Peel Institute on Violence Prevention

Strengthening Violence Prevention through Increased Service Collaboration and Coordination

A Preliminary Literature Review

[May 2014]

Table of Contents

Introduction

This report builds upon the ongoing work in the Region of Peel to improve services for those who have experienced violence. At the heart of this work is the aspiration to better meet the needs of our increasingly diverse population and to move towards the elimination of all forms of violence within the region. In order to achieve this end there has been a strong interest—not just in Peel, but both nationally and internationally—for increased inter-agency service collaboration by both service-providers and policy-makers alike. Furthermore, a desire to improve service-delivery exists across different fields throughout Ontario. For example, within the mental health and addiction sectors is the aspiration to make "every door the right door;"[1] in other words, to reduce confusing service navigation through increased service coordination. This type of system would provide clients a range of evidence-based services that are coordinated with other health or care programs that they may need. This easily translates to the domestic violence sector, as the benefits of increased service collaboration for survivors of violence are well-documented and championed by numerous articles, literature reviews, studies, and advocates. Moreover, extensive literature (Bennett & O'Brien 2007; Joanne Klevens 2008; Lafrenière et al. 2009; Macy & Goodbourn 2012—to name a few) exists in the domestic violence and abuse sector on past successful service coordination models and implications for the field. This report seeks to add to this wealth of research by reviewing other literature reviews and journal articles that discuss community coordination and inter-agency collaboration of services to examine the impact and relationship of coordinated efforts on violence prevention. Increased multidisciplinary agency collaboration through service coordination serves not only as a way to address gaps and barriers in service access and delivery, but research shows that ultimately this approach contributes to the prevention of all forms of violence. Given that the Peel Institute on Violence Prevention is interested in reducing and eventually eliminating all forms of violence within the region, this literature review provides a broad scope of the relevant issue at hand.

Moreover, this literature review is meant to compliment two pieces of work by the Peel Institute on Violence Prevention. The first of which is a retrospective, pilot fact-finding study, the second is a catalogue of population-level domestic violence statistics. The foundation of the retrospective study is the collection of baseline data in support of priority issues identified by experienced care providers, sector workers, researchers, and survivors with lived experience from Peel. This study was guided by our conceptual framework (please see Appendix A) of capturing demographic data, reviewing the extent of coordination of services, and the extent to which services are offered in a comprehensive manner. For the pilot study, the Institute reviewed case files from Family Services of Peel (FSP) in the area of coordination of services. To this end, both this literature review and the retrospective study are centered on close collaboration between service providers and individuals with the lived experience of violence within the region and beyond. Moreover, both are a part of the Institute's goal of creating a collaborative research organization dedicated to addressing all forms of violence in Peel. In regards to the catalogue of population-level domestic violence statistics, it is the result of an extensive, comprehensive search of which agencies and organizations across Peel, Ontario, and Canada collect statistics on domestic violence. Our research focused on who is collecting data, how this data is collected, and to what purpose—namely what were the resulting publications that utilized this data. The

[1] Ministry of Health and Long-Term Care, Government of Ontario, *Every Door is the Right Door. Towards a 10-Year Mental Health and Addictions Strategy*, (2009)

importance of data monitoring in relation to service collaboration and violence prevention will be discussed later on in this literature review.

The key questions behind this literature review are:

- What is known about community coordination and inter-agency collaboration of services for survivors of all forms of violence from existing literature?
- What contributes to improved coordination of services? What are the benefits to survivors? Are there examples of successful models of service coordination and collaboration? If not, what analysis exists that explains the difficulties in forming coordinated and seamless responses?
- What are the barriers to successful collaboration and coordination of services for survivors of violence? What are the conditions that promote and enable strong collaborative relationships and coordination of service?
- Given that increased service coordination has a positive impact on the effectiveness and accountability of services for those impacted by violence, what are the implications of this in regards to violence prevention?

Methodology

The following inclusion and exclusion criteria were applied to the literature search:

Inclusion:

- Peer-reviewed articles and grey literature that explore the issue of services for women, men, immigrants, Aboriginals, elders, and disabled populations affected by relationship violence.
- Studies and reports written in English that focus on the following regions: North America, Great Britain, and Australia.
- Studies and reports published during the period of 2004-2014.
- While domestic violence services were the basis of our search, given that we are interested in multidisciplinary, inter-agency service coordination, articles that looked at collaborations between domestic violence services and the sectors of mental health, substance abuse, and elder abuse, were also included in our review.

Exclusion:

- Violence related to workplace, military, street crime, and trafficking.

The literature review included the following databases:

Databases	Search Terms Used
PUBMED (http://www.pubmed.com)	Violence OR abuse AND coordination OR integration (any field); Coordinated Community Response to domestic violence OR abuse
Google Scholar (http://scholar.google.ca/)	VAW services coordination; VAW services AND Aboriginals OR men OR elders; Violence OR abuse prevention; VAW services AND role of survivors; VAW service barriers Coordinated Community Response to elder abuse AND violence against women; male survivors of sexual abuse literature review; Family Justice

	Centers Ontario; domestic violence coordinated community response Ontario; coordinated response batterers program
Scholars Portal (http://scholarsportal.info/)	VAW services coordination; Violence OR abuse prevention; VAW service barriers for immigrant women; VAW service barriers for aboriginal women; Coordinated Community Response to domestic violence OR abuse;
SAGE Journals (http://online.sagepub.com/)	VAW services coordination; Violence OR abuse prevention; VAW service barriers; VAW service barriers for disabled populations;
Proquest (www.proquest.com)	VAW services coordination; VAW services AND Aboriginals OR men OR elders; Violence OR abuse prevention; VAW services AND role of survivors; VAW service barriers
EBSCO (http://search.ebscohost.com)	Coordinated services for disabled survivors of violence literature review; aboriginal women violence prevalence AND access to coordinated services

Results

We reviewed all of the articles that appeared to be related to our subjects of interest and excluded ones that did not fit our inclusion criteria. Of the 102 articles and reports initially found, 57 were selected as relevant to our literature review. Literature that was unable to meet our standards for the purpose of this report failed for the following reasons:

- The reports were related to our interest in service coordination; however they were published in or focused on middle-income countries and therefore were outside our geographical criteria.
- Despite the articles' abstracts and keywords meeting the inclusion criteria, the reports were not actually related to collaboration amongst care services for those affected by violence.
- Many articles mentioned the need for increased collaborative efforts throughout abuse services; however the authors did not elaborate on this in any shape or form, nor were the reasons behind this need disclosed.

Limitations of this Literature Review

Given the ambitious goal of the Peel Institute on Violence Prevention, to work towards the elimination of violence for all populations, this literature review has a very large scope and consequently is limited in its breadth. This is an initial and preliminary review that is recognized to be a 'work in progress.' A long term goal of the Institute is to continue to collect in-depth information on all areas of work related to abuse. In addition, since this report focuses on service coordination and collaborative efforts, other sections (such as obstacles to service access) were condensed to allow the literature review to focus mainly on our research questions.

Why Inter-agency Collaboration is Necessary

Relationship violence is a major and widespread global problem that negatively effects both immediate and long-term physical, mental, and emotional health of individuals and is a serious violation of human rights. Relationship violence and abuse includes a range of situations experienced by both women and men, including intimate partner abuse, elder abuse, childhood abuse, and sexual abuse. Since the highest proportion of abusive relationships are those within intimate relationships, this literature review will focus primarily on intimate partner violence (IPV), also known as domestic violence. Women represent the majority of those directly affected by violence; in 2011 in Canada alone for every 100,000 women in the population, 1,207 women experienced violence. [2] Moreover, Canadian women are four times as likely to experience intimate partner violence.[3] In Peel alone, incidences of reported domestic violence are on the rise. For every 100,000, Peel Regional Police responded to 14,116 domestic disturbances in 2012, as opposed to 13,319 incidents in 2009.[4] Given the prevalence of intimate partner abuse, it is essential that services for those affected by violence meet the needs of the population that they serve. In 2013, a regional assessment conducted by the Safe Centre of Peel (SCOP), collaboration, the relationships between grassroots and mainstream organizations, and partnerships were identified as strengths in Peel's current service delivery model. However, collaboration was also listed alongside service navigation as a regional system weakness because despite the best efforts of community agencies, service-users still encounter numerous gaps and barriers in accessing services. (Walters-Boadway, 2013). Lack of coordination between services is a major issue that stands out to service-users both inside the region and out. The current system of services is often likened to navigating a maze; survivors emphasize that when they experienced service collaboration and coordination, it was more than helpful to them.[5] Interviews with survivors revealed that they are aware and appreciative of the collaborative approach. The sharing of information gave them: the ability to talk to people who held consistent information about their cases, that agencies understood the bigger picture of their daily lives, and that they had received an enormous amount of support. (Robinson & Tregidga 2007).

Service Barriers for Immigrant Populations

Research has indicated that immigrant women, particularly those who are newly arrived, are more vulnerable to domestic violence due to language barriers, economic dependence, and a lack of knowledge about community resources.[6] The 2013 article, *Measuring Violence Against Women: Statistical Trends*, Statistics Canada revealed that survivors of violent crime may still not turn to the legal system or formal sources of support for help and that help-seeking rates decrease dramatically when looking at immigrant populations, particularly that of recent immigrants. In fact, studies (Robinson & Tregidga 2007; Ilene Hyman, et al. 2006) have shown that recent immigrant women are significantly less likely to use social services compared with non-recent immigrant women.

[2] Maire Sinha (editor), "Measuring Violence Against Women: Statistical Trends" Canadian Centre for Justice Statistics (2013)
[3] Maire Sinha (editor), "Measuring Violence Against Women: Statistical Trends" Canadian Centre for Justice Statistics (2013)
[4] Peel Regional Police, *2010 Annual Statistical Report* (2011) & *2012 Annual Performance Report* (2013)
[5] Colleen Purdon, *Final Report: Rural Strategies for Women with Abuse, Mental Health, and Addiction Issues Project* Grey Bruce Violence Prevention Coordinating Committee (2008)
[6] Sheetal Rana, Addressing Domestic Violence in Immigrant Communities: Critical Issues for Culturally Competent Services, National Online Resource Center on Violence Against Women. (2012)

Given this increased vulnerability, immigrant populations need easy access to support and resources when seeking help for violence. However, barriers to service access and delivery are exacerbated when survivors of violence fall outside of the white, middle-to-upper class, English-speaking, female population. (Ilene Hyman, et al. 2006). Violence experienced by women from immigrant populations are rendered less visible, often overlooked, and can even be excused for cultural reasons. There is a lack of appropriate services and intervention strategies as well as culturally and linguistically appropriate services for immigrant women. (Guruge & Humphreys, 2009). Racialized stereotypes held by professionals in regards to both violence and gender representations contribute to immigrant women's expectations and experiences of racism from services. The uncertainty of one's membership to a community, fear of potential deportation, and unfamiliarity with laws and rights can trigger anxiety about disclosing personal matters. Also, institutionalized racism and sexism creates obstacles not only to service access, but it places the responsibility for service approachability upon immigrant women. (Burman et al., 2004; Taylor & Putt, 2007; Bennett & O'Brien, 2007).

Our literature review revealed a number of commonalities in relation to how to improve services for abused immigrant populations. Research (Burman, et al., 2004; Guruge & Humphreys, 2009) indicates that greater communication between agencies and communities is necessary as this will facilitate the building of contexts that broaden responsibility for women's and children's safety, as will an increase in service-providers consideration of delivering culturally sensitive services. The development of partnerships between mainstream and ethno-specific agencies is also recommended, as "health professionals must collaborate with social workers and settlement workers to address structural barriers that limit women's access to and use of formal social support."[7]

Service Barriers for Aboriginal Populations

Studies have found that Aboriginal women have a higher likelihood of being victimized compared to the rest of the Canadian female population. In 2009, almost 67,000 Aboriginal women aged 15 or older living in Canada reported being directly affected by violence within the previous year. (Brennan 2011; Perreault 2011). Overall, the rate of self-reported violent victimization among Aboriginal women was "almost three times higher than the rate of violent victimization reported by non-Aboriginal women."[8] These statistics supplement a recent call by the United Nations for the Canadian government to hold a national inquiry on the nearly 1200 missing and/or murdered aboriginal women and girls, who have vanished within the past 30 years.[9] This higher violence prevalence in comparison to non-Aboriginal women is mirrored in the United States and both survivors and professionals involved in Aboriginal-related care services point to the direct relationship between the historical experience of Aboriginal people and current level of violence against women throughout the Aboriginal population. Aboriginal survivors of violence do not report abuse due to mistrust of agencies and criminal justice services, fear of family or community ostracization, concerns over confidentiality and safety, and experiences with systemic racism in relation to social services. The mistrust of services is tied to

[7] Sepali Guruge and Janice Humphreys, "Barriers Affecting Access to and Use of Formal Social Supports Among Abused Immigrant Women," Canadian Journal of Nursing Research (2009): 41, 3, 65
[8] Shannon Brennan, *Violent victimization of Aboriginal women in the Canadian provinces*, Statistics Canada (2009), 5
[9] James Anaya for the Human Rights Council, *Report of the Special Rapporteur on the rights of indigenous peoples: The situation of indigenous peoples in Canada*, (2014)

past and present challenges between the justice system and Aboriginal communities and a large amount of work needs to be put forward through collaboration and new approaches to overcome this obstacle. (Wahab & Olson, 2004).

Service Barriers for Male Populations

The literature on male survivors of both domestic violence and sexual assault is estimated to be at least 40 years behind that of female survivors.[10] That being said, in assessing other literature reviews and reports, (Walker, et al. 2005; Davies & Rogers 2006; Carney, Buttell, Dutton 2007; Douglas & Hines 2011), it is clear that male survivors face numerous barriers in both help-seeking and access to services. With the former, disclosure is limited by the stigma and misinformation surrounding male sexual assault, which is a consequence of patriarchal gender expectations surrounding masculinity. With relation to the latter, gender bias serves as the main barrier in service access for men who seek assistance for domestic violence. Domestic violence, health care, and criminal justice services sometimes turn away or disregard male survivors on the basis of gender, stating that they only assist female help-seekers.[11] This is due to the reality of funding structures as the vast majority of resources available for services related to abuse are targeted to women because women victims vastly outnumber male victims. As a result, often service-providers can give the impression that they are biased against men due to the higher ratio of male-on-female violence and their work with women affected by violence. Given these factors, there is a lack of experience and resources throughout the various sectors that deal with those affected by violence. Consequently, this in turn makes collaboration via cross-sectoral training essential to closing service gaps as additional education in a collaborative environment would be the most effective step forward to remedy this situation. (Douglas & Hines, 2011).

Service Barriers for Disabled Populations

Literature on domestic violence and disabilities, (Plummer and Findley 2012; Coker et al 2005) state that women with disabilities experience abuse at similar or increased rates as compared to the general population. A critical issue for disabled women is the reality that for many their care-givers are their abusers. Due to the scarcity of resources, services, and supports, disabled women end up relying on their care-givers and put up with abuse because they have no other options. Disabled women suffer from various forms of abuse and neglect and often are targeted by perpetrators due to their perceived vulnerabilities. When women with disabilities reach out for assistance with domestic violence or abuse, they are generally met with little to no support by social services and the health care system in general. The supports required by women with disabilities often include care-giving and instrumental help with day-to-day living; the kind of supports that can be very difficult to access within our current system. This lack of accessible resources is the main cause of domestic violence shelters and agencies being unable to meet the needs of disabled clients and is further exacerbated by a lack of coordination between agencies, particularly in obtaining personal care assistance and sign language interpreters. (Plummer & Findley, 2012).

[10] Susan McDonald and Adamira Tijerino, "Male Survivors of Sexual Abuse and Assault: Their Experiences," Research and Statistic Division, Department of Justice Canada, (2013)
[11] Emily M. Douglas and Denise Ann Hines, "The Helpseeking Experiences of Men Who Sustain Intimate Partner Violence: An Overlooked Population and Implications for Practice," *Journal of Family Violence*, (2011): 26, 6, 481.

Service Barriers for Elderly Populations

While other literature reviews focus on the prevalence and difficulties elderly populations face in accessing domestic violence services, (Nelson et al. 2004; Beaulaurier et al. 2007; Cooper et al. 2008), Joanne M. Otto and Kathleen Quinn (2007) detail the reasons for why service collaboration between domestic violence and elder abuse services is a challenge. Language and age serve as major barriers, as elderly survivors of violence do not fit the usual definitions of domestic violence, perpetrators do not fit the "intimate partner" label as they are often adult children or caregivers, and programs for survivors are generally geared towards those well below the age of 65. As a result, elderly survivors often see themselves as outside of the range for these services. Also, domestic violence services are often not equipped to deal with the circumstances of elderly clients, namely chronic medical issues, disabilities, and long-term care situations.[12] As with women with disabilities, for the elderly, their abuser is most often their care-giver. Challenging the abuser therefore, means that they will lose urgently needed help and support- which often leaves the elderly person in the position of having to deal with abuse in order to survive. Otto and Quinn also cite the lack of funding for cross training and collaborative initiatives as the basis for the challenges to service coordination between domestic violence and elder abuse agencies.

General Benefits of Increased Inter-agency Collaboration

The benefits of inter-agency collaboration are two-fold. For service-users, collaboration can help close the aforementioned service barriers. For service-providers, collaboration between services can improve the ability of workers to respond to their clients' needs if and when they are able to work collaboratively with others who have common goals and a common understanding of the issues. Working collaboratively can take workers, regardless of their agency or sector, outside of their "silos."[13] This can increase a service-provider's ability to make effective referrals, to inform other related services, build more effective systems to support clients.

Collaboration can create deeper levels of engagement with clients, increase clarity, reassurance, and accountability, and improve both client screening and safety. Moreover, collaboration allows different agencies to meet with individual clients simultaneously which enables information from about clients to be consistent across agencies and reduces the number of meetings that clients have to attend.[14] More specific benefits to increased inter-agency collaboration are attached to the unique barriers and gaps that different populations encounter when attempting to access services. It should be noted that collaboration without a common analysis or understanding can lead to significant concerns. The protocol and collaboration between women's shelter and children's aid societies has led to situations where women have been further victimized after leaving an abusive situation – if child welfare holds them responsible for their child being exposed to abuse. It is critically important to note that collaboration should be based on philosophical principles of intervention that can be shared and accepted by all stakeholders.

[12] Joanne Marlatt Otto and Kathleen Quinn, *Barriers to and Promising Practices for Collaboration Between Adult Protective Services And Domestic Violence Programs, A Report for the National Center on Elder Abuse*, (2007), 5-13.
[13] Prepared by Ian DeGeer and Barb Hotson for the Coalition to End Violence Against Women, *The Niagara Region Domestic Violence Report Card 2011/12, The System Matters.* (2012).
[14] Purdon, *Grey Bruce Violence Final Report*, (2008)

Obstacles to Service Collaboration

Despite the desire for increased inter-agency collaboration, barriers to cooperation between services for those affected by violence have long been noticeable by both service-providers and service-users. The literature reviewed cited numerous challenges to service collaboration, including confidentiality issues, power differentials, vastly differing understandings of the issue and appropriate interventions, fragmented governmental, legal, and policy systems, the considerable time and effort that interagency collaboration requires, and the high rate of staff turnover. Limited financial resources and the competition for funding also serve as a substantial obstacle for cooperation between agencies. (Macy & Goodbourn, 2012). Funding is the main challenge for domestic violence and sexual assault service collaboration, as according to Sarah Fotheringham (2006) sexual assault services are concerned that their issue may become overshadowed by domestic violence because funding for their programming is small compared to that of domestic violence programs. As such, barriers to inter-agency collaboration stem from a wide range of reasons. Nevertheless, differing worldviews by the professionals involved as well as a lack of experience and knowledge in relation to other sectors were the two most commonly listed obstacles in achieving stable, collaborative interagency relationships.

In regards to the former, service agencies tend to embrace "an identity-focused model in which each agency provides a set of services distinct from other agencies."[15] This model prevents positive interaction with other organizations. Although generally many agency leaders agree that the development of integrative, systems-based model would be most effective, they listed agency egocentrism, in that agencies do not always view others positively, and loyalty to one's agency, policies, and philosophies, as the main reasons for why agencies fail to apply this model.[16]

Agencies lack of experience and knowledge with issues outside of their mandate serves as a substantial obstacle to service collaboration. Rebecca J. Macy and Melissa Goodbourn (2012) provide an example of this in their literature review of articles that focused on collaboration between substance abuse and domestic violence agencies. They looked at one study of 388 substance abuse and domestic violence staff in 74 programs, which found "little awareness of the co-occurring condition coupled with professional prejudice, misinformation, paradigmatic conflicts, and weak or nonexistent linkages between agencies."[17] Since every service and sector have unique separate histories of development, this has resulted in distinct service-delivery, which can cause collaboration between the sectors to be superficial. To continue with the aforementioned example, substance abuse treatment providers suffer from "a lack of knowledge about how to appropriately intervene with IPV, as well as a lack of organizational support."[18] A significant issue is the lack of funding available for coordination and collaboration activities. Although many funders stress the need for coordination, it is very difficult to obtain funding to actually do the work required to bring agencies together and work through the various challenges and obstacles to be able to develop a fully coordinated response.

[15] Lisa Ann Haeseler, "Organizational Development Structure: Improvements for Service Agencies Aiding Women of Abuse," *Journal of Evidence-Based Social Work* (2013): 10, 20.
[16] Ibid.
[17] Larry Bennett and Patricia O'Brien, "Effects of Coordinated Services for Drug-Abusing Women Who Are Victims of Intimate Partner Violence," Violence Against Women (2007): 13, 4, 396-397.
[18] Macy, Rebecca J. and Goodbourn, Melissa, "Promoting successful collaborations between domestic violence and substance abuse treatment service sectors: a review of the literature," *Trauma, Violence, & Abuse* (2012): 13, 4, 245

A lack of training for issues outside service-providers main area of concern prevents the development of positive relationships with staff from other service sectors and impedes increased understanding of the co-occurrence of violence and other issues.

Although the lack of experience and knowledge of other sectors can serve as a hindrance, it is also a major incentive for service coordination, as only through collaboration via formal partnerships and cross-sectoral training, can these issues be remedied. Collaboration accelerates the development of cross-agency referral systems, routine screening procedures and policies, formal service linkage agreements, and creates an environment which allows for more effective working partnerships. (Macy & Goodbourn, 2012).

Successful Past Collaborations between Services

Notwithstanding the long list of barriers to increased service collaboration, there have been a large number of past collaborative initiatives across the English-speaking world that have been successful in their endeavours and have documented their experiences. The following are a sample from the wide range of successful coordinated collaborations in the domestic violence and abuse field.

Inter-Agency Collaboration

To advance service care for women of domestic violence and abuse, studies stressed that social service agencies must work more collaboratively both internally and externally to improve service. For example, Lisa Ann Haeseler (2013) looked at the organizational development models of four social service agencies in New York that aid abused women and studied their effectiveness. Also, Haeseler interviewed eight agency leaders over the course of two months to gather their views on which development models most positively impacted care. Findings reveal that to improve care, agencies must develop partnerships with others to expand communication and collaboration efforts. Haeseler's article concludes that with additional staff, resources, and developing an appreciation of other agency missions, multiple agencies can develop long-term strategic plans and overcome their obstacles to working collaboratively with other agencies.

It should be noted that over 15 years ago when the government of Ontario instituted specialized domestic violence criminal courts at the provincial level, a key component of the model was the creation of inter-agency and inter-sectoral committees within each court. These Domestic Abuse Response Teams or Domestic Violence Court Coordinating Committees were an important component of the specialized court process. Through a structure that brought all key players to a common table, (from community based women's shelters to police and criminal justice sector representatives), together to work through common problems, most importantly these very different sectors began to communication with each other.

Coordinated Community Response

Coordinated Community Responses (CCRs) strive to "provide a community-wide response to VAW and to promote cooperation among service agencies"[19] and are considered within the violence against women field to be "the most important accomplishment in the past twenty five years."[20] CCRs were developed as a result of the fragmentation of IPV services and a lack of public accountability. The rationale behind these efforts was based on the belief that coordinated services would translate into reduced levels of IPV as this would mobilize community leadership and resources; thereby maximizing the effectiveness of existing services and reducing counterproductive services.[21] CCRs have changed how both agencies and communities respond to survivors of violence. This approach can be broken down into five stages of collaborative growth. (1) Coexistence or the awareness of other agencies; (2) informal communication between agencies to learn about one another; (3) formal relationships between the agencies to coordinate services and prevent redundancy for service-users; (4) increased service delivery effectiveness; (5) and collaboration as a result of the development of long-term strategies to create a system designed to facilitate coordination and collaboration.[22]

There are numerous examples of CCRs in action. One of which, as described by Daniel J. Whitaker, et al., (2007) is the Collaborative for Abuse Prevention in Racial and Ethnic Communities (CARE) project. CARE was implemented a network model involving VAW agencies in two Latino communities; in the city of Chelsea (CARE Chelsea) and in Berkshire County (CARE Berkshire) by the Massachusetts Department of Public Health. The goal of the network model was to increase culturally competent services based on the premise that greater collaboration among VAW organizations will increase the provision of culturally competent services for minorities. MDPH mandated that a lead agency would coordinate formal relationships among a network of VAW agencies; the lead agency would hire a bilingual and bicultural network coordinator to organize the activities of the network; and (c) each network would consist of at least five types of agencies (DV prevention, shelter program, rape crisis center, children services, and refugee/immigrant program) to cover a range of services. The collaborative network model led to both DV and shelter agencies having expanded their ability to support culturally appropriate services for Latinos and increased client referral follow ups.

In Ontario, the Ministry of Community and Social Services has been providing a small amount of base funding for domestic violence coordinating committees for many years. These groups vary in the extent of formal organization, some have become quite active in policy and program development, others functions largely as networking groups to promote public education and improved collaboration between agencies. They have become an important mainstay in the communities as a vehicle that continues to identify the need for inter-agency and inter-sectoral collaboration. Currently a move is underway in Ontario to bring all of the coordinating committees together to encourage greater coordination and collaboration on a provincial level.

The Duluth Model: Domestic Violence and Criminal Justice Services Collaboration

[19] Daniel J. Whitaker, et al., "A Network Model for Providing Culturally Competent Services for Intimate Partner Violence and Sexual Violence," *Violence Against Women* (2007): 13, 2, 193
[20] Ginette Lafrenière et al, *Enhancing VAW Service System Delivery in the Central West Region of Ontario. Building Bridges between Theory, Practice and Action*, (2009), 4
[21] Joanne Klevens et al, "Exploring the Links Between Components of Coordinated Community Responses and Their Impact on Contact With Intimate Partner Violence Services," *Violence Against Women* (2008): 14, 3, 346-347
[22] Ginette Lafrenière et al, *Enhancing VAW Service System Delivery*, 4-5

Described as "one of the most promising methodological innovations in the past 20 years for addressing domestic violence,"[23] the Duluth Model first emerged in the 1980s and encourages reforming the criminal justice system response by developing a coordinated community response. A number of the aspects of the Duluth model were used in the development of the Ontario Specialized domestic violence court process. Its CCR components include mandatory arrest policies, follow-up support for victims, swift prosecution, active monitoring of offender probation conditions compliance, monitoring of the system-wide response to domestic violence cases, and court-mandated participation in a Batterer Intervention Program.[24] The latter component is noteworthy because the Duluth Model has been adapted as a gender-based, cognitive–behavioral approach for Batterer Intervention Programs and its success has led to its widespread usage across the United States. This aspect of the Duluth Project will be discussed later on in this literature review. Referring back to the Duluth Project in terms of services collaboration between domestic violence and criminal justice sectors, recent efforts have focused on improving methods of risk assessment and information sharing amongst practitioners and advocates. These improvements that have resulted in lower rates of recidivism and various communities have adopted and expanded this model to meet their unique needs. (Herman, et al., 2014).

Safety Audit

The Praxis Safety and Accountability Audit (Safety Audit) was developed by Ellen Pence, Executive Director of Praxis International, and was designed as a way for communities to be more responsive to battered women. Literature on Pence, (Sadusky, et al, 2010; Scaia & Connelly 2010; Shepard 2005) analyzed how Safety Audits changed the framework for responses to domestic violence. Safety Audit addresses the gaps between survivors' daily experiences and how services respond to them by uncovering how and why social institutions often fail to meet clients' needs. Its methodology is based on the idea of a coordinated community response to domestic violence. Safety Audit uncovers to what extent safety and accountability are incorporated into daily routines and practices of workers who act on that person's case. Seasoned practitioners in local institutions and team members work together to reveal practices within and between systems that compromise battered women's safety. These collaborative partnerships are critical to the success in implementing the Safety Audit. Benefits for agencies involved in Safety Audits include: "(a) a respectful, constructive way to investigate and solve a problem; (b) a motivation to collaborate instead of tiring of yet another meeting; (c) solutions to problems, such as new or revamped policy, forms, training, and connections, instead of a sense of inaction and discouragement; (d) new ways of working together in a community collaboration; and (e) a sense of accomplishing something important for battered women and the community."[25] On a latter note, Safety Audit has also been used to critically assess the United States legal system's response to violence against indigenous women and has been used to examine racial disparity in the child welfare system. The government of Ontario undertook a very limited Safety Audit during the last 20 years, however, dropped the approach largely due to

[23] Melanie Shepard, "Twenty Years of Progress in Addressing Domestic Violence: An Agenda for the Next 10," *Journal of Interpersonal Violence* (2005): 20, 4, 437
[24] Melanie Shepard, "Twenty Years of Progress," 439
[25] Jane M. Sadusky, et al, "The Praxis Safety and Accountability Audit: Practicing a "Sociology for People"" *Violence Against Women* (2010): 16, 9,1033

the expense. Nevertheless, this model remains arguably one of the most effective ways to develop a truly collaborative approach that holds abusers accountable and protects the safety of victims.

Family Justice Centers

There are many reports that list Family Justice Centers (FJCs) as a best practice in the field of domestic violence and prevention services, (Erwin, 2006; Bebble et al., 2009; and Kamimura et al., 2013). FJCs originated in San Diego, California in 2002 and were spearheaded by Casey Gwinn, the City Attorney of San Diego at the time. They are the result of a collaborative partnership between community-based domestic violence services and criminal justice professionals. FJCs are a "one-stop shop" service delivery model which involves a multi-disciplinary team of professionals working together at a co-location to provide coordinated services to survivors of violence.[26] FJCs are centered around the concept of other co-location service delivery models; having a single place for those affected by violence to have access to and receive comprehensive services including but not limited to legal and medical assistance, safety planning, counselling, and housing and transportation assistance. Nevertheless, FJCs are distinguished from other multi-disciplinary models by the full-time presence of these criminal justice system professionals, namely police officers and prosecutors. The multi-agency collaborative effort results in more support for survivors of violence by bridging service access gaps, better case management, and a more fluid exchange of information and resources.[27] FJCs can be adapted to meet the particular characteristics of a community and as such each location is unique in the services it provides and therefore mirrors the needs of the local community it serves. The documented outcomes include: a reduction in homicides rates; increased survivor safety and autonomy; reduced fear and anxiety amongst those affected by violence; increased access and efficiency in domestic violence services; increased prosecution of offenders; and increased community support for services for survivors.[28]

In 2005, the US Congress added Family Justice Centers to the Violence Against Women Act and provided federal funding for 15 FJCs. As of 2013, there are 54 FJCs now located across 25 US states. Due to their success and overwhelming support from survivors, FJCs have spread around the world with centres now operating in Canada, Mexico, and Great Britain, with more to follow in Africa, Europe, and the Middle East. In Ontario, the Family Violence Project of Waterloo Region, Mosaic Counselling and Family Services, and Safe Centre of Peel, in collaboration with Legal Aid Ontario follow the FJC model and aim to deliver co-location, seamless services to domestic violence survivors. Critics of FJCs express concerns over possible negative consequences as a result of government involvement, the potential for the involvement of individuals inexperienced in the dynamics of domestic violence, and the fear that FJCs will either cost too much or take away funding from other local domestic violence programs. Merely co-locating in the same building has little benefit if services still have very diverse approached to the issue and understandings of the problem This is one of the reasons that many community based women's shelter have had grave concerns about participating in a Family Justice Centre where, for example, child welfare staff are also housed. The proximity of offices will not

[26] Casey Gwinn, et al, "The Family Justice Center Collaborative Model," *Saint Louis University Public Law Review* (2007): 27, 79, 79-120
[27] Ibid
[28] United States Department of Justice Office on Violence Against Women, "The President's Family Justice Center Initiative Best Practices," (February 2007).

necessarily create a more accountable and safety response for women, but in fact, can cause more women to be re-victimized if other services that are seen as destructive and non-helpful are more easily able to be engaged. In addition, FJCs are located in urban areas and only open during business hours and that immigrant and minority populations might be distrustful of the government and police presence. (Erwin, 2006; Lafrenière et al., 2009). The Family Justice Center Alliance acknowledge these concerns, but propose that FJCs do not make law enforcement the focus of intervention and prevention efforts, but due to the criminal nature of violence, the criminal justice system is important in the overall approach in service delivery for domestic violence.[29]

Coordinated Community Response & Elder Abuse

Literature on responding to elder abuse stresses the necessity of increasing CCRs, as multiagency partnerships will enable the expansion of awareness, education, resources, and support for elderly survivors of violence. Doing so will bring together stakeholders and partners in the community to provide more comprehensive options for abused seniors in their justice and human service delivery systems. The Alberta Council of Women's Shelters produced 'A Plan of Action: Community Development Model,' in 2007, to assist communities in designing a community based, collaborative approach to elder abuse. In addition, the Alberta Elder Abuse Awareness Network compiled a list of collaborative efforts in Alberta that use a coordinated community response towards the issue of elder abuse. Action Group on Elder Abuse, Veiner Centre, Community Response to Abuse and Neglect of Elders (CRANE) Project, SeniorConnect, and the Elder Abuse Intervention Team (EAIT), are a couple of example of multidisciplinary, cross-agency partnerships that seek to decrease elder abuse and neglect by promoting access to information and services in a coordinated manner. The EAIT is particularly notable due to its collection of evidence on the extent of elder abuse. Three front-line workers from the three agencies, Edmonton Community Services (ECS), Catholic Social Services (CSS), and Edmonton Police Services (EPS), conducted hundreds of surveys amongst seniors, police members, the medical and mental health community, and other professionals. This data was used to create an Elder Abuse Team Proposal in collaboration with Capital Health and United Way, which has guided service delivery in Edmonton for elder abuse survivors since 1998. (Alberta Elder Abuse Awareness Network, 2007).

For a number of years, the government of Ontario has funded the Ontario Network for the Prevention of Elder Abuse (ONPEA). This network provides a small staff team who are tasked with supporting inter-agency networks working on elder abuse, in various communities across the province. ONPEA has worked to increase knowledge about elder abuse and to explore effective ways for agencies and institutions to work together to deal with the many forms of elder abuse including physical, financial, emotional, and so forth. Furthermore, they are dedicated to implementing the Ontario Strategy to Combat Elder Abuse, a province-wide strategy to address and prevent the abuse of seniors. Coordination of community services, cross-sectoral front-line staff training, and an education campaign to promote awareness about elder abuse across Ontario are the three main focuses of the strategy.

Sexual Assault Response Teams

[29] Casey Gwinn, et al, "The Family Justice Center Collaborative Model," 118

As with CCR, this literature review also looked at Sexual Assault Response Teams (SART). SART is a coordinated approach to sexual assault between medical services, survivor services, and criminal justice services and have increased the likelihood that particular services will be provided to victims. Women who lived in communities with coordinated services had more positive experiences with the medical, legal, and mental health systems and survivors of violence were more likely to be treated than those who did not live in such communities.[30]

Zweig and Burt (2004) highlighted the success of SART in their exploration of the impact of Services Training Officers Prosecutors (STOP) funding on victim service (VS) programs. This study assessed the degree to which: (a) funding support for collaboration led to improved program services and community interaction; (b) interaction among community agencies leads to improvements for VS programs."[31] Community interaction was explored by capturing the behavioral practices of agencies across 32 states by measuring "communication (talking with other agencies and sharing information), coordination (agencies work together for particular cases and may train one another's staff), and collaboration (agencies jointly work on protocol development, integrate their services, and have an institutionalized level of commitment to work together) between VS programs."[32] The study found that interaction between VS programs and other agencies within the community can improve service delivery and that while STOP facilitated great levels of change in agencies that had limited collaboration before funding, VS programs that already had a high level of interaction saw limited impact. STOP funding merely allowed these VS agencies to continue their collaborative work. As such, this study supports the argument that interaction between agencies, not funding, reaps the most improvements for VS program services.

Domestic Violence and Substance Abuse Service Collaboration

The Women, Co-occurring Disorders and Violence Study (WCDVS) is a heavily documented successful coordination of services for survivors of violence. Out of the number of articles which document the study, (Cocozza, 2005) examined the WCDVS the most succinctly. The WCDVS sought to address the lack of adequate services for women with co-occurring mental health and substance use disorders who have lived experience by applying new service approaches and assessing their effectiveness. Study sites had to develop interventions with four key program characteristics: integration, comprehensiveness, trauma-informed treatment, and survivor involvement in treatment. The study explored the extent to which participation in the intervention conditions resulted in better outcomes as compared to survivors who received usual care conditions. The sample for this cross-site, multi-model intervention study consisted of over 2,000 women and focused on four primary outcome variables: mental health status, post-traumatic symptoms, drug use problem severity and alcohol use problem severity. The result was that women in the intervention conditions, which were designed to provide comprehensive, integrated, trauma-informed and survivor-involved approaches, showed greater improvement

[30] Janine M. Zweig and Burt, Martha R. Burt, "Impacts of agency coordination on nonprofit domestic violence and sexual assault programs in communities with STOP formula grant funding," *Violence and Victims* (2004): 19, 5, 614.
[31] Ibid.
[32] Zweig and Burt, "Impacts of agency coordination on nonprofit domestic violence," 617

than women who received services in the comparison conditions. Furthermore, these effects are much more pronounced when services emphasize integrated counseling.[33]

A pilot study by the Illinois Department of Human Services (IDHS) furthers these conclusions, as this study explored how substance abuse and domestic violence collaboration would work at the community level. In 2000, four programs were chosen by IDHS to develop and implement integrated service models. The evaluation study used a non-random sample of 255 women seeking services from pilot agencies. These women were interviewed at program entry and again 4 to 6 months later. The result of this pilot study was that coordinated or integrated services for women with the co-occurring conditions saw significant changes in that self-efficacy increased, while substance use decreased. (Bennett & O'Brien, 2007).

Specific Recommendations for Improvement

Not surprisingly, the main recommendation throughout the literature reviewed for this report is to work towards building collaborative effort and initiatives. The reports reviewed provided a wide range of suggestions and recommendations for instigating collaborative initiatives and coordination of services. For example, some of the grey literature offered step-by-step guides to enabling and implementing collaborative efforts. Please see Appendix B for Macy and Goodbourn's, 'Key Strategies and Recommendations for Collaboration' and Appendix C for Carmela DeCandia's, 'Quick Reference Guide: Integration Strategies'. Some of the literature however offered more specific recommendations that deserve particular note given their implications on violence prevention. Three have been selected for further discussion.

(1) Data Monitoring

There is a strong need for the collection of reliable data on the extent of domestic violence by policy makers and stake holders alike. This collection would be instrumental in guiding the future of policy and service development in the violence against women sector, yet given the variability of statistics, it is hard to achieve coherence in data-collection. While difficult, our literature search revealed several examples of the establishment of local and regional data monitoring projects and these examples demonstrate how data collection in conjunction with multi-agency collaboration can result in improved services for survivors of violence.

Cheshire Domestic Abuse Project

A 2008 study by Gill Hague and Sue Bridge provides an example of a successful establishment of a cohesive data-monitoring system in their examination at how co-ordinated community responses result in improvements in services for survivors of violence through their assessment of the Cheshire Domestic Abuse Project (CDAP). CDAP was based off of work in London, Ontario as its approach was to attempt to provide wide-ranging services for survivors. CDAP went on to achieve its projected outcomes in almost all of the areas it set out to, including attracting additional funding, increasing reported incidents and arrest rates, and reducing repeat

[33] Joseph J. Cocozza, etc al., "Outcomes for women with co-occurring disorders and trauma: program-level effects," *Journal of Substance Abuse Treatment* 28 (2005), 110-118

incidents. The project had five major strands of work: extensive domestic abuse training programmes, a police project, an outreach project, an education project, and a data-collection/monitoring project. The latter was meant to establish an organized data-monitoring system across the county for the purpose of feeding the results back into improving agency practice. By the end, the project had developed a database with over 14,000 cases. Those behind CDAP stress that collaboration and senior management support was crucial to their success. The project included three qualitative studies on service user views which complemented the quantitative statistical evidence and built a more complete picture of services. The data was converted into a usable form and was fed back through police newsletters, a regular full performance report and a general newsletter, distributed throughout the county. These newsletters provide information, highlighting trends and producing relevant statistics for each agency to support policy development. As such, the project became a functional two-way conduit of information to underlay, support and provide data and evidence for services and to feed into local strategic development. (Hague & Bridge, 2008).

Domestic Violence Report Cards

A report card is essentially a snapshot of how a particular community is responding to domestic violence. It serves as a way to record, measure, and compare responses to violence against responses in the past by using baseline data to compare changes over a period of time. In Ontario, Niagara Region's Domestic Violence Report Cards, Hamilton Vital Signs report, Woman Abuse Community Report Card Project, Record Card on the Strategic Framework To End Violence Against Aboriginal Women, and the NWT Family Violence Report Cards are just a few of the many examples of report cards. Generally, report cards utilize qualitative data collection methodologies gained through interviews, surveys, and focus groups to obtain information from service users and service providers. Report cards are crucial to the development of improved services for survivors of violence. Not only do they help researchers and agencies build a better understanding of domestic violence in relation to their communities, but by evaluating the current response to domestic violence, current practices that are effective are highlighted and can be continued and counterproductive practices eliminated. Throughout the report cards, collaboration is repeatedly listed as an increasingly popular practice amongst service providers and the reports strongly encourage the continuation and expansion of service collaboration. [34]

Domestic Violence Death Review Committee

For over ten years, Ontario has had a provincial committee reviewing all domestic violence related homicides. The Domestic Violence Death Review Committee (DVDRC) is an initiative of the Office of the Chief Coroner for Ontario. Since 2003, data has been collected from homicide cases involving domestic violence that have been investigated by the Office of the Chief Coroner. The DVDRC collects two sets of data: (1) Data relating to the actual number of homicide cases where domestic violence has been identified as an involvement factor; and (2) Data relating to the findings of cases that have been reviewed by the DVDRC.[35] This data is used to produce annual reports on the incidence of domestic homicide in Ontario with

[34] *Niagara Region Domestic Violence Report Card 2011/12: The System Matters*, The Coalition to End Violence Against Women (2012)
[35] Office of the Chief Coroner for Ontario, *Domestic Violence Death Review Committee Annual Report 2012* (2014)

recommendations for how to create a more effective, coordinated and seamless community response to domestic violence. In the ten years that this report has been published, the DVDRC documented the positive changes that have been made in the VAW sector as a result of these reports. Namely, the increase of collaborative and multi-disciplinary efforts in Ontario and how this has resulted in improved services for survivors of violence. The DVDRC urge agencies in the sector to continue and expand this collaborative work and in order to make Ontario both healthier and safer.

(2) Inclusion of Survivors' Voices

It is noteworthy that those behind the Cheshire Domestic Abuse Project also contribute their success to their utilization of survivors, as their voices were central to the project's operation and included an integration of diversity issues. Survivors' voices was a recurring theme throughout the reports reviewed by this literature search as their words and experiences are key to the development and implementation of more accountable, more responsive, and client-centred services for those affected by violence.[36] Moreover, survivor participation reaps benefits beyond the realm of development. When asked why they want to share their stories, survivors reveal a multitude of reasons. At the core of these however is the desire to connect with others; to support and educate others. (Hague & Bridge, 2008).

Despite this, there are many factors which can prevent survivor engagement. Professionalization and funders' demands for a more managerial approach can kill collaborative efforts. The impacts of poverty, of social class, and of cultural differences as well as the physical, mental, and emotional effects of abuse can deter survivors from participating. In regards to agency-based obstacle, the revictimization of survivors in terms of exploitation by agencies, the power dynamic of language used by professionals, patronizing working practices, and the issues of safety and confidentiality dealing with trauma all serve to limit participation. (Hague & Bridge, 2008) Personal reasons such as lack of time or support as well as fears surrounding safety and confidentiality also play a role. It is interesting to note that research shows that the most common method of engagement, having survivors attend policy or forum meetings, rarely works because an overly bureaucratic approach and too much procedure alienate survivors.[37]

Involvement must be full and meaningful, essentially used in all areas of policy and service development, to be effective. Engagement only works when survivors feel useful and validated. There must be a system in place for moving the result into a policy change and to feed the results back to those who participated. Agencies must address equality and diversity within survivor representation by consulting all areas of the community. Finally, to avoid exploitation, survivor consultation must have mutual benefits. For their input, survivors should be offered payment, either financial or in the form of childcare and/or transportation.[38] Also, it is crucial to

[36] *Café Scientifique: An Open Discussion of the Experiences of Immigrant and Racialized Women Survivors of Sexual Assault in Accessing Primary Health Care Services* (2013)
[37] Gill Hague and Audrey Mullender, "Who Listens? The Voices of Domestic Violence Survivors in Service Provision in the United Kingdom," Violence Against Women (2006): 12, 6, 578
[38] Hague and Mullender, "Who Listens? The Voices of Domestic Violence Survivors," 578

include the four most basic necessities when engaging survivors: providing empathy, individualizing care, supporting empowerment, maintaining ethical boundaries.[39]

In addition, survivors' voices are considered to the creation and enhancement of collaborative services that respond to violence against women, mental health and substance use. BC Society of Transition Houses' 2011 report states that all services must be violence and/or trauma-informed, resources should be directed towards the most marginalized, those with lived experience must be included in collaborative initiatives, and that all relevant agencies and ministries "need to be involved in meaningful collaboration – not only representatives from frontline anti-violence, mental health and substance use sectors." [40]

(3) Working with Abusers

Literature on violence prevention repeatedly listed working with abusers as a crucial strategy (Morrsion et al. 2004; Babcock et al. 2006, DeGue et al. 2012). Studies on the effectiveness of programs for abusers in regards to reducing recidivism have yielded mixed results. The previously mentioned Duluth Model is a popular service delivery model for batterers' programs. The Duluth Model was adapted for Batterer Intervention Programs, meant to educate men arrested for domestic violence and mandated by the courts to domestic violence programs. This approach is based on the work of Paulo Freire where education is linked to social change. The model was developed with significant input from women survivors of abuse and accountability to women is a primary tenant. The model uses a social education approach to enable men to recognize their patriarchal attitudes, develop awareness about the resulting choices that they make, and supports men in building new attitudes in the hopes of modifying their behaviour. The model is inherently linked, however, to a wider community response that includes an effective criminal justice system that holds men accountable for abusive behavior and supportive agencies that assist and protect women survivors.

Edward W. Gondolf's (2004) longitudinal, 4-year follow-up evaluation showed a clear de-escalation of re-assault and other abuse; most reach sustained nonviolence and only about 20% continuously re-assault. However, a recent study found that batterers who completed the Duluth Model program were just as likely to recommit assault. However, program participants reported "significant decreases on average physical, emotional, and verbal aggression measures immediately following the intervention, as well as decreases in violence supportive attitudes."[41] Advocates of the Duluth Model stress that program effectiveness largely depends upon the intervention system of which the program is a part of and its success implementations. Programs that specifically utilize a coordinated response also have mixed results. Various authors (Cissner & Puffett 2006; Labriola et al. 2007; Thomas & Bennett 2009) have studied whether CCRs implemented in BIPs were effective that decreasing re-assaults. Some found that CCRs yielded positive results for BIPs as the percentage of re-assaults dropped with program completion. Others however, found that CCRs had limited effects on the success of a BIP and stated that CCRs need to be more developed before they can be effective at reducing recidivism. (Bennett et al., 2007; Salazar et al., 2007). It is noteworthy though in the studies that with negative

[39] Shanti J. Kulkarni, Holly Bell, and Diane McDaniel Rhodes, "Back to Basics: Essential Qualities of Services for Survivors of Intimate Partner Violence," *Violence Against Women* (2012): 18, 1, 91-94
[40] BC Society of Transition Houses, *Report on Violence Against Women, Mental Health and Substance Use*, (2011), 20.
[41] Katharine Herman, et al., "Outcomes From a Duluth Model Batterer Intervention Program at Completion and Long Term Follow-Up," Journal of Offender Rehabilitation, (2014): 53, 13

conclusions all stressed the importance of collaboration between service providers, as this would allow for the necessary mobilization of resources and increase the flow of information between agencies, which may lead to increased program effectiveness. Babcock et al., 2006)

Implications on Violence Prevention

The notion that a collaborative approach has positive implications for violence prevention was consistent throughout the literature reviewed. The World Health Organization's (2010) work on violence prevention lists collaboration as the first step to preventing all forms of violence. WHO underscore the need to develop a shared vision across all sectors to work towards violence prevention. Primary prevention, defined as the reduction of new instances of intimate partner and sexual violence by addressing the factors that make the first-time perpetration of such violence more likely to occur, must involve different sectors and new ways of working together. A shared vision can influence people in different sectors and encourage their participation in working towards violence prevention. (World Health Organization, 2010) For the WHO's full list, please see Appendix D for 'Steps for implementing intimate partner and sexual violence prevention policies and programmes.' On a later note, for multi-agency collaboration to work, WHO recommends establishing clear working protocols, including the referral pathway of survivors, between services offered by the same facility or by different sectors, and establishing regular (monthly) meetings to ensure coordination.[42]

Multi-Agency Risk Assessment Conference (MARAC)

Amanda L. Robinson and Jasmin Tregidga (2007) looked at a research project that involved high-risk victims of domestic violence to determine their levels of revictimization one year after being referred to a Multi-Agency Risk Assessment Conference (MARAC) and their perceptions of this type of intervention. MARACs are a collaborative initiative that enables multi-agency information sharing so that action plans can be established to reduce harm to high-risk individuals and their children.[43] An initial study about MARACs' effectiveness had positive results; roughly 60% of survivors had not been revictimized in the 6 months post MARAC and the results revealed the benefits of taking a multiagency approach to helping women (and their children) that are experiencing domestic violence. This study furthers that evidence, as it follows service users revictimization rate for a longer period of time and therefore provides longitudinal account of the impact of taking a multiagency approach to domestic violence.

In the study of 102 study participants, despite being high-risk individuals, police data revealed that 47% did not experience any incidents of repeat violence during the 12-month period post MARAC.[44] The article went on to list five key ways in which taking a collaborative approach can benefit those who have experienced violence: (1) increased and ongoing communication; (2) conducting risk assessment and helping to identify those in dangerous situations who will need increased assistance; (3) providing advocacy to victims; (4) translating policy into action; and (5) holding perpetrators to account, as research shows that a multiagency

[42] World Health Organization, *Responding to Intimate Partner Violence and Sexual Violence Against Women: WHO Clinical and Policy Guidelines*. (2013), 39
[43] Robinson and Tregidga, "The Perceptions of High-Risk Victims," 1131
[44] Robinson and Tregidga, "The Perceptions of High-Risk Victims," 1139-1140

approach to the prosecution of domestic violence cases results a reduction in recidivism with the interaction among successful prosecution, probation, and court-ordered counseling.[45]

Conclusion

Ultimately, this literature review hopes to further the efforts that already exist in the Region of Peel to enhance services for those who have experienced violence, by demonstrating the need for increased multi-agency, cross-sectoral collaboration and service coordination. For this report, the questions of what is known about community coordination and inter-agency collaboration of services for survivors of violence, what contributes to and limits improved coordination of services, benefits to survivors, examples of successful models of service coordination and collaboration, conditions that promote and enable strong collaborative relationships, and the implications of service coordination on violence prevention were explored. This work was meant to compliment the wealth of literature that exists in regards to the subjects of interest, particularly to highlight the necessity of effective coordination of services, the many obstacles that hinder this, and why it is crucial in the path towards domestic violence elimination.

As this literature review has demonstrated, increased inter-agency collaboration is crucial because of the multitude of service barriers and gaps that exist for help-seeking individuals. The diversity of the populations that seek assistance for violence makes collaboration essential because without it, a lack of knowledge about issues outside of one's particular agency mandate will persist, service-providers will continue to work in isolation, and service collaboration, which survivors have stressed a strong desire for, will remain elusive. Despite the need for increased service coordination, collaborative efforts between agencies struggle because of a lack of funding and financial support for collaboration efforts; professional prejudices and differing philosophies create conflicts between agencies; unique histories of development across the various sectors can result in agency egocentrism; and above all a lack of experience, knowledge, and training amongst service-providers. These issues were cited across the various articles examined for the literature review and need to be overcome in order to strengthen collaborative interagency relationships and service coordination.

Past successful examples such as the Coordinated Community Response projects like Family Justice Centers, the Duluth Model, Safety Audits, the Women Co-occurring Disorders and Violence Study, Sexual Assault Response Teams, and the Multi-Agency Risk Assessment Conference, to name a few, all underscore the fact that a collaborative approach has positive implications for future policy and service development as well as violence prevention. To expand upon the latter, this report explored three recommendations in particular in regards to violence prevention: data-monitoring, inclusion of survivors' voices, and working with abusers. The Cheshire Domestic Abuse Project, Domestic Violence Report Cards, Domestic Violence Death Review Committee demonstrate that a reliable collection of data on the extent of domestic violence alongside multi-agency collaboration can guide future preventive strategies. Meaningful engagement of survivors and the utilization of their voices in all areas of policy and service development can enable the creation of better services for those affected by violence. Finally, studies have shown that working with abusers has been linked to reduced recidivism and is

[45] Robinson and Tregidga, "The Perceptions of High-Risk Victims," 1132-1135

another crucial strategy in the path towards elimination domestic violence. As such, given the numerous examples of successful collaboration of services as well as the known benefits of increased service coordination and its implications for violence prevention, it is clear that expanding inter-agency collaboration in the Region of Peel is necessary to continue to improve community services for survivors of violence and abuse.

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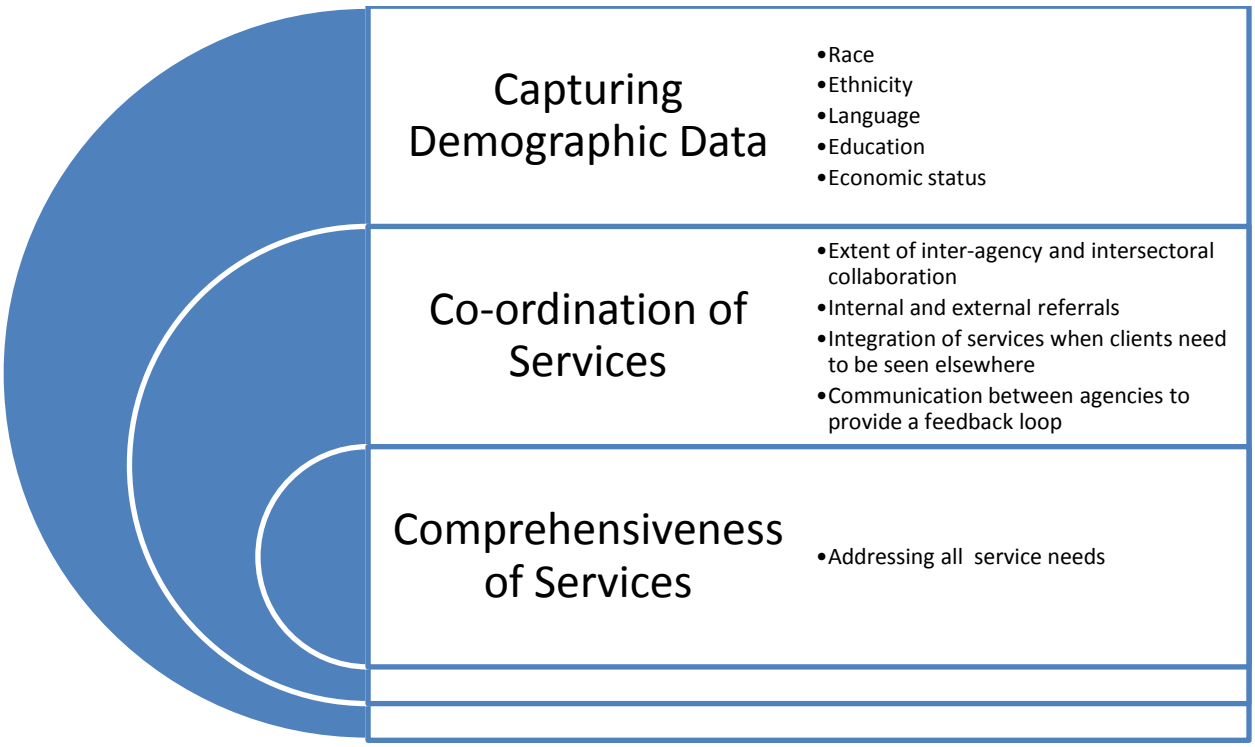
Appendix A
Conceptual Framework:

Guide to Retrospective Study / File Review



Appendix B

Key Strategies and Recommendations for Collaboration

Macy and Goodbourn provide recommendations for different levels of the service system, including the provider, agency, and policy levels:

- **Provider**. Recommendations for the treatment provider level included training in the co-occurrence of IPV and substance abuse.
- **Agency**. To promote collaborative relationships, several documents suggested that agency should implement:

  (a) Dedicated case management services at both agency types to facilitate service referral and coordination;
  (b) Interagency case consultation to coordinate services and treatment planning for women using the services of both agencies;
  (c) Co-location of providers from collaborating agencies' offices to promote service accessibility for women and foster interagency staff relationships;
  (d) Assigning one staff member to act as an interagency liaison to facilitate collaborative efforts;
  (e) The development of positive, productive working relationships at all agency levels, including among the agencies' board members, directors, and staff service providers
- **Policy**. Several documents also recommended changes in state-level policies to promote collaboration among agencies at the community level. One such recommendation proposed policy to require training and continuing education in the co-occurrence of IPV and substance abuse for professional credentialing and licensing. Another policy recommendation was attention to funding community-based services in a way that promotes interagency collaboration.

(Macy and Goodbourn, 2012, 247)

Appendix C

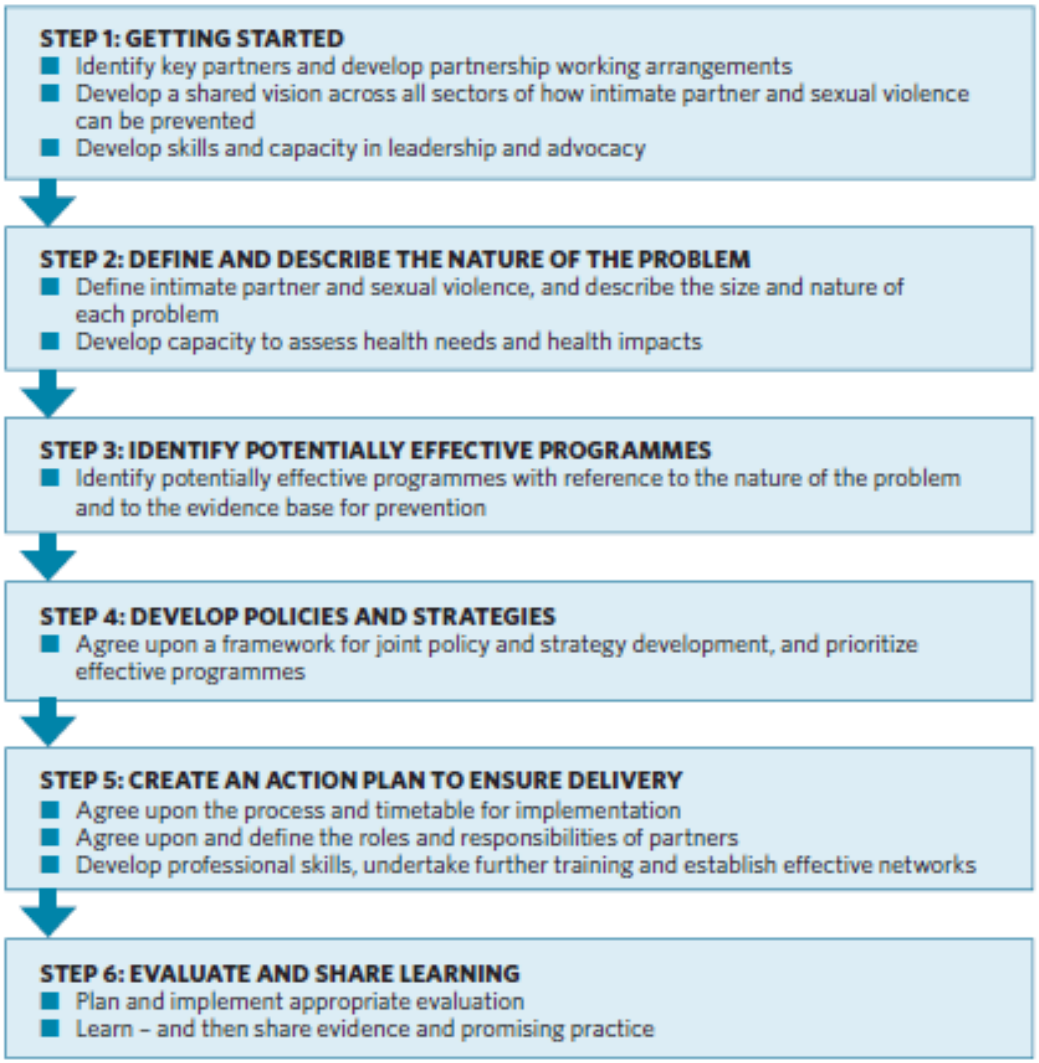
Quick Reference Guide: Integration Strategies	
Level 1: Awareness and Understanding	
Assessment of Domestic Violence and Homelessness*	During the assessment process, providers should move at the survivor's pace, include questions that support a better understanding of a survivor's history of homelessness and DV, and ensure safety and confidentiality.
Organizational Needs Assessment	Revisit organization's mission and goals; assess areas of expertise. Conduct a needs assessment to identify and evaluate current services.
Construct Capability Statement	Capability statements should include an overview of the population the organization serves, and a summary of programs and supports provided.
Outline Service Delivery Model	Prepare a description or outline of the service delivery models used.
Understand the Referral Experience	Obtain feedback from survivors on their experiences with the referral process to identify strengths and weaknesses in current referral network.
Awareness and Understanding of Community Capacity	Conduct an environmental scan of the community to find additional supports for survivors. Create a list of potential partners to work with in the future.
Assessment of Current Partnerships	Assess current partnerships to understand what types of collaborations have worked well in the past.
Level 2: Communication and Coordination	
Meet with Agency Leadership	Meet with leaders from both agencies to discuss opportunities for sharing information and resources.
Provide Staff with Information	Provide all staff with information on services and resources available at partner agencies. Explain how the referral process will work.
Organize a Joint Agency Meeting	Organize a joint agency meeting and invite all staff to attend. Discuss what each agency brings to the partnership.
Establish Formal Memorandums of Understanding	Construct written, non-binding agreements that outline specific outcomes expected of each agency and the overall partnership.
Provide Cross-training to Staff	Facilitate cross-site training to staff from each organization. Detailed support is given to those who work directly with families and members of cross-site teams.
Form Cross-site Teams	Form cross-site teams to support survivors who will benefit from accessing services at both agencies.
Create Feedback Mechanisms	Set up opportunities for both staff and survivors to provide feedback on how the partnership is working.
Coordinate Policies and Procedures	Adjust current policies and institute procedures across systems that allow for resource sharing.
Level 3: Collaboration	
Develop Shared Goals	Jointly develop shared goals for the partnership.
Align Policies and Procedures	Create protocols that respect the mission, values, culture, and work of partner agencies.
Create a Leadership Structure	Establish a leadership structure for the collaboration.
Consider both internal and external implications.	Consider both internal and external implications.
Evaluate the Collaboration	Develop a well-defined framework to help measure and evaluate service outcomes and the collaboration.
Staffing and Supervision	Make sure all staff and supervisors understand their roles.
Co-location	Consider co-locating staff to improve communication and allow for a more coordinated and responsive system of care.

(DeCandia, C.J., et al, 2013, 37-38).

* Although this guide is from a report on service integration between domestic violence services and homelessness services, the strategies listed can be utilized between any cross-sectoral collaboration.

Appendix D

Steps for Implementing Intimate Partner and Sexual Violence Prevention Policies and Programmes



(World Health Organization, 2010, 59)