- ^{lxxiii} Guelph/ Wellington Sexual Assault & Domestic Violence Care & Treatment Centre. (2011). *2010/2011 Ministry of Health Quarterly Statistical Form Sexual Assault for Clients 16 and Over*.
- ^{lxxiv} Guelph/ Wellington Sexual Assault & Domestic Violence Care & Treatment Centre. (2012). *2011/2012 Ministry of Health Quarterly Statistical Form Sexual Assault for Clients 16 and Over*.
- ^{lxxv} Guelph/ Wellington Sexual Assault & Domestic Violence Care & Treatment Centre. (2013). *2012/2013 Ministry of Health Quarterly Statistical Form Sexual Assault for Clients 16 and Over*.

Research Contact Information:

MAVIS MORTON, PHD

Assistant Professor
Department of Sociology and Anthropology
University of Guelph

Tel: 519-824-4120 x52576
Email: mavis.morton@uoguelph.ca
Website: <https://www.uoguelph.ca/socioanthro/mavis-morton>

LINZY BONHAM, MSW

Coordinator
Guelph-Wellington Action Committee on
Sexual Assault and Domestic Violence

Email: actioncommitteecoordinator@gmail.com
Website: www.theactioncommittee.ca

Report design by:



ANNELIESE DESIGNS

www.anneliesedesigns.com