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Identifying Gaps in Data Collection Practices of Peel Agencies that Serve Survivors of Interpersonal Violence: A Pilot Study

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Determinants of Community Health (DOCH-2)

Final Project Report

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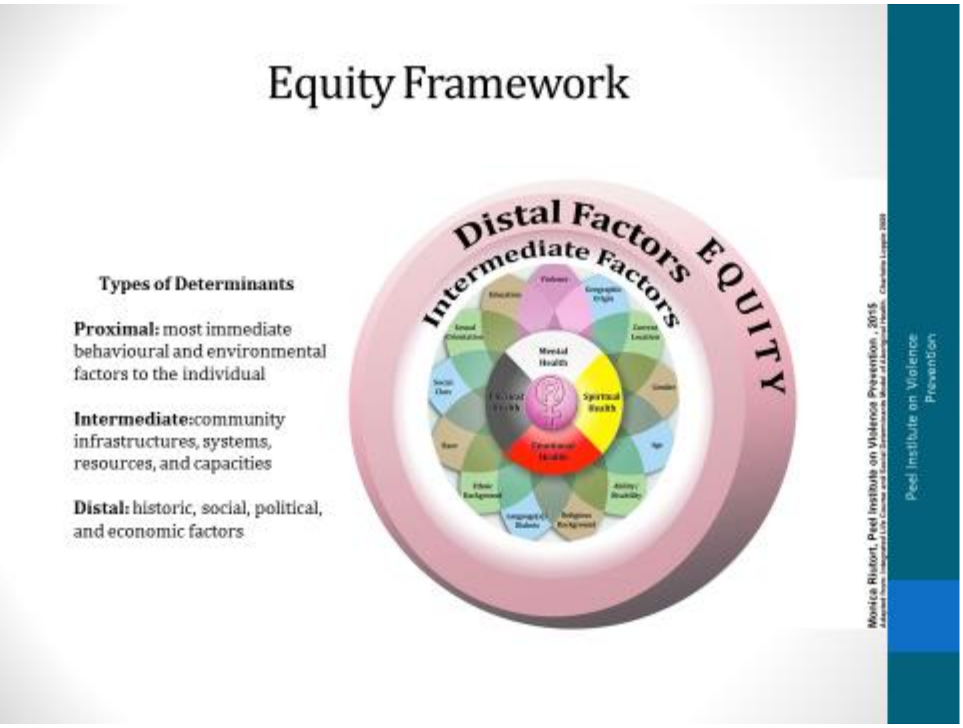
ABSTRACT

Survivors of interpersonal violence (SOIV), more likely to suffer from multi-system medical complaints, indulge in high-risk behaviours and have adverse socioeconomic outcomes. As a result, survivors of interpersonal violence are more likely to access health and social services. However, SOIV currently face significant barriers to timely and adequate health and social services. Their needs are not adequately met by the current health and social services landscape. There is a need for these service sectors to make their programming more client-centered and achieve greater collaboration and integration of services to provide unified and effective care to this population. Good data monitoring practices have been identified as key factors in achieving these goals. Currently, no standardized data monitoring practices exist among agencies in Peel serving SOIV. This project aims to understand the current landscape of data monitoring practices in Peel. As a pilot study, we interviewed two agencies that serve SOIV in Peel and subsequently analyzed the interviews using a qualitative thematic approach. Major domains of questioning were as follows: Nature of current data collection practice; collaboration and integration of services; and client satisfaction and outcomes measurement. The study found that data collection practices were largely funder-driven and not client-centric. Despite internal motivation, improvements to current practices were limited by time, personnel, and financial resources. There was limited collaboration among agencies within the social service sector and within the health care sector, and this resulted in a redundant and inefficient system that provided poor quality of care to clients. Lastly, we found that data collection practices between the two agencies were remarkably different.

Key Words: Survivor of Interpersonal Violence, data collection, social services, access, client-centered, collaboration, health outcomes

AGENCY DESCRIPTION

This DOCH-2 research project is conducted in association with the Institute on Violence Prevention, a multidisciplinary collaborative initiative that was founded in June 2013 through funding from the Ontario Trillium Foundation. The Institute is based out of the Family Services of Peel organization. The goals of the Institute are to prevent all forms of violence in the Region of Peel; engage in research about best practices for victims of violence; inform policy development for violence prevention; and develop program evaluation tools to improve services and support for survivors of violence. The Institute on Violence Prevention strives to achieve these goals by collaborating with service providers and survivors of violence; gathering data on evidence-based practices; and evaluating current data collection processes.[1] The Institute on Violence Prevention serves a very diverse population that includes both males and females from youth, senior and ethnic groups who have experienced any form of interpersonal violence.[1] Their efforts are aimed at reducing the prevalence of interpersonal violence which has been reported to be as high as 17.7% in Canada.[2] The agency operates within a conceptual framework that encompasses proximal, intermediate, and distal social determinants of health with a particular focus on race and ethnicity (figure 1). This framework addresses the fact that survivors of violence are a part of broader contexts such as families, communities and society as a whole; thus their health is also affected by these same factors. Overall, this provides a holistic view of survivors of violence to allow more targeted and balanced efforts towards meeting both the short-term and long-term needs of this population.[1]



Equity Framework

Types of Determinants

Proximal: most immediate behavioural and environmental factors to the individual

Intermediate:community infrastructures, systems, resources, and capacities

Distal: historic, social, political, and economic factors

Monica Riutort, Peel Institute on Violence Prevention , 2015

Peel Institute on Violence Prevention

Fig. 1. Determinants of community health conceptual framework.

INTRODUCTION AND REVIEW OF LITERATURE

Health and Socioeconomic Outcomes of Survivors of Interpersonal Violence

Experience of interpersonal violence has been linked to adverse short-term and long-term health of individuals. These individuals are more likely to suffer from multi-system medical complaints, indulge in high-risk behaviours, and have lower socioeconomic outcomes. In turn, survivors of interpersonal violence (SOIV) are more likely to access health and social services, and their outcomes are only worsened by the inability of these institutions to respond effectively to the needs of this population. The rest of this first section will explore 1) health and socioeconomic outcomes; 2) utilization of health and social services by SOIV; and lastly; 3) failure of the current system to meet the needs of the SOIV population.

In the acute setting, survivors of assault require acute formal and informal support for their physical and psychological symptoms but may not seek or receive it in a timely manner. Even in countries like Canada where health care is universal, medical therapy may be readily available but interpersonal and societal barriers often stand as an impediment for survivors' ability to seek timely help.[3] Du Mont *et al.* report that while the uptake of specialized sexual assault services by male survivors of assault is significant, there is still severe under reporting.[4] They feel uncomfortable when seeking help, they may not perceive services as available or helpful, or fear being treated as the perpetrator.[3,4] Female victims of domestic violence similarly have under reporting of assault.[5] Fear of being dismissed, shame, and lack of time are among the many factors that serve as barriers to accessing health care.[5] Survivors of violence rarely reveal their history to their primary health care providers, let alone any doctors, and this adversely affects their long-term health.

The physical, but more importantly, the mental and emotional effects of assault linger long after the event. Literature shows that individuals who have experienced violence are more likely to participate in high-risk activities (e.g. smoking, alcohol); suffer from multi-system medical issues; and have higher rates of chronic illness.[6] Vulnerability to this sort of a poor response and to the consequent adverse health outcomes reflect the various risk factors that a substantial minority of the survivor population are associated with. In Du Mont's study of male victims of adult sexual assault, based out of Domestic Violence Treatment Centres in Ontario, Canada, a notable minority of participants had vulnerabilities such as young age (<24yo); being aboriginal, being transgender, unemployed/student, or on disability; working in the sex trade, and living on the streets, in a rehab centre or in a correctional facility.[4] Furthermore, psychiatric or developmental disability was significantly associated with the male victim population.[4] It is evident that such a population with these risk factors would have a difficult time rehabilitating from the emotional and physical trauma of assault and would be highly vulnerable to having mental health problems, chronic disease, high-risk behaviours, and poor socioeconomic outcomes in the long run.

Poor health and socio-economic outcomes consequent to assault are prevalent across all victim populations, and female survivors show many of the same risk factors as mentioned earlier pertaining to male victims of violence. The sense of isolation that women experience lingers on long after the abuse has ended and long after removal from the situation. Studies have shown that the effects of abusive relationships remain sometimes decades after the abuse has ended, which subsequently affects future relationships, physical health and the quality of life.[7-9] It is important to note, while discussing the risk factors and poor health outcomes of survivors of violence, how heterogeneous this population is. Furthermore, each subpopulation based on factors such as race and gender identity have individual risk factors and outcomes that need population-specific care. This specific care will assist to reach more survivors and provide effective short-term and long-term support. This lends importance to understanding the socio-demographic profile of these patients.

It is evident that survivors of violence have many risk factors that, compounded with the pervasive nature of violence, make this population highly vulnerable to long-term adverse health outcomes. Studies have shown significant association between the experience of violence at any age and a wide range of chronic illness.[12] Also, due to poor disclosure by victims to health care professionals and the sometimes inadequate acute treatment of the mental impact of abuse often resulting in serious impact to the sub-acute and chronic stages which could affect poor long-term health, socioeconomic wellbeing, and quality of life.[5,6] One of the strongest associations with chronic disease has been shown between experience of violence and development of cardiovascular disease. Studies reveal that experience of abuse at any age is associated with long-term cardiovascular disease along with a host of other illnesses.[10,11,12] While much of the literature looked at consequences of sexual abuse, Afifi *et al*. found that harsh physical punishment (pushing, grabbing, shoving, slapping, and hitting) was also associated with higher odds of cardiovascular disease.[12]

The mechanism shown for long-health problems focuses on the indirect pathways of harm, primarily the prolonged stress response.[13] This maladaptive response manifests as physiological changes within the body that cause depression and higher physiological stress response and subsequent maladaptive coping strategies such as smoking and overeating, behaviours that are known cardiovascular risk behaviours.[13] This interaction between assault, depression and subsequent high risk behaviours has furthermore been associated with a myriad of other chronic illnesses including cancer, through cancer related risk behaviours like smoking, alcohol, and overeating; chronic respiratory disease, through increased smoking rates among individuals having experienced violence; and diabetes, again through higher risk-behaviour prevalence with obesity being the single most important risk factor.[14-19] Nelson *et al.* report that long standing stress from childhood experiences of violence lead to negative coping strategies in adulthood, psychiatric problems such as depression, anxiety, and often unexplained physical symptoms of chronic pains and irritable bowel syndrome that have a significant impact on an individual's life.[20]

Evidently, survivors of violence bear a significant burden of disease and morbidity. This means that this population needs to be reached more efficiently after an assault with effective physical and mental treatment and ongoing long-term support to prevent development of long-term adverse health outcomes. By this same token, we must realize that despite the societal and interpersonal barriers discussed earlier that survivors face in disclosing assault, victims of violence are more likely to require and utilize medical and social support.[4,6] Du Mont *et al*. found that most male victims of sexual assault utilize more than one service and concluded that it is important to provide access to a comprehensive range of psychiatric, medical, forensic treatment options and referrals to community services for ongoing support.[4] Similarly, Palmer *et al.* report that, "Although survivors of childhood abuse often are described as having difficulty relating to professionals, these respondents persisted in seeking help and tended to report at least one experience with professional services that was very helpful. Their self-esteem and family functioning in adulthood was associated with having had a very helpful professional or service provider."[21] Other studies repeatedly show that survivors of violence (men and women of all ages) have advocacy needs around housing, or shelter, legal assistance, safety planning, finding employment, custody battles, among various other tasks that can be overwhelming [2,-4,6-9]. It becomes evident that in response to the higher utilization of health and social services by survivors, there needs to be a well-coordinated, accessible and effective network of services that can meet the long-term medical, emotional, functional and advocacy needs of this population.

However, what we find is that the current system of health and social services often fail to adequately meet the needs of survivors of violence.[22,23] As discussed previously, experience of violence is still associated with increased rates of chronic disease, psychiatric problems, poor socioeconomic outcomes and poor quality of life. Literature has identified some key factors in the system's poor response to the needs of SOIV. Firstly, there is a need to gain a better understanding of the profile of this population and more importantly, to set up the system to provide individualistic care. This requires services more tailored towards needs of the ethnic, racial, gender, and language constitution of a population.[24] Secondly, survivors of violence access services from a wide a variety of agencies including mental and medical health, economics, child custody, and child protection.[23] Provision of this type of complex care, usually all at once, requires comprehensive and unified care models. Research shows that agencies must work in a more collaborative and coordinated manner to not only provide a higher quality of care to this population but also improve the efficiency and reduce costs of the often overlapping and redundant patchwork of poorly integrated social and health services that exist.[25-28]

Data Collection

An important but often overlooked component of operating effective and highly efficacious system of services is data collection and monitoring. Data collection and monitoring are critical to developing and improving programs to meet the needs of the survivors of violence populations. As discussed above, in order to achieve a more efficient and efficacious service system, health and social service agencies require better demographic data about the population they are serving in order to meet the idiosyncratic needs of their client population.[24] At the same time, agencies need to obtain outcomes and satisfaction data in order to evaluate their performance in meeting their clients' needs and continue making improvement to their services. Furthermore, in order to provide the simultaneous, collaborative, and effective care that the survivor of violence population needs, agencies must have an effective system of sharing and collecting data for effective interdisciplinary referral and support.[22,25-28]

The present study aims to qualitatively assess the data collection practice in the Peel Region, Ontario. We hope to identify areas where current collection practices are deficient and, in conjunction with literature, identify the most effective data collection practices within the context of the survivors of violence population in Peel and the health equity mandate of our parent agency. The following sections further detail some essential requisites to improving quality of care for SOIV where adequate data collection practices play a significant role.

Data Monitoring Practices and More Client-Centered Service Programming

The survivor of violence population requires comprehensive and unified care that involves inter-agency and inter-disciplinary referral and support. Moreover, successfully addressing the complex care for survivors of violence requires client-centered efforts that target specific risks and protective factors across individual, interpersonal, institutional, community and societal levels. As discussed earlier in the review, survivors at the individual level need comprehensive individualistic response to address their particular needs and concerns for best short and long-term outcomes. Du Mont *et al.* showed in his study that male victims of violence are increasingly seeking help and have vulnerabilities and outcomes that are distinct and require gender specific support. He was particularly referring to the finding of a significant minority of male victims identifying as transgender and therefore the need for collecting this information about patients and providing gender-sensitive care. Likewise, other studies have found that domestic violence disproportionately impacts women of colour. Moreover, many studies point to racial and ethnic disparities in health outcome and quality of care. It is fair to infer that to reduce such health inequities, agencies must be able to tailor their programs to better target preventative efforts for these populations and provide more population specific care to survivors.

Monitoring inequities in healthcare is increasingly becoming recognized as an important component of equitable and effective provision of services.[29-32] In fact, in Canada, the

Canadian Institute of Health Research and Chief Public Officer have emphasized the need for the development of tools for health equity measurement.[33,34] The Institute on Violence Prevention echoes these sentiments. As an agency that serves a diverse survivor of violence population that includes both males and females from youth, senior, and various ethnic groups and racial groups, the Institute operates within an equity-based framework and seeks to advance equity monitoring in the health and social service sectors of Peel. On this token, the study aims to further understand the data collection practices among Peel agencies.

In order to monitor inequities, develop equity-based service models, and provide client-centered care, collecting patient-level socio-demographic data is critical. There is increased understanding of the importance of collecting socio-demographic in health equity monitoring.[31,35] Many studies highlight the importance of collecting data on race, ethnicity and primary language in order to measure disparities, initiate programs to improve quality of care, and provide patient-centered care that will ultimately eliminate inequities.[36-38]

However, detailed socio-demographic data that are necessary for monitoring are currently not routinely collected from patients in the Canadian healthcare settings or at the level of service agencies.[36-38] Limited information is collected about their catchment population, service users, incoming and outgoing referral, and the efficacy and outcomes of their services. This hinders the quality of care and support that can be extended to SOIV and the agency's ability to cater their services to their target population.[22,23] Without the ability to adequately assess the profile of service users and the efficacy of their programs and services, it is difficult to determine areas requiring improvement and where gaps exist. Therefore strong data monitoring practices are essential to informing policy and service development.[39]

Data Monitoring Practices and More Collaborative and Integrated Service Delivery

SOIV require comprehensive and unified care that necessitates inter-agency and inter-sectorial collaboration and support.[40] In the Peel region, there are currently many barriers to service access for SOIV, particularly for marginalized populations (e.g. elderly, immigrant, disabled, aboriginal).[40-45] The current system is comprised of service providers that are operating within their own "silos".[39] SOIV find themselves traversing through a complicated labyrinth of services that fail to meet clients' needs and only serve to produce client confusion and frustration.[40] Improved collaboration between social agencies can provide many benefits to SOIV. In fact, increased collaboration has been recognized in the 2010 WHO guidelines (for intimate partner and sexual violence prevention) as one of the first steps to eradicating all forms of violence.[46] Developing formal partnerships between service agencies may help to address the barriers to service access, reduce redundancy, improve efficiency of services, increase accountability and ultimately enhance client satisfaction and safety.[39] A great example of the benefits of systems and service integration is the Family Justice Centre approach which was first introduced in San

Diego, California as a "one-stop shop" for violence services. This community partnership model between domestic violence and criminal justice services provided a single location where SOIV could access medical, legal, community programs and services. The interdisciplinary collaborative approach helped to overcome service access barriers and permitted more fluid exchange of information, and improved referral processes. Overall, several positive outcome measures resulted from Family Justice Centres, including reduced client fear and anxiety, lower homicide rates, increased survivor safety and autonomy as well as increased prosecution of violent offenders. As a result of the initial successes, this model has been recognized by the federal government and has been more widely adapted in many other regions in North America, including the Region of Peel.[47]

However there exist numerous barriers to service agency collaboration; these include financial burden, lack of human resources, non-supportive government and policy systems as well as lack of education and training around the roles of other agencies and sectors.[39] The literature has yielded several recommendations for the improvement of inter-agency collaboration; mentioned among these recommendations were establishing reliable data monitoring and collection practices.[48,49] Data communication and information sharing across agencies allows for increased awareness and knowledge of other agency services, more informed referral processes, improved consistency, and it helps to shift some of the burden of service access away from clients.[39]

Previously Reported Initiatives in Improving Data Monitoring Practices

The health care sector in Ontario has implemented several strategies to address the growing need for systematic evaluation and performance review.[50,51] Several hospitals in Ontario have adopted a balanced scorecard that was originally developed for industry and business organizations, but has more recently been adapted to health care settings. The balanced scorecard focuses on a number of indicators of accountability and efficacy related to four broad domains; 1) system integration and change; 2) patient & family satisfaction; 3) clinical utilization and outcomes; 4) financial performance and condition; and 5) Women's health perspective.[50,54] These changes are also happening on a provincial level. In response to the need for better assessment of system performance, Health Quality Ontario and the Canadian Institute for Health Information established a committee to evaluate primary care performance. The committee identified nine independent characteristics that define a high-performing primary health care system and use this framework to inform decisions about necessary changes to health care services.[50] Clearly there is a trend toward systematic evaluation of health care services and sectors in Ontario.

The same principles of data monitoring in the health sector should also be applied to social services in the community. There has been some preliminary research conducted to assess the impact of referral programs for survivors of intimate partner violence, however, the indicators and measured outcomes were highly heterogeneous among different service providers. Some studies performed in the United States focused on changes in self-reported perceptions of safety; while other studies measured changes in surrogate markers such as police phone calls, emergency department visits, and changes in the use of community resources and services.[41] In Ontario, there have been some similar coordinated initiatives to carry out community evaluation processes. For instance the *Woman Abuse Community Report Card Project* aimed to capture and measure the community agency response to SOIV. The assessment was conducted through a service provider survey administered to agency staff in 5 regions: Owen Sound, Kenora, London, Thunder Bay and Toronto. The survey focused on a number of indicators and descriptive measures within 4 central domains[52]:

1) Community collaboration (e.g. inter-sector working agreements or protocols, referral activity).
2) Common understanding and analysis of woman abuse (e.g. staff training and education on domestic violence, consistent completion of routine risk assessment and safety planning procedures).
3) Effective service delivery (e.g. inventory of current services offered, wait-list lengths, barriers to service access, referrals).
4) Accountability and prevention (e.g. public education/outreach for prevention of domestic violence, client feedback).

Similarly, the Niagara Region conducted a domestic violence report card of their own. The data focus was on regional statistics surrounding police services (e.g. number of domestic violence reports, charges), parole services (e.g. number of individuals on probation or parole for a history of domestic violence), service users (e.g. number of clients served, number of referrals made, number of clients on the wait-list), and housing services (e.g. number of clients accessing shelters or secondary housing) just to name a few.[53] These report cards provided a platform for highlighting efficacious practices as well as ineffective practices that need to be improved or eliminated. Furthermore these evaluation tools allowed progress and changes over time to be monitored and compared both within and across social agencies. From this initial research, it is evident that there is an increasing need and interest in the area of standardized data collection practices, however, more efforts in this area are required to further inform future development of standardized data monitoring and evaluation tools for social agencies serving SOIV.

In the Peel region, there is currently no systematic tool or method in place to evaluate service user profiles nor the quality and efficacy of the services provided to SOIV.[1] Furthermore, current data collection practices are not standardized among agencies in Peel, inconsistent even within the same agencies and deficient as such that they do not provide sufficient data for meaningful assessment and feedback of the quality of services provided by these agencies. Moreover there is a clear gap in the continuity of care that SOIV experience due to the lack of agency collaboration and information/data sharing.

As a long term goal, The Institute on Violence in Peel aims to develop standard guidelines and tools to improve data collection practices and evaluation processes across agencies in Peel that serve SOIV. With a focus on equity and improving the social determinants of health that affect SOIV in the Peel community, the Institute hopes to develop tools that will be based more on client outcomes (rather than institutional performance indicators) and be tailored to the uniquely multicultural constitution of the Peel population. The current project aims to understand the current data collection practices of Peel Agencies serving SOIV in Peel. Furthermore, the Institute wants to know, what are the perceived deficiencies, barriers, and required improvements needed in these current practices so that the service providers in Peel may better serve the client? The current proposed project will act as a pilot study to achieve a better understanding of the nature of data collection practices of Peel agencies that serve survivors of violence and how these practices might be improved upon.

METHODS

Design and Rationale: In summary of the literature, there is evident adverse health and socioeconomic outcomes for survivors of violence. This population has a higher uptake of health and social services than the general population. In response, they need accessible services that are comprehensive and unified in providing for the timely and complex care that they require. However, what we find is that the current system of health and social services are often failing to meet the needs of survivors of violence. The experience of violence is still associated with increased rates of chronic disease, psychiatric problems, poor socioeconomic outcomes and poor quality of life. This population also has many barriers to access. Literature shows that to combat these inadequacies, there needs to be, firstly, more client-centered programming and, secondly, a more collaborative and integrated service delivery model. In order to achieve these service goals, data collection and monitoring are important. Currently, there seems not to be standardized data collection and monitoring practices in Peel. The goal of the Peel Institute on Violence Prevention is to achieve a higher quality of care for SOIV.

This study aims to better understand the current data practices within the social service sector in Peel that services SOIV.

In light of this goal, the study employs a mixed method approach to gain richer and more contextual information about the data collection practices among Peel Agencies. Firstly, we conducted semi-structured interviews (Appendix B) with managers of two agencies in Peel that were subsequently transcribed and analyzed qualitatively using a thematic analysis approach. The data collection is meant to be expanded in the future to include 10-15 more agencies in order to provide a more robust and representative analysis of the Peel data collection practices.

Semi-structured interviews were chosen to gain rich empirical data from current frontline service providers in the Peel Region regarding the current data collection practices. Firstly, we hoped that interviews with agencies would help us understand what information is currently collected, how it is collected, for what purpose it is collected, and how it informs the efficacy of their programs. Secondly, we sought to gain valuable insight from experienced professionals within the field about how programs in this field are currently evaluated and how this is affecting the provision of services and subsequent outcomes of their clients. Thirdly, and more importantly, we wanted to obtain opinions and suggestions regarding deficiencies in current practices, barriers to inadequate data collection and subsequently barriers to providing complete and coordinated care to their clients. We also hoped to understand how these deficiencies and barriers translate to poor health and socioeconomic outcomes for clients. In conjunction with literature, we hoped to define important domains and measures that could be applied to assess the efficacy of social service programs to better meet the needs of their clients. Because there are limited standardized methods to evaluate the performance of social services and a need for more research in this field, semi-structured interviews with professionals in the field provided rich data that would inform development of such tools in the future.

Population: For this study, we approached two social service agencies in the Region of Peel, Ontario, that provide services to our study population: Survivors of Interpersonal Violence in Peel. We interviewed individuals within the agencies who are knowledgeable of the current and existing data collection practices. These were the managers at each agency. They are responsible for compiling and reporting agency-wide data and statistics to government organizations. This may include data in the area of client demographics, services offered/used as well as other data that is collected for both public and private funders. The agency managers were able to describe the rationale or reason behind their data monitoring practices and whether these practices are for evaluation of their services, internal reports or funding purposes. In addition, the agency managers provided a unique perspective on gaps in data collection and areas for improvement. The inclusion and exclusion criteria are as follows:

Inclusion:

- Agency managers employed by social agencies that provide programs/services to SOIV in the Peel region
    - SOIV inclusion criteria: age 18-80, male or female, survivor of intimate partner abuse or rape, survivors of child abuse, survivors of elder abuse, perpetrated by family, partner, child, or caregiver, immigrant, aboriginals, elders, disabled, and located in Peel
    - SOIV exclusion criteria: violence related to workplace, military, street crime, trafficking

Exclusion:

- Social agencies that operate outside of Peel

Data Collection and Analysis: Semi-structured interviews were conducted with the agency managers in sixty to ninety minute sessions. While we maintained our questioning open-ended to a certain degree to give the interviewee the freedom to lead the conversations, we also ensured that we asked the interviewees questions pertaining to three main domains of data collection practices that have been found important in literature and the experience of our supervising agency. Firstly, we asked about their general data collection practices. We inquired about purpose of the data collected, how it is collected, who collects it, and what is collected particularly in regards to socioeconomic data and client-centered programming. Secondly, the interviewees were inquired about collaboration, referrals and data sharing. Here we wanted to glean information about the degree of collaboration with other agencies serving SOIV, information being collected and shared around referrals, and the barriers to collaboration of services. Lastly, our questioning focused around client satisfaction and outcome data collection. We wanted to know how data is being collected in these two areas and subsequently being applied to improving services. In addition to these three domains of questioning, the interviewees were asked about their perception of best practices and poor practices with respect to data collection and monitoring and recommendations moving forward.

The interviews were recorded and subsequently transcribed for qualitative analysis. The interview transcripts were analyzed using a thematic analysis approach.[55] Although grounded theory principles of qualitative analysis were applied, our data was more structured around certain specific domains as previously detailed, and ideas were delineated and themes were generated within each. Any additional information relevant to data collection practices was not discarded, as it was still informative towards the overall understanding of data collection practices. Following the classic methodology of this thematic approach, ideas were coded and grouped to give categories and more general themes. Ideally, data collection and analysis would continue until reaching a point of data saturation.[55] Data saturation is a point at which no new ideas emerge from the data. In this pilot study, however, we only had the capacity to conduct two interviews at this time. Further interviews will be conducted in the future to provide for a more complete and robust analysis. Although our small sample size is limited in drawing meaningful and representative conclusions from our data as it currently stands, we hope that it will be a good starting point for analysis of future interviews.

Two reviewers analyzed each interview and generated themes. In this manner, we were able to achieve the broadest perspective in analysis of the interviews and ensure there was no influence of viewpoints. The following results and discussion reflect the collection of themes from both reviewers. However our limited number of reviewers also serves as a limitation to generating robust analysis. This is discussed further in the limitations section below.

The reason for choosing to conduct a qualitative analysis, especially one utilizing thematic analysis, was the scarcity of previous literature and understanding about nature of data collection and monitoring practices in the social services sector serving SOIV, particularly within the Peel Region. Through more open collection of information from front-line services providers, we are able to gain a greater depth of understanding of the current data collection practices and determine how they can be improved.

Ethics Review Process and Outcomes

Our project was submitted for a delegated review process under the University of Toronto REB and was approved on February 6, 2015 after two resubmissions (Appendix C - Ethics Tracking Form). As a result of feedback from the board, we 1) focused the scope of our research question; 2) removed a quantitative chart review component of the project that was deemed infeasible within the timeframe due to the individual client consent that would be required; 3) Revised our interview guide to make it more relevant to scope of study; 4) Developed a contingency plan in case our two agencies withdrew participation.

In terms of ethical considerations, there was no direct benefit or compensation for participants. Some possible considerations we had were towards the concerns for individual reputations and job security of the participants who were interviewed, due to the possible sensitive nature of internal data collection and monitoring practices and their link to funders of programs at these agencies. For this purpose, all participants were provided informed consents that ensured confidentiality in analysis and reporting of all information, secure storage of the information collected, and the option to withdraw from the study at any time (Appendix A).

RESULTS AND DISCUSSION

These interviews provided a preliminary glimpse at the current landscape of data monitoring practices in Peel agencies serving SOIV. The agency interviews were qualitatively analyzed in 4 major domains that were highlighted in the literature and supported by experiential evidence: 1) General data collection practices; 2) Referral data & collaboration; 3) Client satisfaction and outcomes; and 4) Client-specific training and education.

Agency 1

1) General Data Collection Practices

(a) Data collection practices are largely influenced and limited by funder requirements.

> "[Do you feel that there's anything that's collected extraneously that's not useful or needed?] No. I think we're probably the opposite right now. I think we're not collecting enough right now."
>
> "[In terms of your data collection practices, have they changed over time and how so?] I can tell you that things have changed as the Ministry has requested more information."
>
> "We recognize the need to have the different information because it can certainly dictate how we offer services. I think it's not for lack of motivation, it's always lack of resources. We would really have to overhaul our database in order to be able to

capture some of that information in different detail and those are costly endeavours and unless the Ministry is willing to fund to make those changes you're kind of going in circles."

(b) *Intake workers and clinicians are responsible for data collection. However there are inconsistencies in data collection amongst staff at the agency due to differing clinician education and training resulting in suboptimal quality data monitoring procedures.*

"Our profession because there's so many different entry points, depending on what or even where you studied… You might have learned something different. Unfortunately not everyone's notes/records are that detailed. So even contained within the file you might not see that outlined. That's another challenge in terms of capturing data and information in clinical files for sure."

"It's up to every clinician though…I think this is part of the issue…with the accuracy and completeness of the data that we sometimes have. If they don't complete that portion…they might have referred them to 10 different places but if they don't log it then that's lost data. Right? That's a bit of a challenge."

Data collection practices at this agency are mainly influenced by external funder requirements (mainly The Ministry of Community and Social Services). The funder-driven data include information largely pertaining to service delivery and service users. These include statistics regarding how the allocated funding was spent and where the funder's resources were being utilized. From the funder's perspective this provides accountability information. However, the Ministry's focus on these accountability measures diverts the spotlight away from other, arguably more important, data that is under-collected or neglected altogether; this includes data that is client-centered that may help improve future programming and service development and improve client outcomes. Evidently the funders provide the strongest external incentive for agency-wide change but, unfortunately, the perceived lack of funder motivation creates a stagnant environment of data collection at the agency. Furthermore, this agency identified lack of funding as the most significant barrier to improving their current data systems which again falls into the purview of funders. The agency manager also identified inconsistencies in the data collection practices within the agency. Intake workers and clinicians/counsellors are responsible for client data collection. However, given the diverse staff backgrounds, this leads to varying charting and data input patterns among agency staff and ultimately suboptimal data monitoring procedures. Overall the current data collection landscape contains definite gaps and deficiencies both within and external to this agency. These practices are both determined and limited by external funders' requirements. Finally, the apparent lack of funding presents a major impediment to further development of more sophisticated and informative data measures.

2) Referral Data & Collaboration

(a) *There is a lack of inter-agency and inter-disciplinary collaboration; within the social sector and across the health sector.*

"[What are your sources of referral in general? Where do your clients usually come from?] A lot of the times it's victim services or victim witness at the courts. So again those are both tied to the legal system. That's a big one. We do get a lot of referrals from family physicians although we don't accept referrals directly. So it's not that we get referrals directly from physicians, they're just directed to contact us. So our services are driven by clients."

"[Is there any formal system of referral?**]** Not specifically…for instance for the PAR program yes but not for VAW because that's driven by contact with clients which in it of itself is a barrier."

(b) *Data and information sharing amongst referral sources, both incoming and outgoing, are deficient.*

"[So there's no existing health information? Whether they received a previous service and whether that worked? Anything like that?] In terms of health information or additional details, I'm at the mercy of what she's willing to tell me or disclose. That's a barrier to getting a holistic picture of what's happening."

"[when you refer them to a different service, are you sending any information to the subsequent organization about what happened?] Only if it's relevant and again if the client consents."

"[there's no formal communication process for the other agency? Once a client does go away, are you still collecting data on that client? Is there any information about the client that's coming back to you in any way?] Not usually. Unless again there's a specific reason for that information to come back or if the client is still accessing services with us, it may be relevant to remain in that contact loop but for the most part, no."

(c) Currently the lack of inter-agency collaboration translates to poorer quality of services that can be offered to SOIV.

"It means the client has told their story to all of these people they've made contact with but there's no clarity about what each service provider does and it creates confusion even for clients because sometimes they're accessing multiple services at once."

"[What would you feel would be an ideal way of achieving that (increased inter-agency communication and coordination?] I don't know exactly what this would like but some sort of centralized referral system; you know who all the players are and you offer all the services but the client when they make contact with that one centralized referral system, they understand all points of contact will be informed

> and obviously they have to consent to that or be specific about what they want shared. Then you could maybe try to follow a client through the system a little bit better."

The agency manager also highlighted lack of formal inter-agency and inter-disciplinary collaboration; within the social sector and across the health sector. This was cited as a major barrier to client access to services. Accordingly, the data and information sharing amongst referral sources, both incoming and outgoing, are deficient. This means that clients are presenting to the agency minimal past health or social information. At the same time, outgoing client referrals are being made to other community programs and services often without sharing client information nor the successes or failures of their previous therapies. Thus, agencies are approaching client care with incomplete client information leading to numerous inefficiencies, redundancies and ultimately poor quality of service provision. Without a systematic or standardized data collection system and network for communication, data is either not being gathered or actually being lost as the client navigates through the health and social systems. In order to mitigate this issue, there needs to be more awareness of the importance of maintaining the referral loop. This necessitates improved client information sharing and adequate communication between referring agencies. To initiate these changes there would need to be formal partnerships in place, inter-agency and inter-sectorial staff training as well as a centralized or standardized data collection system to facilitate the flow of client information between agencies and sectors. Again the major barrier to establishing better collaborative initiatives and data sharing appears to be the lack of available resources and funding.

3) Client Satisfaction & Outcomes

(a) *Client Outcomes are determined by the client's perception. No objective or standardized measures are used.*

> "[Are there any objective measures of improved outcomes that are collected?] Not that I can think of in terms of what's on there in terms of their actual functioning. [For example, how many were re-employed or found housing or something along those lines?] No not those kinds of outcome measures. It is clients' subjective opinion of the quality of the service or their subjective opinion of whether they're feeling safer, whether they feel they're more informed compared to when they first accessed questions."

(b) *Client feedback is not directly collected by the agency and there are challenges to obtaining and utilizing this data.*

> "[Is there any data collected about the outcomes and client satisfaction?] We don't collect that data. That goes straight to the Ministry. The Ministry of Community and Social Services for VAW clients, we give them a little card with our agency identifier and they go online and complete the survey online. That addresses client satisfaction."

> “[Is there any way that the feedback gets back to the agency?] Yeah, eventually it does come back. Sometimes it comes back as we’re not getting enough of these from our clients. From my understanding, the information does get back to senior management.

The agency faces various barriers to obtaining a comprehensive analysis of client satisfaction and outcomes. The agency measures client outcomes and evaluates the successes of their services using subjective client feedback. This includes clients’ perception on their satisfaction with the programs and services as well as their perceived personal improvement. Although this provides some valuable evaluative data, objective and evidence-based measures that have been highlighted in the literature are not used. This includes objective data pertaining to improved client safety (e.g. reduced hospitalizations, police phone calls and emergency department visits) and client functioning (e.g. employment and housing security). As a result, the data monitoring process does not obtain a complete account of the clients’ progress; subsequently the information is limited in utility for informing future service changes and developments. Furthermore, client feedback is not collected directly by the agency. Instead The Ministry of Community and Social Services collects and processes this data and then releases the resulting information to the agency at a later date. This causes a disturbance in the data collection process and consequently a delay in the return of potentially informative data to the agency's attention. Overall at this particular agency, client outcome data lacks objectiveness, completion and utility.

4) Client-specific Training and Education

(a) Ongoing client-specific training and education are limited by financial resources.

> "[Do you have regular training sessions for your staff?**]** Not specifically. Again the barrier to that is always funding and time constraints. Professional development unfortunately tends to be the one of the first things to go when there's budget constraints."
>
> "[Is there any formal inter-agency training/education?**]** Again not specifically but I know…I can use the VAW sector as an example. There's a…I think we're moving towards that."

The agency manager acknowledged that continued client-specific education and training are crucial in allowing the service providers to approach clients more completely. The knowledge of the relevant determinants of health would allow clinicians and counselors to take a more holistic approach to client care and allow multiple contributing factors to be addressed appropriately. Unfortunately there is often insufficient funding to support this valuable initiative.

Agency 2

1) Data Collection Practices

(a) *Data collection practices are heavily influenced by funders. They require data surrounding service users (mainly demographic information) but may be lacking in their outcome data requirements.*

"["for whom or what purpose does your agency collect data?] We collect demographic data to understand who we are serving to make sure that we are serving the wider community that we are targeting with our services. We also collect demographic data in order to report back to funder because they require it.

"[what is the data that pertain more towards funders vs. your own purposes?] Actually it is pretty much the same."

(b) *Improvements in data collection practices are limited by available funding and resources.*

"[is there any data that you feel that you would like to collect or need to collect that you aren't collecting at the moment?] I think it would be great to be able to collect more standardized measures data but there is such limitations to that and such a burden on the client and the resources of the system."

(c) *Client data at intake is gathered in a systematic way. However, there is difficulty with ensuring completeness and accuracy of the data. This has implications on how and what services the client is able to access.*

"So when clients approach the organization, there is either an intake done over the phone or in person at our walk-in services and we have a consistent format."

"[So at the moment the Clinician's notes are not fed back into the intake forms?]: yeah we don't really go back and change a lot of the information…sometimes we are not very good at even going back. It's captured in the session notes but it will not be reflected in the original intake information."

(d) *Data collection practices have evolved to become more standardized and evidence-based to try to better evaluate their services for SOIV. Unique internal agency motivation was a strong driver for these changes.*

"[how have your data collection practices changed over time?] I say we've become more structured in the way we do data collection and analysis. We started out with using logic models and developed in the evaluation forms from the logic models. Up until that point, we had kind of done questionnaires but they were not grounded in the logic model."

"logic model is just simply said, it's a way of, it's a format that looks at a way to explain your programs. So you have really activities and then you have short-term,

> mid-range and long term outcomes for your programs. And usually the short-term outcomes are a change in awareness and knowledge, and the mid-terms are more change in behaviours, and the long term goals a more of a motherhood kind of goal statement about what you want to achieve in your program."
>
> "[So you mentioned that the changes in the way you collected data has become more structured and standardized? What was the motivation or incentive for that?] Quality of service and also growing funder expectation. Those two things go hand in hand. I say compared to most social services, we are way ahead in terms of what we are doing here, because we have an internal interest in the quality of service and kind of evidence based practice."

Similar to other organizations, this agency's data collection practices are strongly motivated by external funder requirements. This means that client information is gathered for the purpose of reporting to funders and demonstrating accountability. Accordingly the focus and utility of gathered data naturally deviates away from their potential benefit of informing continuing agency efforts and developments. At the same time, the agency identified insufficient allocation of funds as a challenge to future improvement of agency data practices.

However, this agency was able to overcome the financial barriers by having a strong internal motivation for further development of data monitoring tools and practices. For instance, they have implemented various standardized and objective data forms that have been adapted to most of their programs and being utilized by all staff members. These include data tools such as the State-Hope scale, pre-program and post-program questionnaires as well as outcome rating scales that were developed using logic-based and evidence-based models. Altogether, these measures provide more informative and objective indications of the success of their services and programs. In addition, these validated data tools allow for more meaningful evaluation of their clients' outcomes upon completion of their programs. Despite having these powerful standardized tools, the agency still faces challenges around their execution. The agency managers voiced some concerns regarding the accuracy and completeness of their data due to the inability to update the client files in an effective manner. This problem may be minimized with continued staff training and database improvements to facilitate ease of use. Overall, the data collection practices at the second organization still have gaps that need to be addressed. However, the agency has taken some very positive steps in the direction of mitigating external funding barriers with strong internal incentive for change.

2) Referrals & Collaboration

(a) There are some formal referral systems and numerous partnerships in place.

> "[is there a more systematic process in place (for referrals)?] For some programs, for example the PAR (Partner Assault Response) program only takes referrals from the courts because they are non-voluntary clients. We have another program called Safer Families that only take referrals form CAS."

"[you mentioned that you are collaborating with certain other social service agencies. Can you elaborate on what that looks like in terms of collaboration?] Oh yeah we are collaboration RS. We are the lead agency for the Heal Network, that's an 18 member collaboration. We have the agency Safe Centre of Peel (SCoP), they are a very interesting group, and we are the lead agency for that. We run groups with CCS (Catholic cross cultural services) in different languages, women abuse groups and we run a concurrent disorders group once or twice a year at William Osler Hospital."

"The Safe Centre of Peel (SCOP) manage navigation for the clients that use the centre. We have actually client navigators that work down there. They help coordinate services internally in SCOP and externally as well. Any services that the client and family require, they help make those connections. And they do follow up with clients to try to ensure that second stage needs are met. Most of the clients that come down to the Safe Centre are clients that are at an early stage, the assault is recent, they are looking at safety issues and legal issues, and shelter, housing needs, etc."

(b) Despite a number of collaborations with other agencies/sectors, referral information both in and out are often lacking.

"[what sort of information is shared between agencies in the referral process?] It's very hard because most agencies are not integrated. Here we are a separate shop, in terms of what is shared, there are different referral process with different programs."

"[what do you think is the greatest impediment for this data being shared?] There is no systemic agreement idea, how do we do that, we would have to have a shared database, we would have to be collecting the same information, people are all over the map with what they are collecting. That is a huge barrier. Social services agencies do not have the resources to put in to data collection and management. And that is a huge problem. And recently funders are becoming more aware of that and with the increasing pressure to collect data, I think there is increasing movement especially by the Region of Peel to look at ways that they might be the storehouse of data. So that's kind of in its infancy."

(c) *The major barriers to data sharing between agencies and sectors are inadequate resources and rigid agency mindsets.*

"Resources is a big impediment but also that relates back to capacity. But also there would have to be some kind of external motivation to create that wave. Social service agencies are so strapped for resources that I don't think they would see that as a priority. Data is really kind of back there in ranking for most social service agencies. We are a little bit different because we are interested in…we've been collecting data for a while. I wonder also about the cultural mindset of individual agencies that could be a plus or it could be a barrier. I think some agencies are more or less inclined to share or they collect data in their own way for their own purposes and making changes is a huge investment, which they often don't have. So if the will is not there to do it and there is no external motivating factor, it's not going to get done."

"[what would you say the external motivating factors would be?] Funders. It's very interesting that you know you are expected to collaborate as a transfer payment agency but the provincial government does not collaborate between their silos."

(d) Ultimately clients are suffering the consequences of lack of integration and coordination of services.

"I think clients would appreciate not having to tell their information over and over again. And certainly for our own use of resources (with better integration), Clients would have to tell their story fewer times, referrals would be falling through the cracks less often, I think there would be more thoroughness and more consistency. That would work for the client. I think agencies each of us do the same work over and over again in our silos because the processes and therefore we are all doing our own thing and we are spending resources on collecting and documenting and recollecting and documenting and we are not sharing."

(e) Information sharing between agencies could benefit SOIV.

> "[what sort of data information would be important or necessary to be shared among these agencies?] Most certainly demographic information to understand who is being served and who's accessing what types of service. (Also) things that we know that impact peoples physical and mental well-being like adverse childhood event and other adverse events, that kind of information would probably be a good thing to share because then a more holistic treatment plan could happen. The outcome information I think that would be a good thing to share too because then people can look and see oh look at the outcome on that program and it may be a good program to refer to. But none of that gets shared. Even some funders don't care about outcome information. The provincial funders are really behind."

Despite engaging in multiple partnership initiatives with other health, social and legal sectors, there still exists a gap in the communication and data sharing between collaborating members. This in turn results in a superficial form of collaboration and although being a good first step in the direction of more meaningful connections, there still is work to be done. Due to the gaps that still exist in collaboration, information sharing is still inadequate. Hence clients are still experiencing considerable redundancies and inefficiencies as they are moving across the various sectors. Clients may have to re-tell their stories and start anew once they present to another agency. Ultimately this leads to poorer support and care for SOIV and suboptimal client outcomes. However these initial steps have allowed clients to be referred to appropriate services because the agency staff have awareness and knowledge of other resources that may further help their clients. To further benefit clients, the agency must continue to develop their partnerships to become deeper and more purposeful. The barriers that were reported for overcoming this problem include lacking funder support and the mindset of other sectors. Funders have yet to identify the importance of data sharing and thus have not provided resources for agencies to establish connections with other agencies and organizations. In addition, the agency managers recognized that some community agencies are willing or enthusiastic about engaging in these types of data sharing initiatives.

3) Client Satisfaction & Outcomes

(a) Client outcomes and program/service success are evaluated using standardized and systematic approaches (e.g. State-hope scale, outcome rating scale, session rating scale, pre/post program questionnaires) at regular intervals.

"we used to do client satisfaction surveys etc, but we've tried to move toward more program outcome evaluations, with pre and post test in all our programs."

"they are done at the first session at the 1st session, 3rd sessions, and the 6th and final session. We work in a six session model. If the client goes beyond the 6th session then we do others."

(b) *Client outcomes are monitored and used to inform both short-term and longer-term service provision.*

> “counsellors use them in the session to help to frame the conversation about how the client is doing today vs. how they did last time. So you can see it’s a visual demonstration of change in different areas of the client’s life. So that can be used clinically but also in terms of our programs we are able to look at the outcome data to see if we are on track with achieving the outcomes we are trying to achieve so that’s very useful to us. And we get good information back from the client satisfaction measure too to see if our services are accessible to people.”

As mentioned above the agency has gravitated towards using more systematic methods of data collection and have incorporated various objective measures. Furthermore these standardized data tools have allowed clinicians and counsellors to appropriately tailor their efforts based on the outcome data. In essence, this provides better ongoing and real-time assessment of their services and client response, compared to just subjective client feedback. In addition, the agency managers reported that these new data monitoring methods are useful in enlightening their future efforts towards client care as well as modifications to service delivery.

4) Training & Education

(a) Extensive client-centered training available and staff are educated in relevant fields. There is an emphasis on taking a holistic approach to serving clients.

> "We like to think that we've developed and are continuing to training/orient people towards trauma informed approach. We do a lot of interim training here and we have a practicum training program and there is an organized training schedule as part of that which includes many of these topics on diversity, anti-oppression, trauma."
>
> "The SDOH or the holistic model is very much part of what the thinking is. Obviously people who don't have good housing, don't have enough food aren't going to be making use of counselling services. We would work with other agencies that are looking at more basic needs like housing, transitional housing and support, income security, employment programs, etc."

The agency recognized social determinants of health (SDOH) as being vital to providing appropriate support for SOIV. As a result, the agency encourages continued staff training and education on a variety of topics relevant to their target population. This translates to more informed and prepared staff who can then deliver more comprehensive and holistic care to clients and addressing all of the factors that may influence the client's health and well-being.

CONCLUSIONS

Interviews with two managers at agencies supporting SOIV yielded valuable insight into the current landscape of data collection in Peel. Several preliminary conclusions may be drawn from the results of this study: 1) current data collection practices in Peel Agencies are suboptimal and mainly funder driven, 2) agency partnerships, data sharing and communication are lacking despite being critical for service quality, 3) validated, objective measures provide more meaningful evaluation of client outcomes and 4) insufficient and misdirected funding poses a significant barrier to improvement of data monitoring practices.

It is clear that there is a continuing trend towards more rigorous data monitoring practices among health and social services serving SOIV. The notion has been well-established in the literature and is supported by the preliminary findings of this study. This reflects the need for better data collection and evaluation of services and programs in order to better inform changes in service provision and delivery. Ultimately, this study provides a platform for future research efforts and may hopefully contribute to the development of a standardized and systematic data collection tool that can be used to gauge the progress and success of social agencies in Peel to the end of improving outcomes for SOIV.

Recommendations for Peel Agencies serving SOIV: We have generated several recommendations to address some of the identified gaps and deficiencies in current data collection practices and to overcome some of the barriers to changing these practices.

1. Improve data collection practices (both consistency and content) through use of more standardized forms/practices to better inform client services and evaluate client outcomes

2. Increase agency collaboration, ongoing communication and information sharing between agencies to improve the comprehensiveness and continuity of care for SOIV

3. Raise agency and funder awareness on the importance of data monitoring practices to generate more incentive and to overcome funding as a major barrier to change

Limitations: Only 2 social agencies in Peel were included as part of this pilot study. This provided a glimpse of the total landscape in the Peel region but more agencies need to be engaged in order to confirm and strengthen the conclusions that were drawn from this study. In addition the agency manager interviews were qualitatively analyzed by only two individuals. Continued iterative analyses may be performed by other individuals to diversify the perspectives looking at the data and increase the quality and quantity of findings.

Lessons Learned: Overall this was a valuable experience; from the challenges that we faced with navigating the ethics review approval and the opportunity to designing and executing a qualitative research study. Furthermore, our experience at the agency renewed our appreciation for social service agencies providing care in the community.

Lastly we further understand the importance of addressing the social determinants of health and the need for approaching medicine in a holistic fashion.

REFERENCES

1. Peel Institute on Violence Prevention (2014). June 2014 Report (pp. 3-18): *Institute on Violence Prevention*.

2. Narula, A., Agarwal, G., and McCarthy, L. (2012). Intimate partner violence: patients' experiences and perceptions in family practice. *Family Practice*, 29, 593-600.

3. Tsui V. (2014). Male victims of intimate partner abuse: use and helpfulness of services. *Soc Work*. 59, 121-30

4. Du Mont, J., Macdonald, S., White, M., Turner, L. 2013. Male victims of adult sexual assault: a descriptive study of survivors' use of sexual assault treatment services. *J Interpers Violence*. 13, 2676-94.

5. Larsen, M.M., Krohn, J., Puschel, K., Seifert, D. 2014. Experiences of health and health care among women exposed to intimate partner violence: qualitative findings from Germany. *Health Care Women Int*. 435, 359-79

6. Myskow, L. (2006). The Impact of Childhood Sexual Abuse on Women's Healthcare, *Cytopathology*, 17, s1, 4-5.

7. Queen J, Brackley MH, Williams GB. Being emotionally abused: a Phenomenological study of adult Women's experiences of emotionally abusive intimate partner relationships. *Issues Ment Health Nurs 2009;30:237-45*

8. Arias I, Pape KT. Psychological abuse: Implications for adjustment and commitment to leave violent partners. *Violence Vict.* 1999;14(1):55-67

9. O'Leary K. Psychological abuse: a variable deserving critical attention in domestic violence. *Violence Vict 1999*;14(1):3-23

10. Renne D. Goodwin and Murray B. Stein, Association between childhood trauma and physical disorders among adults in the United States, *Psychological Medicine*, 2004, 34, 509–520.

11. Stene LE, Jacobsen GW, Dyb G, Tverdal A, Schei B, Intimate partner violence and cardiovascular risk in women: a population-based cohort study, *Journal of Women's Health*, 2013, 22, 3, 250-258.

12. Afifi T, Mota N, MacMillan H, Sareen J, Harsh physical punishment in childhood and adult physical health, *Pediatrics*, 2013, 132, 2, e333-e340.

13. Kelly A. Scott-Storey, Abuse as a gendered risk factor for cardiovascular disease: a conceptual model, *Journal of Cardiovascular Nursing*, 2013, 28, 6, E1-E8.

14. Crane CA, Pilver CE, Weinberger AH, Cigarette smoking among intimate partner violence perpetrators and victims: Findings from the National Epidemiologic Survey on Alcohol and Related Conditions, Am J Addict. 2014 Sep;23(5):493-501. doi: 10.1111/j.1521-0391.2014.12136.x.

15. Keren Lehavot and Jane M. Simoni, Victimization, Smoking, and Chronic Physical Health Problems Among Sexual Minority Women, Annals of Behavioral Medicine, 2011, 42, 269–276.
16. J. Midei and K. A. Matthews, Interpersonal violence in childhood as a risk factor for obesity: a systematic review of the literature and proposed pathways, International Association for the Study of Obesity, 2011, 12, e159–e172.

17. Jennie G. Noll, Meg H. Zeller, Penelope K. Trickett, and Frank W. Putnam, Obesity Risk for Female Victims of Childhood Sexual Abuse: A Prospective Study, Pediatrics, 2007, 120, 1, e61-e67.

18. Carmen Vives-Cases, The effect of intimate partner violence and other forms of violence against women on health, Journal of Public Health, Volume 33, Issue 1, Pp. 15-21.

19. Lorena Garcia, Lihong Qi, Marianne Rasor, Cari Jo Clark, Joyce Bromberger, and Ellen B. Gold, The Relationship of Violence and Traumatic Stress to Changes in Weight and Waist Circumference: Longitudinal Analyses From the Study of Women's Health Across the Nation, Journal of Interpersonal Violence, 2014, 29, 8, 1459–1476.

20. Nelson, S., Baldwin, N. & Taylor, J. (2012). Mental health problems and medically unexplained physical symptoms in adult survivors of childhood sexual abuse: an integrative literature review, *Journal of Psychiatric and Mental Health Nursing*, 19, 211– 220.

21. Palmer, SE., Brown, RA., Rac-Grant, NI., Loughlin, MJ. (2001). Survivors of childhood abuse: their reported experiences with professional help. *Woc work*. 46(2), 136-45.

22. Haeseler, L. A. (2013). Organizational Development Structure: Improvements for Service Agencies Aiding Women of Abuse. *Journal of Evidence-Based Social Work*, 10(1), 19-24.

23. Haeseler, L. A. (2013). Improving Service Practices: Collaborative Care for Women of Abuse. *Journal of Evidence-Based Social Work*, 10, 10-18.

24. Kirst, M., Shankardass, K., Bomze, S., Lofters, A., Quinonez, C. (2013). Sociodemogrpahic data collection for health equity measurement: a mixed methods study examining public opinion. *Int J Equity Health*. 12, 75.

25. Bolman, L., & Deal, T. (2003). Reframing organizations: Artistry, choice, and leadership (3rd ed.). San Francisco, CA: Jossey-Bass.

26. Brilliant, E., & Young, D. (2004). The changing identity of federated community service organizations. Administration in Social Work, 28, 23–46.

27. Lawson, D. (2003). Incidence, explanations, and treatment of partner violence. American Counseling Association, 81, 19–33.

28. Skinner, K., & Whyte, B. (2004). Going beyond training: Theory and practice in managing learning. Social Work Education, 23, 365–381.

29. Agency of Healthcare Research and Quality: Measuring healthcare quality; 2009. [Online] 2009. [Cited: April 27, 2015.] www.ahrq.gov/qual/measurix.htm.

30. Institute of Medicine, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care: Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: The National Academic Press; 2002

31. Krieger N, Williams . Healthcare disparities at the crossroads with healthcare reform. New York: Springer; 2011. Monitoring socioeconomic determinants for health disparities: tools from the public health disparities Geocoding project; pp. 269–312. R.A. (ed.)

32. Weinick RM, et al: Measuring racial and ethnic health care disparities in Massachusetts. Health Aff 2007, 26:1293–1302.

33. Canadian Institutes of Health Research: Health equity matters - IPPH strategic plan, 2009-2014; 2010. [Online] 2010. [Cited: March 12, 2010.] http://www. cihr-irsc.gc.ca/e/40524.html#4_4.

34. Public Health Agency of Canada: The chief public health Officer's report on the state of public health in Canada. Ottawa: Ontario Minister of Health; 2008. 2008.

35. Lofters A, Shankardass K, Kirst M, Quiñonez C: Sociodemographic data collection in Canadian healthcare settings: an examination of public opinion. Med Care 2010, 49(2):193–199

36. Bierman AS, Lurie N, Collins KS, et al: Addressing racial and ethnic barriers to effective health care: the need for better data. Health Aff 2002, 21:91–102.

37. Hasnain-Wynia R, Baker DW: Obtaining data on patient race, ethnicity and primary language in health care organizations: current challenges and proposed solutions. Health Serv Res 2006, 41:1501–1518.

38. Rodney P, Copeland E: The health status of black Canadians: Do aggregate racial and ethnic variables hide health disparities? J Health Care Poor Underserved 2009, 20:817–823.

39. Peel Institute on Violence Prevention (2014). Strengthening Violence Prevention Through Increased Service Collaboration and Coordination. *Institute on Violence Prevention: May 2014 Internal Report*.

40. Robinson, A. L. & Tregidga, J. (2007). The Perceptions of High-Risk Victims of Domestic Violence to a Coordinated Community Response in Cardiff, Wales. *Violence Against Women*: 13, 11, 1130-1148.

41. Hyman, I. et al. (2006). Help-Seeking Rates for Intimate Partner Violence (IPV) Among Canadian
Immigrant Women, *Health Care for Women International*: 27, 682–694.

42. Bennett, L. & O'Brien, P. (2007) Effects of Coordinated Services for Drug-Abusing Women Who Are Victims of Intimate Partner Violence. *Violence Against Women*: 13, 4, 395-411.

43. Wahab, S. & Olson, L. (2004). Intimate Partner Violence and Sexual Assault in Native American Communities. *Trauma, Violence, & Abuse:* 5, 4, 353-366.

44. Plummer, SB. & Findley, P. A. (2012). Women With Disabilities' Experience With Physical and Sexual Abuse: A Review of the Literature and Implications for the Field. *Trauma, Violence, & Abuse*: 13, 1, 15-29.

45. Otto, J. M., & Quinn, K. (2007). Barriers to and Promising Practices for Collaboration Between Adult Protective Services And Domestic Violence Programs, *National Center on Elder Abuse*.

46. World Health Organization (2010), *Preventing intimate partner and sexual violence against women: taking action and generating evidence*.

47. Sadusky, J. M., et al. (2010). The Praxis Safety and Accountability Audit: Practicing a "Sociology for People" *Violence Against Women*: 16, 9, 1031-1044

48. Macy, R. J. & Goodbourn, M. (2012). Promoting successful collaborations between domestic violence and substance abuse treatment service sectors: a review of the literature. *Trauma, Violence, & Abuse*: 13, 4, 234-251.

49. DeCandia, Carmela, etc al. *Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness*. The National Center on Family Homelessness. (2013).

50. Zelman, WN., Pink, GH., and Matthias, CB. (2003). Use of the Balanced Scorecard in Health Care. *Journal of Health Care Finance*, 29(4), 1-16.

51. Health Quality Ontario and the Canadian Institute for Health Information. (2013). Ontario Primary Care Performance Measurement Summit Proceedings Report, *Queen's Printer for Ontario*, 15,33.

52. Kirst, M., Zhang, YJ., Young, A., Marshall, A. O'Campo, P., & Ahmad, F. (2013). Referral to Health and Social Services for Intimate Partner Violence in Health Care Settings: A realist Scoping Review. *Trauma, Violence & Abuse,* 13(4), 198-208.

53. Coalition to End Violence Against Women (2012). *Niagara Region Domestic Violence Report Card 2011/12: The System Matters*.

54. Hospital Report 2005: Complex Continuing Care. *Hospital Report Series*. Canadian Institute of Health Information, 2005. Web. 1 April. 2015.

55. Strauss, A., & Corbin, J. M. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Sage Publications, Inc.