Back to Basics: Service Users Report on the Importance of Material Resources and Empowering Responses

A Community Engaged Evaluation Research Study of an Ontario Sexual Assault and Domestic Violence Protocol

by

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ABSTRACT

BACK TO BASICS: SERVICE USERS REPORT ON THE IMPORTANCE OF MATERIAL RESOURCES AND EMPOWERING RESPONSES

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Since the 1980s, coordinated community responses (CCRs) have flourished throughout North America and the United Kingdom to improve the local response to violence against women. Existing research on CCRs have primarily assessed this model from the service provider perspective. This community engaged evaluation research fills a gap in the literature through the inclusion of women’s voices in the evaluation of a sexual assault and domestic violence protocol, implemented by a CCR in one Ontario community. Using feminist intersectionality and collaboration theory, the current study examined the extent to which the protocol objectives were met, the barriers and challenges experienced by women in their attempt to access and receive services. Moreover, this study examined whether the protocol was meeting the needs and issues facing women who have experienced violence. Twenty-six semi-structured interviews were conducted with women who disclosed experiencing violence to service providers mandated by the protocol. The findings revealed that meeting women’s basic needs and the manner in which service providers respond to women is crucial. Women were more likely to benefit from services and report positive experiences when service providers attended to their interconnected needs and provided a caring response.
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Chapter One: Introduction

Prevalence of Violence Against Women

Violence against women\(^1\) is a pervasive social problem, affecting thousands of females in Canada and globally. Violence against women crosscuts age, class, religion, race/ethnicity as well as other points of identity that shape women’s experiences (Eley, 2005; Tjaden & Thoennes, 2006; Danis & Lockhart, 2010). According to the 2004 Canadian General Social Survey (GSS), 196,000 females reported being physically and/or sexually assaulted by a current or former intimate partner in the preceding year (Johnson, 2006). In 2009, the GSS revealed that the prevalence of self-reported domestic violence remained stable since the 2004 cycle (Statistics Canada, 2011). Moreover, in 2004, the GSS unveiled that 460,000 women were sexually assaulted\(^2\) (Gannon & Mihorean, 2004). According to the 2009 GSS, the prevalence of sexual assault against women remained steady since the preceding cycle (Perreault & Brennan, 2009). On average, a woman is murdered every six days by her intimate partner (Canadian Women’s Foundation, n.d.). Aboriginal women (Brownridge, 2003; LaRocque, 2002), younger women (Romans et al., 2007) and women with disabilities (Brownridge, 2006; Cramer & Plummer, 2010) experience heightened rates of violence within the context of an intimate relationship (Perreault & Brennan, 2009; Canadian Women’s Foundation, n.d.). Immigrant women encounter unique barriers accessing and receiving sexual assault and domestic violence services (Shirwadkar, 2004; Canadian Women’s Foundation, n.d.).

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\(^{1}\) For the purposes of this research study, the term “violence against women” refers to both sexual assault and domestic violence. Since the First Response Protocol refers to sexual assault and domestic violence, I will use these terms when referring specifically to the Protocol. I will also use these terms when referring to one type of violence (i.e. history of domestic violence initiatives).

\(^{2}\) This figure excludes incidents of sexual assault between intimate partners.
Two common forms of violence against women – domestic violence and sexual assault – are gendered phenomena, primarily perpetrated by men against women (Dobash & Dobash, 2004; YWCA, 2009; Tang, 1998; Tjaden & Thonnes, 2000). Women are more likely to be injured, requiring medical care/hospitalization and mental health services, absence from work due to sustained injuries, and intervention from the criminal justice system (Pollack, Green, & Allspach, 2005; Tjaden & Thonnes, 2000; Ullman et al., 2006; Yuan, Koss, & Stone, 2006; Daane, 2005; Perreault & Brennan, 2009). For the purposes of this research study domestic violence refers to violence between current and former intimate partners in dating, cohabitating and marital relationships, and includes: physical, emotional, verbal, psychological, financial, sexual, and spiritual abuse. Moreover, sexual assault refers to unwanted sexual activity perpetrated by a stranger, dating, marital or intimate partner. This researcher has chosen to use gender specific language to reflect the gendered phenomena of domestic violence and sexual assault.

**Addressing Violence Against Women via Coordinated Community Responses**

Women may seek formal support from service providers related to their experiences of sexual assault and/or domestic violence (SADV). Women may come into contact with a variety of service providers either by seeking support or through involuntary contact with agencies such as the police and/or child welfare. Additionally, women may experience barriers and challenges accessing services and support related to their experience of violence, such as not knowing what services are available in the community or how to access them, and having to re-tell her story to multiple service providers. The barriers and challenges experienced by women in their attempt to access and receive services may be further compounded by their social location within society.
For example, a low-income woman living in a rural area may not have access to transportation, and therefore cannot access services, which are primarily located in the city. Coordinated community responses (CCRs) have flourished throughout the United States, Canada and the United Kingdom to respond to violence against women at the local level. However, evaluation research on the effectiveness of CCRs is lacking. The current research study is an evaluation of a sexual assault and domestic violence protocol implemented by a CCR to improve the social response to sexual assault and domestic violence in one Ontario community.

**The Guelph-Wellington Action Committee on Sexual Assault and Domestic Violence.**

The Guelph-Wellington Action Committee on Sexual Assault and Domestic Violence (the Action Committee) is referred to as a Violence Against Women Coordinating Council (VAWCC), which is a specific type of CCR in Canada, and Ontario specifically. The Action Committee is currently represented by 27 agencies and organizations from various sectors across Guelph-Wellington including: criminal justice, victim services, social services, addictions/mental health, health care, education and the community that provide services and support to women and children who have experienced SADV (see Appendix A for a list of members). The Action Committee’s mission is to facilitate agencies “[w]orking in collaboration to coordinate, advocate and educate on issues and services regarding sexual and domestic violence” (Guelph-Wellington Action Committee on Sexual Assault and Domestic Violence, 2013).

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3 Since initiation of the current research study, there have been changes in membership. Three new agencies have joined the Action Committee, including: Parkwood Gardens Church, Sanguen Health Centre and the Child Witness Centre, but were not included in the research.
4 In 2013, the Action Committee added human trafficking to their focus, but was not included as part of the current study.
In 2003, the Action Committee developed a First Response Protocol (the Protocol) with funding from the Ministry of the Attorney General to guide their work and improve the local response to violence against women. The purpose of the Protocol is to establish and formalize principles and practices for the Action Committee member agencies in an effort to increase victim safety and offender accountability. Additionally, the Protocol seeks to coordinate and collaborate the response to sexual assault and domestic violence in the community.

**The First Response Protocol.**

The first draft of the Protocol was implemented in 2006, and later revised in 2010. The Protocol outlines how member agencies should respond if a woman discloses SADV to any one of the Action Committee member agencies. The goal of the Protocol is to ensure that “no matter where a person who has experienced or is experiencing sexual assault and/or domestic violence turns in our community, there will be no wrong door” (Guelph-Wellington Action Committee on Sexual Assault and Domestic Violence, 2013). The purpose of the Protocol is to assist in achieving the Action Committee’s stated mission. The most recent version of the Protocol was published in 2010 and outlines steps to a “consistent, caring and effective first response” to a SADV disclosure to any one of the Action Committee member agencies. The Action Committee initiated the larger research study because they were interested in evaluating their Protocol and hearing about women’s experiences accessing and receiving services.

**Study Purpose**

The current study was part of a larger piece of research conducted by academic and community partners through a community-university partnership to evaluate the
Protocol implemented by the Action Committee. The academic and community partners involved in this research study were: the Action Committee and the University of Guelph. The larger study sought to evaluate the Protocol from a service provider and service user perspective to assess how well the Protocol was working to improve the system response to SADV in Guelph-Wellington. The current study narrowed its focus to evaluate the Protocol from the service user perspective because studies examining CCRs to address violence against women have primarily derived data from service providers (Allen, 2006; Allen, 2005; Clark et al., 1996; Greeson & Campbell, 2012), while largely neglecting women’s voices (Allen, 2006; Hague, 1997; Hague & Mullender, 2006, Wendt, 2010). It was important to include women as service users in this research because the most valuable data about the effectiveness of a program or initiative is derived from those using the services, rather than those providing the services (Greeson & Campbell, 2012; Sullivan, 2011). Additionally, research on protocols guiding the work of CCRs to address sexual assault and domestic violence is lacking. Thus, a secondary purpose of this research study is to contribute to the academic literature on CCRs as a response to violence against women through the inclusion of women’s voices and research on a sexual assault and domestic violence protocol, which facilitates the work of CCRs. Sexual assault and domestic violence service provision are not well theorized within the academic literature, particularly from the service user perspective. There are two main theoretical frameworks that are most useful for understanding this topic –intersectionality (Crenshaw, 1989; Crenshaw, 1991) and collaboration theory (Gray, 1989; Wood & Gray, 1991). An integrated theoretical approach was necessary because intersectionality helps to explain that women’s experiences of violence differ (Crenshaw, 1989; Crenshaw,
1991; Sokoloff & Dupont, 2005; Bograd, 1999) and that service delivery needs to attend to the multitude of varying and interconnected needs of each woman (Kulkarni, Bell & McDaniel Rhodes, 2012; Danis, 2003; Zweig, Schlichter, & Burt, 2002; Campbell & Ahrens, 1998). Collaboration theory (Gray, 1989; Wood & Gray, 1991) provides an understanding of the necessity of holistic service delivery from the service provider perspective for the benefit of service users.

**Research questions.**

The research questions that guided the current study were developed in collaboration with the Action Committee. Two main research questions, as well as a series of sub-questions were examined from the service user perspective:

1. a) Is the First Response Protocol being implemented as written?
   b) To what extent are the objectives of the First Response Protocol being achieved?
   The objectives are:
   
   (i) To provide a consistent and caring response regardless of where an individual discloses abuse;
   (ii) To explain confidentiality, the limits of that confidentiality and obtain informed consent for service;
   (iii) Offering safety planning and risk assessment; and,
   (iv) To provide coordinated, effective follow up and support.

2. a) To what extent are service users satisfied with their experiences of service providers as they are mandated by the First Response Protocol?
   b) To what extent do the current protocol objectives meet the needs and issues facing women and children who experience sexual and/or domestic violence?

The following section provides a roadmap and outlines the chapters of the current research study.
Outline of Research Study

Chapter two provides an overview of the academic literature on coordinated community responses (CCRs) to sexual assault and domestic violence, specifically domestic violence coordinating councils (DVCCs) and sexual assault response teams (SARTs) as well as sexual assault and domestic violence service provision. Additionally, the chapter uses an integrated theoretical framework combining intersectionality and collaboration theories to offer an understanding of the importance of comprehensive service delivery for women who have experienced violence.

Chapter three outlines the methodological orientation used to guide this evaluation research study as well as how dimensions of community engaged research and principles of community engaged scholarship, community based research and participatory action research were employed to carry out this research study. The chapter also details the research study design and data analysis procedures using qualitative data analysis software.

Chapter four presents the findings of the data analysis. Findings of the data analysis include topics about women’s contact with service providers, their overall service delivery experience, barriers and challenges accessing and receiving services as well as gaps in services. The chapter is interspersed with excerpts from women about their experiences with service providers and the system response to violence against women.

Chapter five identifies connections between the findings of the current research study and previous literature and theories as well as implications of the findings. Finally,
this research study will conclude the study with limitations and directions for future research.
Chapter Two: Literature Review and Theoretical Framework

Violence against women is a complex social phenomenon requiring criminal justice professionals and broader community agencies to work collaboratively, as opposed to working in isolation, to better support women experiencing violence. In the 1980s, early efforts to address sexual and domestic violence primarily targeted the criminal justice system (Clark et al., 1996; Department of Justice Canada, 2003). More recently, there has been a shift towards a multi-sector coordinated response, broadly referred to as coordinated community responses (CCRs). Coordinated community response (CCR) is an umbrella term used to refer to coordinated responses to violence against women. A review of the literature reveals inconsistency in the language used to refer to domestic violence coordinated responses, while there is greater consistency with sexual assault coordinated responses. The language used to refer to domestic violence coordinated responses varies depending on the jurisdiction of the CCR. Research from the United States commonly uses the terms “coordinated community response” (CCR) (Shepard & Pence, 1999; Garner & Maxwell, 2008; Clark et al., 1996) and “domestic violence coordinating council” (DVCC) (Allen, 2006; Allen, 2005; Griffiths, 1997). In contrast, researchers from the United Kingdom commonly use the language “coordinated responses” (Hague & Bridge, 2008) and “multi-agency initiatives” (Hague, 1997). Finally, in Canada, and Ontario, “domestic violence community coordinating committee” (DVCCC) (Building a Bigger Wave, n.d.) is used to refer specifically to single focused domestic violence coordinated responses. Violence against women coordinating council (VAWCC) is used in the Canadian context to refer to dual focused...
domestic violence and sexual assault coordinated responses. Despite the variation in language used, all of the terms refer to coordinated responses implemented to address violence against women. For the purposes of the current research study, this researcher will be using the term CCR more generally to refer to coordinated responses to violence against women. Additionally, DVCC will be used to refer to domestic violence coordinated responses and SART to refer to sexual assault coordinated responses. Violence against women coordinating council (VAWCC) will be used to refer specifically to dual focused coordinated responses in the Canadian context.

**Addressing Violence Against Women via Coordinated Community Responses**

Coordinated community responses (CCRs) are models implemented in communities to improve interagency coordination and elicit a consistent response to violence against women at the local level. More specifically, DVCCs and SARTs function as a vehicle to facilitate the implementation of a CCR, bringing stakeholders together from a variety of sectors and agencies to collectively assess the current response to violence against women, identify the issue(s) and develop a solution (Griffiths, 1997; Allen & Hagen, 2003; Clark et al., 1996) with a shared vision (Sullivan & Allen, 2001). In summary, CCR refers to a model of coordinated service delivery, which DVCCs and SARTs implement to improve the social response to violence against women in their community. DVCCs and SARTs commonly develop and implement protocols as part of their formal structure. Protocols outline parameters for service providers for sexual assault and domestic violence service delivery (National Sexual Violence Resource Center, 2011; Pence & McDonnell, 1999; Ontario Women’s Directorate, 2009; Hague &
Bridge, 2008; Clark et al., 1996). A thorough search of the academic literature reveals that not much has been written or researched within academia about domestic violence and sexual assault protocols. Despite the lack of research on sexual assault and domestic violence protocols specifically, this researcher consulted literature examining DVCCs and SARTs which implement protocols to guide domestic violence and sexual assault service provision. Currently, existing literature surrounding CCRs, specifically DVCCs and SARTs, primarily originates from the United States and the United Kingdom, and is outdated. This literature review only includes research on CCRs that closely mirror the Guelph-Wellington Action Committee on Sexual Assault and Domestic Violence (the Action Committee). It was important to limit the literature search to domestic violence and sexual assault coordinated responses that are similar to the Action Committee because some coordinated responses restrict membership to violence against women advocates and criminal justice professions and others limit their response to a specific organization such as a university campus. Thus, to make parallel comparisons between the findings of the current research study and prior research it was necessary that the literature on DVCCs and SARTs is similar to the Action Committee. This literature review offers an understanding of CCRs, as well as interventions and best practices for domestic violence and sexual assault service provision. The literature addresses the following questions: (1) What are CCRs, specifically DVCCs, SARTs and VAWCCs? (2) How does collaboration via CCRs impact service delivery for women? (3) What are best practices and common interventions for sexual assault and domestic violence service provision?

*The Action Committee is referred to as a violence against woman coordinating council (VAWCC), which addresses sexual assault and domestic violence.*
This literature review provides an overview of CCRs to violence against women, specifically DVCCs, SARTs and VAWCCs as well as evaluation research of CCRs organized into benefits and challenges of collaborative work. Then the chapter will discuss the impact of coordinated responses to sexual assault and domestic violence service delivery from the perspective of the service user and service provider. Next, the chapter will discuss interventions and best practices for sexual assault and domestic violence service provision. Subsequently, the chapter will outline feminist intersectionality and collaboration theories as an integrated framework to help conceptualize and understand the benefits of a coordinated and collaborative approach to sexual assault and domestic violence service delivery in an effort to improve the community response to violence against women.

**Coordinated Community Responses to Violence Against Women**

**Origin of coordinated community responses.**

The coordinated community response (CCR) model emerged during the battered women’s movement in the 1970s in North America. The model is built upon the notion that “…we have to look at the whole picture. We can’t continue approaching post-abuse issues for women in a piecemeal fashion” (YWCA, 2009: 12). The Domestic Abuse Intervention Program, founded by Ellen Pence, was the first single focused domestic violence CCR model implemented in the 1980s in Duluth Minnesota. Coordination was defined by the Domestic Abuse Intervention Program as “a dynamic process that went beyond the improvement of communication or case handling within current policies and procedures” (Gamache & Asmus, 1999: 66). The Domestic Abuse Intervention Program sought to function as a monitoring and coordinating organization for service providers...
intervening in domestic violence cases (Pence & Shepard, 1999). The Domestic Abuse Intervention Program primarily focused on coordination between the criminal justice system and violence against women sectors, such as legal advocates, activists and administrative staff from the local shelter as well as law enforcement and court officials (Pence & Shepard, 1999). DVCCs emerged from the Domestic Abuse Intervention Program model. Despite the predominance of the Domestic Abuse Intervention Program model, other models have since developed and expanded to include broader agencies within the community (Allen, 2005; Harris et al., 2001; Gamache & Asmus, 1999). One reason for this stemmed from the fact that the Domestic Abuse Intervention Program model silenced the issue of marital rape (Yllo, 1999), which meant that sexual violence within the context of an intimate relationship was still a private issue between a husband and wife. Additionally, the silencing of sexual violence by the Domestic Abuse Intervention Program also served to support men’s control over their wives by failing to address it as a public issue. However, the Domestic Abuse Intervention Program model was further adapted in the 1990’s to respond to sexual assault via SARTs in an effort to address secondary victimization commonly experienced by sexual assault victims. Sexual assault victims were often traumatized by long hospital wait times and medical examinations required for evidence collection often performed by inexperienced doctors and nurses (Johnson & Dawson, 2011). Variations of the Duluth model have been implemented worldwide to improve the social and legal response to violence against women (Shepard & Pence, 1999; Adler, 2002; Hague & Bridge, 2008; Hague 1997; Greeson & Campbell, 2012; Campbell, Patterson & Lichty, 2005). The current section provided background on the development of CCRs, specifically DVCCs and SARTS.
The chapter will now highlight the similarities and differences between DVCCs and SARTs to provide a preamble to be followed with a discussion of the structure and purpose of DVCCs and SARTs including their development, purpose/mission, membership, structure, activities.

**Domestic violence coordinating councils.**

Domestic violence coordinating councils (DVCCs) emerged to address the criticisms about gaps in service delivery and a fragmented response to domestic violence (Shepard & Pence, 1999; Sullivan & Allen, 2001). DVCCs primarily exist in the United States, United Kingdom as well as Canada. However, there is a lack of research on DVCCs in the Canadian context. A DVCC is a strategic response implemented in a community to enhance the local response to domestic violence through comprehensive, collaborative and integrated service delivery (Gamache & Asmus, 1999; Adler, 2002; Griffiths, 1997; Hague & Malos, 1998). Gamache and Asmus (1999) assert that a DVCC refers to any model that was created for the purpose of assuming the lead role coordinating the local response to domestic violence. While there is limited empirical evidence to support DVCCs, theoretically they have been touted as a best practice to improve the local response to domestic violence (Allen, 2006; Allen 2005; YWCA, 2009). Despite limited empirical evidence, communities have assumed for more than 20 years that collaboration and coordination will improve the social response to violence against women. Although this not a valid premise to proceed on, communities are relying on wishful thinking and assuming what makes sense theoretically will translate into practice.
Broadly speaking, DVCCs commonly strive to increase women’s safety, increase batterer accountability (Allen, 2006; Uekert, 2003; Hart, 1995), increase coordination among service providers (Johnson & Dawson), and end violence against women (Griffiths, 1997). More specific, but diverging goals of DVCCs may include: strengthening relationships and increasing cooperation among stakeholders, fostering institutionalized change such as implementing or amending a domestic violence policy or initiative (Allen, 2005), increasing communication (Johnson & Dawson, 2011), meaningful batterer accountability and implementing mechanisms for ongoing monitoring and evaluation. Evidently, there is diversity across DVCCs in terms of their goals, which are dependent on local conditions but they also share commonalities. DVCCs often set out specific goals, which are generally dictated by the local conditions of the community (Allen, 2006). For example, increasing public knowledge of domestic violence may make sense in one community, while another may need to work on increasing services and accessibility for rural women. Therefore, the specific goals of a DVCC are individualized and dependent on the current response and gaps in service delivery in the local community and evaluations cannot be compared across jurisdictions. Instead, DVCCs need to be evaluated against their own predefined goals (Allen, 2006).

As DVCCs continue to flourish, it is evident that there is no universal model for engaging in multi-agency domestic violence work (Hague & Malos, 1998; Hague, 1997; Allen 2005; Johnson & Dawson, 2011; Griffiths, 1997; Clark et al., 1996). DVCCs’ organizational structure range along a continuum, from informal information sharing meetings, relying on pre-established relationships to highly formal collaborative coalitions with written agreements (Johnson & Dawson, 2011). DVCCs commonly hold
regular meetings for all agency members to collectively discuss the local response to
domestic violence (Allen, Watt & Hess, 2008; Hague & Malos, 1998; Clark et al., 1996;
Intervention Program, the first domestic violence coordinated response, found that it was
more beneficial to meet with agency representatives individually in a private space as
opposed to convening in a large group. Service providers were more open and willing to
honestly discuss issues within their own agency as well as issues at the larger systemic
level. Consequently, the Domestic Abuse Intervention Program opted to meet with
individuals or convened small groups of agency representatives to highlight problems and
formulate solutions (Gamache & Asmus, 1999).

DVCCs may also implement a range of formal structures and processes including
using an agenda, keeping minutes, forming subcommittees, written agreements (i.e.
protocols, constitutions), written mission statement, goals and objectives, leadership
structures/steering committees and a formalized decision making processes (Hague &
Malos, 1998; Hague & Bridge, 2008; Griffiths, 1997). Despite the range of general goals,
vision and mandate, an online search of DVCC mission statements revealed nuanced
differences across communities throughout North America. For example, the mission of
the London Coordinating Committee to End Woman Abuse in Canada is to “[end] woman abuse through leadership and actions that achieve both social justice for women
and an integrated response to abused women and their children (LCCEWA, 2014).
Similarly, the Montgomery County Domestic Violence Coordinating Council in the
United States aims to “reduce the incidence of domestic violence and create a safe
community for families to live free of abuse” (Montgomery County Government, 2011:
1). In contrast, the mission statement of the York Region Violence Against Women Coordinating Committee’s in Canada is “through collaboration we will develop coordinated, proactive and effective approaches to assist and empower women who have experienced violence against women in York Region” (YRAWCC, n.d). Evidently, while there are similarities across DVCCs in terms of their mission statement, how they attempt to improve the lives of women who experience violence may differ.

DVCCs bring stakeholders together from statutory and voluntary sectors to respond to domestic violence at the local level (Shipway, 2004). DVCCs commonly comprise of representatives from a variety of sectors including; criminal justice, violence against women, child welfare, social assistance and housing, health care, addictions/mental health and education (Allen, 2006; Allen, 2005; Harris et al., 2001; Hague 1997; Griffiths, 1997). Less commonly, religious/spiritual institutions, local businesses (Allen, 2006; Allen, 2005; Griffiths, 1997; Clark et al., 1996) as well as animal shelters (Uekert, 2003) are members of DVCCs.

**Sexual assault response teams.**

Sexual assault response teams (SARTs) were established to address under-reporting of sexual assault (Greeson & Campbell 2012; Wilson & Klein, 2005) and the shortcomings of the criminal justice system, health care and advocacy organization’s response to sexual assault (Cole & Logan, 2010; Campbell & Ahrens, 1998). SARTs are prominent in the United States, although they do exist in Canada. However, existing academic literature on SARTs is solely derived from the United States. Traditional responses to sexual assault were characterized by insensitivity, poor forensic evidence collection, inadequate medical care and failing to address victims’ full range of needs
Victim’s experiences were exacerbated if the victim was under the influence of drugs and/or alcohol at the time of the incident or if the victim was previously or currently involved in an intimate relationship with her abuser. Situational and contextual factors fueled service providers’ perceptions of disbelief and victim blaming (Bryden & Lengnick, 1997; LaFree, et al., 1985; Pollard, 1992; Spohn & Holleran, 2001; Spohn, Beichner, & Davis-Frenzel, 2001). SARTs were an attempt to improve the community response to sexual assault by offering victims of sexual assault a continuum of care via seamless and collaborative service delivery among multiple service providers (Greeson & Campbell, 2012; ICJIA, 2003). SARTs act as a mechanism, which helps to facilitate a coordinated response by bringing agencies together with a vested interest in improving the local response to sexual assault. SARTs seek to evaluate the current response, identify key issues and implement a solution (Greeson & Campbell, 2012; Oregon Attorney General’s Sexual Assault Task Force, 2009). The general notion underlying SARTs is that “when systems work together in a collaborative way to provide a coordinated response to sexual violence, they work better and smarter, encourage victims to access services, are more effective in holding offenders accountable, and ultimately, protect victims and communities” (Mallios & Markowitz, 2011: 2). SARTs are perceived to be the “gold standard” of sexual assault service delivery, and they have expanded rapidly throughout the United States (Campbell et al., 2012), and to a lesser extent in Canada (MacPherson & Purdon, 2012). Not much is known about the effectiveness of SARTs (Greeson & Campbell, 2012; Campbell et al., 2012), but the
preliminary results are promising (National Sexual Violence Resource Center, 2006).

A victim-centered philosophy forms the cornerstone of SARTs (Oregon Attorney General’s Sexual Assault Task Force, 2009; Wilson & Klein, 2005), meaning that victims' needs are placed at the forefront of sexual assault coordinated responses. However, the goals of SARTs strive to balance the needs of victims of sexual assault and the criminal justice system (Oregon Attorney General’s Sexual Assault Task Force, 2009). SARTs aim to improve service delivery via coordinated and holistic victim care (National Sexual Violence Resource Center, 2006). Offender accountability through increased arrests by the police and prosecutions by the criminal justice system is also a commonly cited goal of SARTs (Wilson & Klein, 2005; Department of Justice, 2004; Wolbert Burgess et al., 2006; National Sexual Violence Resource Center, 2006). They may also engage in efforts to increase public knowledge about sexual assault and awareness of services in the community (Department of Justice, 2004; National Sexual Violence Resource Center, 2011; 2006; Oregon Attorney General’s Sexual Assault Task Force, 2009; Campbell & Ahrens, 1998). The extent to which each SART prioritizes these goals differ, and vary across jurisdictions (Greeson & Campbell, 2012).

Like DVCCs, the organizational structure of SARTs vary and is tailored to meet the needs of the local community (Ledray, 1999; Greeson & Campbell, 2012). They range from highly formalized collaborative groups guided by written documents to less formal multi-sector teams that rely on informal information exchange and relationship building (Greeson & Campbell, 2012; National Sexual Violence Resource Center, 2006). For example, the purpose of the SART protocol in Waterloo, Ontario is to “share information and work together in providing a coordinated community response to sexual
violence in Waterloo Region...The protocol establishes a common understanding and framework of the provision of services to victims/survivors of sexual violence, enabling greater coordination and collaboration between community partners (Sexual Assault Response Team of Waterloo Region, 2012: 8-9). SARTs commonly designate a leader who is responsible for coordinating and leading meetings (Zajac, 2009). SARTs may also rely on a variety of structures and processes to guide their collaborative efforts including regular meetings (U.S. Department of Justice, 2004; Ledray, 1999; National Sexual Violence Resource Center, 2006) written documents (i.e. protocols, mission statements, bylaws) (Greeson & Campbell, 2012; National Sexual Violence Resource Center, 2006), cross-sector training (National Sexual Violence Resource Center, 2006), mechanisms for accountability and formal evaluation (Zajac, 2009).

The core membership of a SART typically includes sexual assault nurse examiners (SANEs), sexual assault victim advocates, police and prosecutors (Greeson & Campbell, 2012; Oregon Attorney General’s Sexual Assault Task Force, 2009; Ledray, 1999; Wolbert Burgess et al., 2006; National Sexual Violence Resource Center, 2011) as well as forensic examiners (National Sexual Violence Resource Center, 2006; Greeson & Campbell, 2012). Membership of a SART may extend beyond the core members to include any service provider from any sector that may come into contact with someone who has been sexually assaulted and has a vested interest in responding to sexual assault (Oregon Attorney General’s Sexual Assault Task Force, 2009; Ledray 1999) including: education, social services, criminal justice, violence against women, health care, community based organizations, military and disability services (National Sexual
Violence against women coordinating councils.

The language violence against women coordinating council (VAWCC) is specific to Ontario, and Canada more generally. There are approximately 48 VAWCCs across the province of Ontario (Building a Bigger Wave, n.d.). VAWCCs are synonymous with DVCCs and SARTs. Approximately 40% of VAWCCs are dual focused committees and address sexual assault and domestic violence concurrently. In other words, despite the language VAWCCs commonly include both DVCCs and SART, while some are single focused and solely address domestic violence or sexual assault. Roughly 23% of VAWCCs in Ontario only address domestic violence (MacPherson & Purdon, 2012). Similar to DVCCs and SARTs, VAWCCs have a long and rich history in Ontario. Approximately one-third have been in existence for more than 20 years, while another one-third have existed for more than 10 years (MacPherson & Purdon, 2012). The majority (80%) of VAWCCs across Ontario receive government funding from the Ministry of Community and Social Services, and 75% have used a portion of their funding to create a paid staff position. This is important because DVCCs and SARTs in the United States often do not have an administrator or coordinator and many operate with little or no funding (National Sexual Violence Resource Center, 2006). Evidently, CCRs receive greater support in Ontario compared to those located in the United States and may be better positioned to facilitate change. Finally, more than half (59%) of VAWCCs in Ontario have developed a protocol to guide their work (MacPherson &
Purdon, 2012). The current section is relevant to the current research study because it provides an overview of the state of coordinated responses in Ontario, Canada.

**Comparing and contrasting DVCCs and SARTs.**

Evidently, DVCCs and SARTs share many similarities, specifically their broader goals to improve service delivery for women who have experienced violence and increase coordination and collaboration among service providers. There is no universal model for DVCCs or SARTs. Moreover, the formal structure and processes vary across individual coordinated responses. Membership of DVCCs and SARTs is broad, and typically includes any service provider that may encounter a victim of sexual assault and/or domestic violence. Moreover, membership of DVCCs and SARTs may also include service providers that have a vested interest the social response to sexual assault and/or domestic violence.

A review of the academic literature reveals two key distinctions that differentiate DVCCs from SARTs, beyond their single focus. First, DVCCs and SARTs have differing primary objectives. The primary objective of a DVCC is to support women through a holistic response addressing her complex needs, and does not necessarily require involvement with the criminal justice system. In contrast, the primary objective of a SART is to collect forensic evidence to prosecute the offender through the criminal justice system. Second, a review of the literature reveals that coordinated responses to sexual assault and domestic violence, specifically DVCCs and SARTs are discussed separately within the academic literature and emerge from differing disciplines. Literature pertaining to DVCCs is predominantly found in sociological, criminological journals and grey literature, whereas literature on SARTs are primarily found in nursing
journals as well as grey literature, such as government publications. Similarly, literature on VAWCCs is found in the grey literature. The divide between domestic violence and sexual assault within the literature on coordinated responses suggests that they are separate issues, which is inconsistent with a feminist analysis. This chapter discusses DVCCs and SARTs separately because they emerge from different bodies of literature, and because of the distinct difference in their objective, not because this researcher believes that domestic violence and sexual assault are dichotomous issues.

The following section outlines existing evaluations of CCRs, and presents the literature in the form of benefits and challenges of engaging in collaboration among multiple service providers. Evaluation research on the benefits and challenges of CCRs is relevant to provide contextual background for the current study from the service provider perspective.

**Benefits of Engaging in Collaboration to Address Violence Against Women**

Evaluation literature on the effectiveness of CCRs is sparse (Allen, 2010; Clark et al., 1996; Campbell & Ahrens, 1998; Sullivan & Allen, 2001). There is limited evidence that DVCCs and SARTs are beneficial and have improved service delivery for victims of sexual and domestic violence in their communities (Allen, 2010; Hague & Malos, 1998; Clark et al., 1996; Shepard & Pence, 1999; Greeson & Campbell, 2012; Noble, Brannon-Patel & Tysoe, 2001). Scholars have noted that evaluations do not hold definitive answers about a single CCR (Garner & Maxwell, 2008: Shepard, 1999). However, “evaluation can help to set priorities, guide the allocation of resources, facilitate the modification and refinement of program structures and activities, and signal the need for redeployment of personnel and resources” (Herman et al., 1987: 11). Multi-agency
coordination and collaboration is intended to be a means to improving sexual assault and domestic violence service provision through survivor safety and autonomy (Laing & Humphreys, 2013). Women often lose control over their lives as a result of the violence they have experienced. Thus, it is important to ensure women maintain control as much as possible over their choices and options when they come into contact with system. Beyond the benefit of better coordination and collaboration, there is limited attention to additional benefits of multi-agency collaborative work.

**Institutionalized change.**

CCRs are well positioned to promote institutionalized change with the “right players.” Institutionalized change refers to “changes created in the structure of the formal helping response (e.g., in policies and procedures). Changes [may take] the form of either altering existing practices or creating new initiatives” (Allen, Watt & Hess, 2008: 69). This is a significant benefit and is promising to promoting systems change because agencies often do not have enough political clout on their own to influence government policies or practices. Instead, CCRs are more effective as a collaborative lobbying the government (Allen, Watt & Hess, 2008). Although CCRs may have the ability to create institutionalized change and increase knowledge, it does not mean that they will or that they do. There is little evidence to suggest that CCRs use their political clout to promote systems change.

**Increase public and professional knowledge.**

Multi-agency collaboratives may engage in activities to increase public and professional knowledge on violence against women, reaching service providers and women within a large geographical area (Hague & Malos, 1998). Existing research has
found that some service providers, specifically judges (CEVAW, 2009; Gamache & Asmus, 1999), police (Kulkarni, Bell, & Wylie, 2010) child welfare workers (Campbell et al., 2010; Hester et al., 2007) and family physicians (Bacchus, Mezey & Bewley, 2002) have a limited understanding of the complexity of sexual assault and domestic violence, impacting their ability to provide support to women. Additionally, women often lack knowledge and do not label their experiences as violent (Bell & Kulkarni, 2006) or they minimize their experience of abuse (Fugate et al., 2005), preventing them from seeking formal support. With greater knowledge within the community among service providers, service users and the general public, those who experience violence may be better served.

**Sharing funding and resources.**

The ability to share funding and resources, eliminating duplication and redistributing those fund and resources where needed is a benefit of multi-agency collaboration (Hague, 1997). This is an important benefit because agencies are struggling to work with the limited funding and resources they do receive. Thus, pooling everything together and redistributing funds and resources may allow collaboratives to achieve more together.

**Challenges of Engaging in Collaboration to Address Violence Against Women**

While there is some evidence to suggest that multi-agency coordination and collaboration has improved service delivery for women who have experienced violence, CCRs are not uniformly effective (Allen, 2006; Allen, 2005; Javdani & Allen, 2011). Collaboration among an array of stakeholders working towards a common goal presents barriers and challenges because each person brings their own working philosophies, goals and limitations from their agency (Greeson & Campbell, 2012; Shipway, 2004). In
contrast to the limited literature on the benefits of multi-agency collaboration, there is extensive literature on the barriers and challenges experienced by DVCCs and SARTs. This review offers an overview of the most commonly cited challenges experienced by DVCCs and SARTs.

**Funding and resources.**

CCR s often exist within a political climate characterized by government cut backs and resource shortages. Funding and resources continue to be a challenge for CCRs, and impedes the efforts of multi-agency collaboratives (Hague, 1997; National Sexual Violence Resource Center, 2006; Shepard & Pence, 1999; Hague & Bridge, 2008; Noble, Brannon-Patel & Tysoe, 2001; Hatmaker, Pinholster, & Saye, 2002; Clark et al., 1996; Malik, Ward & Janczewski, 2008; Campbell, 2010; Cole & Logan, 2010). Lack of funding and resources impacts agencies’ and CCRs’ ability to offer services (Harris et al., 2001; CEVAW, 2009; Wendt, 2010; Malik, Ward & Janczewski, 2008). More specifically, funding impacts service providers in various ways including staff availability, which in turn effects the availability of services as well as the capacity for support groups (Campbell, 2010). Funding may be used to create an administrative or coordinator position to ensure that the collaborative is making strides and progressing (Welsh, 2005). Various agencies also offer tangible assistance such as grocery and thrift store vouchers, provide financial assistance for women to change their locks and personal emergency alarms (MERS) as well as money for transportation and child care. Thus, without funding and resources, these services would not be possible. Funding is also needed so that CCRs can evaluate their efforts and offer insight on what is working and where improvements are needed so that they can improve as a collaborative. More
generally, lack of funding affects CCRs’ ability to develop creative and innovative strategies (Hague, 1997) and thrive as a collaborative (Griffiths, 1997).

Hague (1997) warns about the danger of competition for funds, and unveiled situations in which funding for multi-agency collaboratives was prioritized over emergency services, such as shelters. Lack of funding and resources can also lead service providers to focus their time and energy on securing funding, while detracting their efforts and attention away from the collaborative (Hatmaker, Pinholster & Saye, 2002; Wendt, 2010). At the outset, when DVCCs are created, staff devotion to coordinating activities is sufficient to facilitate the functioning of a CCR. However, CCRs require ongoing funding and resources to be sustainable and flourish long-term (Gamache & Asmus, 1999; Hague & Bridge, 2008).

**Membership and active participation.**

Obtaining membership of key stakeholders and ensuring members are active is challenging for collaboratives. DVCCs and SARTs appear to have widespread representation from various agencies and organizations across a variety of sectors, but some members are inactive (Allen, 2006; Hague, 1997; Noble, Brannon-Patel & Tysoe, 2001; ICJIA, 2003; MacPherson & Purdon, 2012; Campbell, 2010). They may be using their membership to disguise inaction without any contribution to the CCR’s mission or vision (Hague, 1997). The ICJIA (2003) conducted a study of three pilot SARTs, which found that obtaining representation from all of the key members at the collaborative meetings was a challenge for each site, and of all the members, prosecutors were least likely to attend. In another study of over 200 domestic violence interagency initiatives in the United Kingdom, Hague (1997) found that agencies including probation, social
services and housing were less active relative to the police, while health care and education representatives were frequently absent. Hague (2001) asserts that “[f]or inter-agency work to be effective, there is some agreement that, from the statutory side, the full range of health, social and housing services, education authorities, the police and other criminal justice agencies all need to take a full part, and that the work done is held back if they do not” (p. 283). Additionally, Allen (2005) concluded “council membership must not only be broad, but characterized by active participation by a diverse set of key stakeholders” (p. 58), which are essential to achieve their goals.

Moreover, the literature highlights specific groups that are rarely represented on CCRs. Scholars have noted the poor representation of survivors on CCRs (Allen, Watt & Hess, 2008; Allen, 2006; Shipway, 2004; Gamache & Asmus, 1999; Hague & Malos, 1998). Allen (2006) noted that survivors are poorly represented on domestic violence coordinating councils. Allen (2006) examined 41 DVCCs, and found that none of the councils examined had an advisory board comprised of domestic violence survivors. Moreover, Hague and Malos (1998) interviewed women about the multi-agency collaborative in their area. The vast majority of women had not heard about the initiative, but they felt strongly that women’s voices should be included, as one woman expressed:

It is totally ridiculous if the inter-agency projects don’t listen to women and ask women what they need. How can they be sure that they are doing the right thing if they don’t consult women? How do they know? They have to ask. It’s still, stupid. Obviously, they should be accountable to women and children (Hague & Malos, 1998: 383).

Evidently, women feel that their options should be voiced at DVCCs. The lack of direct input from service users raises questions about whose interests are being served and their commitment to survivor safety. If CCRs do not receive input from survivors themselves,
their efforts may be benefitting the council and/or select agencies as opposed to those they are aiming to serve (Allen, 2006; Campbell, 2010). Scholars agree that the inclusion of survivors on CCRs would be beneficial because they are in the best position to offer insight into improving service delivery (Shipway, 2004; Allen, 2006; Hague & Malos, 1998). There are diverging views on how to incorporate survivor representation on CCRs. How CCRs incorporate input from survivors will depend on the local conditions and vary across communities (Hague & Mullender, 2006). Allen (2006) asserts that although there was limited survivor representation on the councils she examined, survivor voices may still be represented through members’ personal experiences. In addition, violence against women advocates bring service users’ experiences and insight to the table (Allen, 2006). There is concern that survivors may propose misguided ideas or suggestions (Gamache & Asmus, 1999), although the same can be said for service providers.

There is some discrepancy within the literature about the status of the members of coordinated responses to violence against women. Scholars suggest that CCRs require participation of upper level management because they have the power and authority to elicit change (Hague & Bridge, 2008; Hague, 1997; Giacomazzi & Smithey, 2001; Hague & Malos, 1998; Uekert, 2003; Clark et al., 1996). Uekert (2003) posits that CCRs are less successful when lower level staff with minimal decision-making authority represent their agency on multi-agency collaboratives. CCRs require the participation of agency upper level management staff to elicit and implement structural and procedural changes. In contrast, Gamache & Asmus (1999) assert that participation of middle managers and front line workers are essential for improving the effectiveness of CCRs because they have first hand experience performing daily activities of their agency, and this is
precisely the level of information needed to inform policy changes that better serve women. Others (Hague & Malos, 1998; Uekert, 2003) concur that front line workers participation in CCRs are essential.

Membership forms the foundation of the collaborative. Allen (2005) suggests “councils with an inclusive climate may still have a limited capacity to produce community change in the absence of the “right players”” (p. 61). Members need to be active in their efforts to advance the council and improve the societal response to violence against women at the local level. Active participation of a wide array of stakeholders is the cornerstone for a CCRs success, which can effectively facilitate change (Allen, 2006; Allen, 2005; Hague, 1997; Greeson & Campbell, 2012).

**Competing philosophies/mandates.**

Competing philosophies and mandates is a commonly cited impediment to multi-sector collaboration (Greeson & Campbell, 2012; Campbell & Ahrens, 1998; Clark et al., 1996, Noble, Brannon-Patel & Tysoe, 2001; Wendt, 2010). Competing philosophies and mandates are inherent with this type of work because service providers are coming together from diverse sectors and attempting to coordinate services, but each individual is guided by their own agency’s philosophy and goals. This makes it difficult for members to agree on collective solutions (Giacomazzi & Smithey, 2001) and goals (Gamache & Asmus, 1999; Malik, Ward & Janczewski 2008; Greeson & Campbell, 2012) as a collaborative. Gamache and Asmus (1999) note that developing a shared philosophical foundation placing victim safety at the forefront and maintaining victim safety as a long-term priority is “one of the most difficult challenges for these councils” (p. 78). For example, salient tension exists between violence against women and child welfare sectors
due to philosophical differences (Hester, 2007; Clark et al., 1996; Schechter & Edelson, 1994; Friend, 2000; Peled, 1996). Violence against women agencies typically support empowering women to make informed decisions, which may include preserving the relationship, while child welfare agencies do not support women staying in an abusive relationship and hold women accountable to protect their children (Hester, 2007). The tension between these sectors is largely attributable to the perception that the philosophy guiding the work of the other compromises the safety of their clients (Mills et al., 2000). A unified philosophy is integral to the effectiveness of coordinating bodies, as Slaught and Hamilton (2005) assert “coordination is not necessarily a product of the existence of a coordinating body but rather results from a unified philosophy that integrates law enforcement and treatment responses” (p. 58).

**Role confusion.**

Due to the structure of CCRs, there is often confusion in terms of who should and should not do what because collaboratives bring multiple disciplines with diverse roles and priorities (Greeson & Campbell, 2012; Campbell & Ahrens, 1998; Clark et al., 1996, Noble, Brannon-Patel & Tysoe, 2001; Wendt, 2010). Role confusion occurs most often because service providers do not understand each other’s roles (Wendt, 2010; Clark et al., 1996). Wendt (2010) conducted a study to examine the barriers to working collaboratively. She found that “there was a lack of understanding about what each agency was responsible for in the community…this was creating frustration, suspicion and misrepresented innuendos about each other” (p. 49). Cross-sector training has also been noted as a strategy to address role confusion (ICJIA, 2003).
Turfism or “turf wars” are also common when multiple stakeholders attempt to work towards a common goal (Giacomazzi & Smithey, 2001; Griffiths, 1997; Hague 1997; Greeson & Campbell, 2012; Campbell & Ahrens, 1998; Uekert, 2003). Turfism refers to agencies participating in CCRs to claim their territory or protect their “turf” and look out for their agency’s interest, rather than trying to advance the collaborative (Giacomazzi & Smithey, 2001). A study of SARTs concluded that “service providers often have different agendas and styles of interacting with victims, and each wanted to claim their “right” and their time with victims as “more important”” (Campbell & Ahrens, 1998: 553). Additionally, Griffiths (1997) notes “turf issues are notoriously difficult to confront in community collaborations, as few organizations wish to be viewed publicly as having the desire for exclusive authority over issues” (p. 967). Uekert (2003) also notes that some agencies’ resistance to participating in a CCR is “political and based on protection of “turfs”” (p. 133). Griffiths (1997) suggests that an external third party mediator can help to identify and resolve turf issues present among members of a CCR.

**Power dynamics.**

Power differentials are often present among members of CCRs and has been noted as a barrier to collaboration (Allen 2006; Allen, 2005 Giacomazzi & Smithey, 2001; Hague 1997; Hague & Malos 1998). Giacomazzi and Smithey (2001) found marginalization of non-law enforcement agencies occurring by agencies within the criminal justice sector, ultimately hindering multi-agency collaboration. Similar findings were reported by Hague (1997) who found that less powerful agencies such as violence against women advocates and refuge groups felt marginalized by more powerful statutory agencies such as the police who had a tendency to attempt to “take over” or to “own” the
work done by the collaborative, according to participants (p. 102). The police have been identified within the literature as a group with significant power that commonly initiate multi-agency collaboratives (Hague, 2001; Giacomazzi & Smithey, 2001) and are frequently represented on CCRs. Hague (2001) notes:

Many forums have been initiated and by the police, and a great deal of careful multi-agency work has undoubtedly been conducted as a result of police action. The evidence from the study is that committed and active participation by the police is vital. However, for an initiative to be most effective, it is also of crucial importance in the majority of cases that the police do not lead or dominate it, and that meetings do not take place in police premises. This is due to the sensitivities involved and the possible difficulties of equalizing relationships with other agencies, for example small women’s refuges. Black women’s groups etc. (p. 283)

This quote demonstrates the importance of striking a balance on CCRs with police involvement because they may take over with relative ease and ostracize less powerful sectors and agencies. Moreover, Hague (1997) found that power differences could be heightened among CCRs due to the sensitive nature of domestic violence and sexual assault, fueling powerful feelings among members. Equalizing power differentials among member agencies of a CCR is challenging. Gray (1985) asserts that stakeholders must possess “roughly equal power” for collaboration to occur.

Evidently, DVCCs and SARTs experience a multiplicity of challenges that are not easy to rectify. However, it is important to be mindful of the challenges impeding coordinated responses to violence against women, otherwise it may be easy to dismiss their small gains. The next section discusses how coordination and collaboration among service providers has impacted women’s service delivery experience.
Impact of Collaborative Service Delivery for Service Users

Studies examining domestic violence and sexual assault service delivery have documented benefits of collaboration among service providers for service users. Generally, they have found that collaboration among service providers has enhanced service delivery for women who have experienced violence, and is more beneficial than isolated service delivery (Kulkarni, Bell & McDaniel Rhodes, 2012; Zweig & Burt, 2007; Zweig, Schlichter, & Burt, 2002; CEVAW, 2009; Harris et al., 2001; Campbell & Ahrens, 1998; Nugent-Borakove et al., 2006). Zweig et al. (2002) examined services geared towards women that experience multiple barriers. Service providers reported that collaboration was integral to successful sexual assault and domestic violence service delivery as one participant stated “[y]ou cannot serve women alone; it will not work. All parts of the system are equally important” (Zweig, Schlichter, & Burt, 2002: 176).

Kulkarni et al. (2012) found that advocates perceived domestic violence services and support to be less effective without support of other community agencies and resources because advocates working in isolation are often unable to meet the multiplicity of women’s needs compared to advocates that collaborate with other service providers. Similar findings are echoed by other scholars (Zweig, Schlichter, & Burt, 2002; Campbell & Ahrens, 1998). Moreover, a study conducted by the Coalition to End Violence Against Women (2009) revealed that female service users reported “[collaboration] was one of the most important and helpful things besides feeling safe and that their lives improved as a result of the collaboration efforts of the agencies they encountered” (p. 36). Specifically, collaboration facilitated referrals to other agencies among service providers, and was reported by women to be helpful.
Moreover, a study conducted by Baker and colleagues (2003) asked women who experienced domestic violence what resources they needed if they decided to end their abusive relationship. Many women listed the need for tangible assistance and resources and emotional support, while some women listed a need for a comprehensive response from their community to gain stability and rebuild their lives so that they do not return to their abusers (Baker, Cook, & Norris, 2003). Evidently, collaboration among service providers has improved service delivery for women who have experienced violence, yet the literature in this area is limited. The following section shifts to a discussion of sexual assault and domestic violence service provision and offers insight into interventions that service providers and service users have identified as integral to sexual assault and domestic violence service delivery.

**Sexual Assault and Domestic Violence Service Provision**

**Disclosure.**

Disclosure is an important element of sexual assault and domestic violence service provision. Disclosing sexual assault and/or domestic violence to a service provider can be distressing for a woman (Kulkarni, Bell & McDaniel Rhodes, 2012) and has implications for her recovery (Campbell, Sharps & Glass, 2001). Thus, it is essential that service providers ensure that women feel safe and comfortable. Previous research has documented important aspects for women when disclosing violence, specifically trust (Belknap & Sayeed, 2003), privacy (Bacchus Mezey & Bewley, 2002; Bates, Hancock & Peterkin, 2001; Shipway, 2004), and confidentiality (Kulkarni, Bell & McDaniel Rhodes, 2012; Simmons et al., 2011). Belknap & Sayeed (2003) found that establishing trust with a service provider was important to facilitate a disclosure of violence. Women
reported that building trust requires more than one encounter with a service provider (Belknap & Sayeed, 2003). In another study, service providers and service users mentioned the importance of a supportive and therapeutic relationship between an individual worker and the woman for a disclosure (Rose et al., 2011). Additionally, literature examining sexual assault and domestic violence service provision in healthcare settings have noted the importance of privacy for a disclosure (Bacchus, Mezey & Bewley, 2002; Bates, Hancock & Peterkin, 2001; Shipway, 2004). Women have reported that a lack of privacy can be a barrier to disclosing violence to a service provider (Bacchus, Mezey & Bewley, 2002; Bates, Hancock & Peterkin, 2001; Fugate et al., 2005). Shipway (2004) contends that “[i]t is essential that if abuse is suspected, where possible the [service providers] provides an opportunity for the client to speak privately to a member of staff” (p. 180). Relatedly, Kulkarni and colleagues (2012) assert that clearly defined boundaries, assurances of safety and confidentiality are important for women who have experienced violence, precisely “because their intimate relationships have been characterized by abuse and betrayal” (p. 94). These studies provide evidence that disclosure is an important step for women when they choose to turn to formal support for assistance. Additionally, how the relationship between the woman and service provider unfolds is dictated by the actions of the service provider after a heavy disclosure of sexual and/or domestic violence.

**Risk assessment.**

Safety is paramount for women who have experienced violence (Laing & Humphreys, 2013) because it is often ongoing (Hester et al., 2007) and escalates in terms of frequency and severity (Shipway, 2004; Hotton, 2001) especially post separation
The literature has identified a plethora of risk factors that are correlated with lethality (Aldridge & Browne, 2003; Campbell, Sharps & Glass, 2001). Service providers have used risk assessment instruments for decades to manage dangerous situations (Kropp, 2008). Roehl and Guertin (2000) define risk assessment as “…the formal application of instruments to assess the likelihood that intimate partner violence will be repeated and escalated” (p. 171). Although, some risk assessment instruments predict intimate partner homicide (Campbell, Webster & Glass, 2009). Performing a risk assessment is a participatory process and should be utilized with a woman, rather than by a service provider about a woman in her absence (Laing & Humphreys, 2013). Research has found that women are good predictors of their level of risk (Heckert & Gondolf, 2004; Weisz, Tolman, & Saunders, 2000). It is important to note that a risk assessment does not guarantee that a woman will be killed by her partner or that violence will reoccur, nor does it mean that she is immune to lethality and/or future violence (Danis & Bhandari, 2010). Rather a risk assessment is used to guide service providers on how to manage risk, which will inform appropriate safety planning strategies. Thus, collaboration among relevant service providers is key for risk management and safety planning, and aligns with a coordinated service delivery model.

There are three types of risk assessment tools; unstructured clinical decision making, actuarial decision-making and structured professional judgment (Kropp, 2008). There are approximately 24 risk assessment tools used across Canada (Campbell, 2010). However, the most commonly used risk assessment tools in Canada are the Danger Assessment (DA), Domestic Violence Screening Inventory (DSVI), Ontario Domestic Assault Risk Assessment (ODARA) and Spousal Assault Risk Assessment Guide (SARA) (Kropp,
Risk assessment tools have varying purposes, and agencies typically use a risk assessment tool that aligns with their mandate. For example, ODARA and DSVI are used to predict future acts of violence, whereas the DA is used to predict lethal violence. In contrast, SARA is used to predict reassault of intimate partner violence and lethal violence (Campbell et al., 2009) (for a detailed discussion of risk assessment models and tools see Kropp, 2008).

The literature identifies benefits of utilizing a risk assessment, primarily for service providers, including:

(i) informing safety planning strategies to keep women and their child(ren) safe (Campbell, 2010; Campbell 1986; Abrams, Belknap, & Melton, 2001; Roehl & Guertin, 2000; Websdale 2000a; Weisz, Tolman, & Saunders, 2000)

(ii) creating a common language and understanding among service providers across sectors working with victims and perpetrators of domestic violence (Campbell, 2010; Abrams, Belknap, & Melton, 2001; Websdale, 2000a)

(iii) informing male batterer intervention programs (i.e. PARS) and developing appropriate treatment plans (Campbell, 2010)

(iv) serving an educational purpose for service providers about domestic violence across agencies and sectors (Websdale 2000a).

(v) assisting the justice system identifying high-risk offenders and advising on appropriate monitoring and management strategies (Campbell, 2010).

A review of the literature reveals risk assessment tools are predominately used for the benefit of service providers. A risk assessment is an essential component of safety planning, which is another strategy used to manage dangerous situations (Davies, Lyon & Monti-Catania, 1998).
Safety planning.

Safety planning has been a primary tenet of domestic violence service provision since the emergence of the battered women’s movement (Davies, Lyon & Monti-Catania, 1998; Hardesty & Campbell, 2004) and is a critical intervention to helping women who have experienced violence achieve safety (Lindhorst, Nurius & Macy, 2005; Davies, Lyon & Monti-Catania, 1998). Safety planning refers to discussions that occur between a woman and an advocate about the violence she is experiencing and brainstorming strategies to keep herself and her children safe (Davies, Lyon & Monti-Catania, 1998). Safety planning is an individualized process that involves “ongoing assessments of risks, resources, and priorities and the creation of strategies to maximize safety and to pursue goals in this context” (Lyon, 2008: 620). Initially, notions of safety planning referred to helping a woman escape from physical violence and leave the relationship. More recently, understandings of safety planning have expanded and examine the complex ways in which women manage violence in the contexts of their intimate relationships and does not assume that ending the relationship is the best option for every woman (Davies, Lyon & Monti-Catania, 1998; Lindhorst, Nurius & Macy, 2005; Shipway, 2004). Moreover, safety planning requires “attention to vulnerabilities across multiple intrapsychic, interpersonal, and environmental dimensions, as well as an evaluation of internal and external resources, available options and the analysis of relative harm/safety implications of assorted action plans” (Lindhorst, Nurius & Macy, 2005: 347). A woman may employ a variety of safety planning strategies to keep herself and her children safe such as placating the abuser, seeking formal and informal support, and packing a bag with emergency essentials for a quick escape (Goodkind, Sullivan & Bybee, 2004). No
single strategy or combination of strategies will be completely effective (Danis & Bhandari, 2010; Davies, Lyon & Monti-Catania, 1998; Lindhorst, Nurius & Macy, 2005; Goodkind, Bybee & Sullivan, 2004). There is a lack of research evaluating the efficacy of safety planning strategies (Hardesty & Campbell, 2004). However, there is some evidence that safety planning has been helpful and important for women living in dangerous and unpredictable situations (Bell & Kulkarni, 2006; Harris et al., 2001; Weisz, 2005), and is an important intervention of service provision.

**Referrals.**

Women are often unaware of the sexual assault and domestic violence services in their community (Kulkarni, Bell & McDaniel Rhodes, 2012; Campbell, Sharps & Glass, 2001; Zweig, Schlichter & Burt, 2002; Fugate et al., 2005; Centre for Research on Violence Against Women and Children, 2002; Simmons et al., 2011) or how to access them (Kulkarni, Bell & McDaniel Rhodes, 2012; Fugate et al., 2005). In a study conducted by Postmus et al. (2009), they found that more than half of the participants did not seek formal support because they did not know where to go or did not have a name of a contact person. This finding is consistent with other research (Fugate et al., 2005). Referrals to sexual assault and domestic violence related services are an important and essential intervention of service provision for women who have experienced violence (Trevillion et al., 2012; Kulkarni, Bell, & Wylie, 2010; Campbell, Sharps & Glass, 2001; CEVAW, 2009; Weisz, 2005; Harris et al., 2001; Macy et al., 2009). Weisz (2005) found that overall, women reported that service providers were helpful if they provided information about other services and offered referrals. Beyond providing a referral, it was important that service providers coached women on how to engage with other services,
specifically if there was limited availability (Kulkarni, Bell, & Wylie, 2010), which is a common experience due to the funding climate. The current section highlighted the existing literature on common interventions for domestic violence and sexual assault service provision. The next section shifts to a discussion of important aspects and characteristics of service delivery beyond the interventions discussed above, according to women as well as service providers.

Characteristics of Domestic Violence and Sexual Assault Service Provision

Empowering support.

The manner in which sexual assault and domestic violence service providers treat a woman and how she feels impacts the quality of her service delivery experience (Kulkarni, Bell & McDaniel Rhodes, 2012; Bell & Kulkarni, 2006; Simmons et al., 2011; Harris et al., 2001; Postmus & Hahn, 2007; Campbell, Sharps & Glass, 2001; Zweig & Burt, 2007; Trevillion et al., 2012; Rose et al., 2011; Hester et al., 2007; Parmar & Sampson, 2007; Mullender 1996; Weisz et al., 2005; Bacchus, Mezey & Bewley, 2002; Roberts & Roberts, 2002; Shipway, 2004; Keeling & van Wormer, 2011; Macy et al., 2009). Several qualities have been identified within the service provision literature and associated with positive and helpful service delivery experiences including; feeling heard (Mullender 1996; Hester et al., 2007), compassion (Kulkarni, Bell & McDaniel Rhodes, 2012; Bell & Kulkarni, 2006), understanding (Bell & Kulkarni, 2006; Hester et al., 2007; Bacchus, Mezey & Bewley, 2002), non-judgment (Kulkarni, Bell & McDaniel Rhodes, 2012; Kulkarni, Bell, & Wylie, 2010; Bell & Kulkarni, 2006; Hester et al., 2007; Roberts & Roberts, 2002; Simmons et al., 2011), validation and acknowledgment of abuse (Shipway, 2004; Bacchus, Mezey & Bewley, 2002), respect (Bell & Kulkarni, 2006;
Hester et al., 2007), empowerment/providing options and choices (Kulkarni, Bell & McDaniel Rhodes, 2012; Bell & Kulkarni, 2006; Keeling & van Wormer, 2011; Macy et al., 2009), empathy/sympathy (Kulkarni, Bell & McDaniel Rhodes, 2012; Bell & Kulkarni, 2006; Weisz 2005; Bacchus, Mezey & Bewley, 2002), patience and not feeling rushed (Shipway, 2004), comfort (Shipway 2004; Simmons et al., 2011), and encouragement (Trevillion et al., 2011; Roberts & Roberts, 2002). Moreover, Kulkarni et al., (2012) found that both survivors and advocates emphasized the importance of offering the “human touch” when interacting with women who have experienced violence because these women have been dehumanized, belittled, and demeaned by their abusers in the context of an intimate relationship. Conversely, women reported unhelpful and negative experiences if service providers did not demonstrate the qualities listed above that service providers and women have identified for positive and helpful service delivery experiences. Harris and colleagues (2001) conclude that “[r]egardless of the type of assistance sought, women repeatedly mentioned the importance of the personal demeanor of service providers when they assessed the outcomes of their encounters with the formal help system, even when they didn’t necessarily achieve the outcomes they had been seeking” (p. 137). The interconnection between how services are delivered has been echoed in other research (Bell & Kulkarni, 2006; Kulkarni, Bell, & Wylie, 2010).

**Importance of emotional support.**

Relatedly, emotional support is widely cited as an important aspect of sexual assault and domestic violence service provision (Macy et al. 2011; Harris et al., 2001; Bell & Kulkarni, 2006; Kulkarni, Bell, & Wylie, 2010; Parmar & Sampson, 2007; Humphreys & Thiara, 2003; Zink et al., 2004; Gerbert et al., 1996; Baker, Cook, &
Norris, 2003; Weisz, 2005; Hester et al., 2007). In a study conducted by Harris et al. (2001), almost half (46%) of the women interviewed ranked counseling/emotional support as the most helpful response, and an additional 19% said additional emotional support and counseling would have been helpful. Similarly, disregard by general practitioners’ of women’s emotional well-being was associated with an unhelpful response (Zink et al., 2004). Macy et al. (2013) sought to investigate agency directors’ opinions of domestic violence and sexual assault service strategies that help survivors. Macy and colleagues (2013) found that agency directors concurred that counseling services provided by agency staff was one of the best forms of support for women. Emotional support and counseling are important aspects of sexual assault and domestic violence service delivery because it helps women make imminent decisions and long-term sustainable changes in their lives (Bell & Kulkarni, 2006). In another study sexual assault nurse examiners (SANEs) described how they attended to the emotional needs of women who had been sexually assaulted because the medical examination process is often an upsetting experience for women. Sexual assault nurse examiners reported that they thoroughly explained the examination procedure, “talking in a soothing tone of voice and reflecting in a calm demeanour, refrain from using medical jargon, moving through the examination at a pace comfortable for the victim and reminding the victim that they were now safe” (Campbell et al., 2006: 394). Evidently, there is consensus within the literature among service providers and service users that emotional support is an important element of sexual assault and domestic violence service provision. Evidently the characteristics of service provision and level of support a woman receives are paramount and have implications for her service delivery experience. Moreover, it is
important that women’s basic needs are attended to so that women can focus on rebuilding their lives. The following section discusses the importance of addressing women’s basic needs, which is a recurring issue rooted in the heart of a feminist analysis, and is necessary if communities have any hope of confronting violence against women in any meaningful way.

**Attending to Service Users’ Needs**

It is essential to understand women’s needs within broader social, political and legal contexts within which women experience violence, which produces and perpetuates violence. Since the battered women’s movement, efforts have been implemented to address violence against women such as shelters, food banks, counselling agencies, priority housing policies, pro-arrest and pro-charging policies (Sheehy, 2002). Research has found that domestic violence and sexual assault services have been instrumental in helping women escape abuse. Women who worked with an advocate accessed more supports within the community, experience less violence and are less likely to experience future acts of abuse compared to women who did not receive advocacy services (Bell & Goodman, 2001; Bybee & Sullivan, 2002; Sullivan, 1991; Sullivan & Bybee, 1999). However, not all women have the same access to services and resources or the same experiences with the criminal and family justice systems.

The inaccessibility or limited accessibility of services in rural communities continues to be a struggle (CEVAW, 2012, YWCA, 2009; Grama, 2000; Shepherd, 2001). Women living in rural communities often need to travel to receive services, which is a barrier to accessing formal support. Additionally, the high attrition rate of sexual assault cases process through the criminal justice system (Johnson, 2012) is additional
evidence of the reinforcement of misogynist beliefs and speaks to the larger legal context in which women experience violence. In Canada, the burden of proof rests with the victim to prove she did not consent and the purpose of cross-examination is to question the credibility of the victim, which subjects the woman to further victimization (Randall, 2010). Thus, the reluctance of the criminal justice system to prosecute sexual assault offenders, unless the victim fits a certain profile leads women to lose faith in the justice system and ensure abuse. The limited accessibility of sexual assault and domestic violence services for rural women and the reluctance of the criminal justice system to prosecute sexual assault are just a few examples of the ways in which violence against women in perpetuated and reinforced through the social, legal and political contexts.

Since the emergence of the battered women’s movement women have indicated that they require a multitude of tangible assistance and resources to live their lives without fear and violence (Shepard & Pence, 1999; Bell & Kulkarni, 2006). Allen et al. (2004) examined the needs of women escaping an abusive relationship, they found “…women work to address their needs across a wide variety of domains and that their needs are far from uniform. In fact, there was significant variability across women regarding the extent to which they sought community resources and where they focused their efforts” (p. 1028). Similarly, Bell and Kulkarni (2005) were unable to agree on a top ten list of needed resources for women escaping abuse. However, there are some common needs identified in the literature by women escaping an abusive relationship. Women’s needs identified in the literature by service users and service providers include; adequate housing (Kulkarni, Bell & McDaniel Rhodes, 2012; YWCA, 2009; Lein et al., 2001; CEVAW, 2009; Shepard & Pence, 1999; Zweig, Schlichter, & Burt, 2002;
access to transportation (CEVAW, 2009; YWCA, 2009; Lein et al., 2001; Simmons et al., 2011; Fugate et al., 2005; Zweig, Schlichter, & Burt, 2002; Kulkarni, Bell, & Wylie, 2010), children’s needs/care (Kulkarni, Bell & McDaniel Rhodes, 2012; Kulkarni, Bell, & Wylie, 2010; Lein et al., 2001; Allen, Bybee, & Sullivan, 2004; Fugate et al., 2005), personal development (ie. upgrading education, obtaining employment, job training) (Allen, Bybee, & Sullivan, 2004; YWCA, 2009; Lein et al., 2001; Zweig, Schlichter, & Burt, 2002) health care (Allen, Bybee, & Sullivan, 2004; Lein et al., 2001) and legal issues/law enforcement (Allen, Bybee, & Sullivan, 2004; Grossman & Lundy, 2003; Kulkarni, Bell, & Wylie, 2010) and financial assistance (Zweig, Schlichter, & Burt, 2002; Kulkarni, Bell, & Wylie, 2010). Bennet and colleagues (2004) assert that “[i]t is unlikely that the effects of domestic violence services can be greatly enhanced without a large-scale government and social commitment to issues such as child care, employment, transportation, affordable housing, and social justice” (p. 827). Women also appreciated the “small things” offered by service providers such as toys, a hairbrush and makeup. The commonalities of women’s needs are indicative of the oppression women are subjected to in society. Tangible assistance and resources are vital to service delivery because it impacts their ability to function effectively in their daily lives (Lein et al., 2001). Kulkarni et al. (2012) found that attending to women’s needs by offering tangible assistance and resources makes women feel cared for and allows them to focus on foundational issues. The current sections provided an overview of the literature surrounding coordinated responses to CCRs, specifically DVCCs and SARTs as well as sexual assault and domestic violence service provision. The following section will
outline the theoretical framework, which helps to explain the importance of collaboration for domestic violence and sexual assault service provision.
An Integrated Theoretical Framework: Feminism, Intersectionality and Collaboration Theory

This section will begin by providing a brief overview of feminist theory and intersectionality, which helps to understand how women’s converging identities impact their experience of violence and their ability to access services. Intersectionality posits that women’s experiences of violence are shaped by dimensions beyond gender, such as race and class (Crenshaw, 1993), which impacts their ability to leave an abusive relationship and reestablish their lives. Then, the chapter will outline collaboration theory, which is built upon the notion that “two heads are better than one” (Gray, 1989) and provides an understanding of how coordination and collaboration among service providers from diverse sectors can improve service delivery for women who have experienced violence.

A feminist framework.

“Feminism” encompasses critical sociological theories that refer to a multiplicity of perspectives, each offering competing conceptions of the source and mechanisms of gender inequality and strategies for elimination (Simpson, 1989; Daly & Chesney-Lind, 1988). Williams (2000) describes feminism as “a general approach to understanding the status of women in society…feminist social scientists share the goals of understanding the sources of [gender] inequality and advocating changes to empower women” (p. 9). The main focus of a feminist analysis is the unequal position of women within society, relative to men. Feminist analyses examine who possess and exerts power in a patriarchal society and critically analyzes how this impacts women. Feminism is one of the most common theoretical frameworks used for understanding violence against women.
A central notion underlying a feminist framework is that domestic violence is a consequence of men oppressing women interacting with patriarchy grounded in historic and current power relations, which serves to maintain the subordination of women through control, coercion and isolation (McPhail et al., 2007). Non-feminist theorizing of female victimizations within the context of intimate relationships often blamed and pathologized battered women (Sokoloff & Dupont, 2005). However, the traditional feminist position argued that violence against women is socially constructed and culturally approved gender inequality (Yllo, 1993). Although feminist theory has been heavily criticized on other grounds, essentialism has been the single long-standing criticism, which ultimately laid the groundwork for the emergence of intersectionality.

**Intersectionality**

Intersectionality (also known as multiracial feminism) emerged from the criticisms launched primarily by women of colour against second wave feminists, which were predominantly heterosexual White middle class women. Second wave feminists assumed that all women experienced inequality on the basis that they shared the same gender. Second wave feminists claimed to be able to speak for all women (hooks, 1984; CRIAW, 2006; McCall, 2005). Women of colour felt marginalized by the hegemony of feminisms which was constructed largely around the lives of heterosexual White middle class women, while misrepresenting the experiences of minority groups, assuming a “false universalism” (Burgess-Proctor, 2006: p. 34). Marginalized women argued that they have the right to represent themselves based on their lived experiences, since they were misrepresented by second wave feminists (CRIAW, 2006). Reilly (2007) stated,
“more than three decades of second-wave feminist critiques have underlined the message that no feminist project, academic or practical, can be based on an assumption of women as a monolithic group with a ‘natural’ common agenda” (p.189).

The term intersectionality was coined by legal scholar Kimberle Crenshaw (1989). Others introduced a similar concept (Davis 1981; Moraga 1983; Smith 1983; hooks 1984; Moraga and Anzaldúa 1984; Glenn 1985; King 1988; Mohanty 1988; Spelman 1988; Sandoval 1991), but there is disagreement within the literature about the term (McCall, 2005; Sokoloff & Dupont, 2005; Ontario Women’s Directorate, 2009). Mann (2000) notes “ [w]ithin gender studies RGC [race, gender, and class] analysis is known by a variety of different names. It has been referred to as intersectionality theory, integrative feminism, the women of color or multiracial perspectives, and multicultural feminism. By any of these names, its focus on multiple oppressions and difference has been its hallmark. This focus is also the distinguishing feature of contemporary feminism’s third wave ” (p. 477). Evidently, there have been a variety of terms used to refer to this theoretical framework. However, despite the terminology used, the cornerstone of this theoretical perspective is concentrated on the multiple and intersecting forms of oppression and difference between groups of women. Intersectionality has been criticized because there is a lot of ambiguity surrounding the term. The concept of intersectionality lacks a clear-cut and universally applicable definition, which has been argued, is necessary for “good theory” and would improve the epistemological perspective (Verloo, 2006). Feminists have embraced intersectionality as a theoretical framework with open arms despite the absence of a clear definition of the concept.

In Crenshaw’s (1991) article Mapping the margins: Intersectionality, identity
politics, and violence against women of colour, she analyzes the intersections between gender and race in relation to the employment experiences of women of colour. She uses her position as grounds to highlight the need to account for multiple and intersecting identities beyond gender, interplaying with multiple systems that shape the society we live in (Crenshaw, 1991). Increasingly, scholars from diverse disciplines are engaging in dialogue about intersectionality. Consequently, more recent definitions of intersectionality do not identify a particular group or social identity structure, and have expanded the concept of intersectionality beyond gender and race (Gopaldas, 2013). Davis (2008) defines intersectionality as “the interaction [among] categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power (p. 68). Intersectionality rejects the ‘single axis framework’ commonly employed by anti-racist and feminist discourses (Crenshaw, 1991: 1244). Such a framework treats each category as a unitary, one-dimensional unit of analysis that obscures the differences between and among women (CRIVAW, 2006). Instead, intersectionality as a theoretical framework offers an understanding of how women’s intersecting identities interact simultaneously to produce relative positions of privilege, power and inequality, which shape their experiences in all realms of life. McCall (2005) asserts that intersectionality is “the most important contribution that women’s studies has made so far” (p. 1771).

Intersectionality posits that gender relations do not occur in a vacuum. Rather women’s experiences are shaped by multiple and interactive social relations such as race, class, sexuality, age, physical ability, and other locations of inequality (AWID, 2004; Burgess-Proctor, 2006). Intersectionality “recognizes that systems of power are
multiplicative, inextricably linked and simultaneously experienced” (Burgess-Proctor, 2006: 31). In other words, intersectionality is a feminist framework, which critically examines how multiple identities work together simultaneously at the micro-structural and macro-structural levels to shape women’s experiences of inequality.

Intersectionality has become recognized as a major epistemological perspective or research paradigm within women’s studies (McCall, 2005; Shields, 2008). Intersectionality merged differing feminist theories together into a single analysis, while still being able to account for varying sources of women’s inequality within society (Burgess-Proctor, 2006; AWID, 2004). Intersectionality refrains from essentializing women’s experiences, as many did during second wave feminism, while maintaining an emphasis on privilege and power and understanding how systems interplay to shape women’s experiences in the social world. Yuval-Davis (2006) posits “to be a ‘good theory’ intersectionality needs constant and precise attention to the fundamentally different logics of social division such as race, class ethnicity and inequalities, as well as the various ways in which these social processes interact to produce various outcomes of their intersections. Moreover, intersectionality has been criticized because it lacks stringent methodological guidelines in terms of how it should be studied and how it can contribute to our understanding of women’s lived experiences. Intersectionality presents new methodological challenges because of its narrow range of methodological approaches that may be used to study intersectionality, which is partially an unintended consequence of the epistemological perspective (McCall, 2005). In other words, researchers studying women’s lived experiences using intersectionality are limited in terms of the methods they can employ. The criticisms of intersectionality are precisely
what, some have argued, makes the theoretical framework so successful. As Davis (2008) asserts “[i]t is precisely because intersectionality is so imperfect – ambiguous and open-ended – that it has been so productive for contemporary feminist scholarship. Its lack of clear-cut definition or even specific parameters has enabled it to be drawn upon in nearly any context of inquiry” (p. 77).

**Intersectionality and Violence Against Women**

Intersectionality is useful for the current study because it recognizes that women’s identities interact to create their social positioning within society and their experience of violence, which has implications for the barriers and challenges they experience accessing services and support. Bograd (1999) rejects that domestic violence is a monolithic phenomenon and contends “intersectionalities colour the meaning and nature of domestic violence, how it is experienced by self and responded to by others, how personal and social consequences are represented, and how and whether escape and safety can be obtained” (p. 276). Additionally, intersectionality offers a complex understanding of domestic violence services and interventions, which can help to protect women “whose lives are affected in complicated ways by multiple hierarchies and forms of discrimination” (Josephson, 2002: 17). In essence, individuals exist within society and social contexts created by systems of power and oppression. Gender inequality alone is not sufficient to explain women’s experiences of sexual assault and domestic violence and ability to seek support, rather gender inequality must be understood as intersecting with other systems of power and oppression to fully understand women’s experiences of victimization as well as their ability to achieve safety and maintain autonomy (Sokoloff & Dupont, 2005; Bograd, 1999; Donnelly et al., 2005; Cramer & Plummer, 2009; Laing,
Marginalized women’s experiences of violence have been largely ignored in the academic literature (Sokoloff & Dupont, 2005; Sumter, 2006; Krane, Oxman-Martinez, & Ducey, 2000). Intersectionality has received praise because it provides a framework to legitimize the experiences of marginalized women that have been hidden from dominant cultural discourses about violence against women (Lockhart & Danis, 2010; Laing, Humphreys, & Cavanagh, 2013; Josephson, 2002; Sokoloff & Dupont, 2005). Crenshaw (1991) conducted a field study of battered women’s shelters within minority communities in a U.S. state and observed the dynamics of structural intersectionality, she noted:

In most cases, the physical assault that leads women to these shelters is merely the most immediate manifestation of the subordination they experience. Many women who seek protection are unemployed or underemployed, and a good number of them are poor. Shelters serving these women cannot afford to address only the violence inflicted by the batterer; they must also confront the other multilayered and routinized forms of domination that often converge in these women’s lives, hindering their ability to create alternatives to the abusive relationships that brought them to shelters in the first place (p. 1245).

Crenshaw’s findings highlight the need to understand how women’s social positioning within society impacts how they experience violence and their ability to cope and rebuild their lives.

In a similar vein, reform efforts to address sexual assault and domestic violence are less likely to meet the needs of marginalized women because they ignore the reality that women who do not fit the status quo and are situated differently in the economic, social and political worlds (Crenshaw, 1991; Donnelly et al., 2005; see Sumter, 2006). Funding agencies commonly allocate resources according to the needs of the dominant class of women, which differ compared to the needs of marginalized women (Crenshaw,
Crenshaw (1991) found that counselors serving women of colour are often in conflict with their funding agencies because they focused their efforts on larger structural issues and addressing issues other than the sexual assault itself when working with this group of women. Reform efforts, which assume a universal experience and needs of all women, effectively limit counselors’ ability to address the needs of women, which provide funding and resources for the status quo, while making it challenging to meet the needs of poor nonwhite women (Crenshaw, 1993; Donnelly et al., 2005). Similar findings are echoed by other scholars, which have found that domestic violence services are commonly grounded in the dominant culture and are delivered by service providers that fit the status quo – White middle class heterosexual women that lack understanding of experiences of minority women (Sue & Sue, 1999; Arredonodo, 1998; Donnelly et al., 2005). In other words, domestic violence services are suited to meet the needs of the dominant class of women (Donnelly, Cook & Wilson, 1999; Cole 2001; Hamby, 2000; West, 1999), resulting in underutilization of services by minority women (Sue & Sue, 1999; West 1999; Chen, Coley & Beckett, 1988a, 1988b; Lockhart & White, 1989). Donnelly et al. (2005) posit that executive directors and need to be cognizant of their colour blindness and consider the needs of nonwhite women because they make decisions about the allocation of finances for violence against women organizations. Thus, if executive directors continue to be colour blind, women of colour will continue to be systematically disenfranchised in their attempt to negotiate their own safety as well as their children’s safety (Donnelly et al., 2005). Sokoloff and Dupont (2005) argue that failing to address multiple oppressions of marginalized groups of women jeopardizes the validity and legitimacy of the antiviolence movement (p. 41).
Scholars (Lockhart & Mitchell, 2010; Sumter, 2006) have called for cultural competency among service providers to appropriately respond to women of various backgrounds, especially publicly funded programs and services (Bent-Goodley et al., 2010). Scholars argue that in order to be effective, social responses to violence against women must be culturally relevant and based on experiences of women who share the same race, class and other systems of oppression. When systems of race, class and gender converge women’s experiences differ and the obstacles they encounter depend on their social positioning within society (Crenshaw, 1993; Josephson, 2002; Lockhart & Mitchell, 2010).

Women’s needs are dependent on intersecting identities and social positioning within society. As evidence, Grossman and Lundy (2003) examined service needs among racial and ethnic groups of women aged 55 and older. They found that White and Hispanic women reported the need for personal emotional support more frequently compared to African American women. Additionally, African American and Hispanic women were more likely to require legal assistance in contrast to their White counterparts (Grossman & Lundy, 2003). Similarly, in another study conducted by Lundy and Grossman (2009), they examined domestic violence service user needs based on age. They revealed that women’s needs were correlated to their age. Older women were found to be more likely to require accommodation related to special needs and/or disabilities, such as wheelchair accessibility, alternate arrangements for hearing and visual impairments and assistance administering medication (Lundy & Grossman, 2009).

Moreover, women may “internalize ideologies that are antithetical to disclosure of domestic violence” as a consequence of gender, race and class intersecting, which has
implications for seeking safety (Bograd, 1999: 281). As an example, a Muslim woman who has been taught to live by Islamic teachings, which emphasizes a strong family bond may learn that male violence against women within the family is necessary on occasion, and is merely a form of familial disciplinary action (Centre for Research on Violence Against Women and Children, 2002). This will likely prevent the woman from seeking services and/or support because she perceives violence to be just that, and does not require state intervention. Additionally, notions of honour, respectability and not wanting to be perceived by others as a victim are common reasons women do not disclose experiencing domestic violence (Anthias, 2014). It is important not to overemphasize cultural differences and underplay structural dynamics, rather they are both equally important to shaping women’s experience of violence (Anthias, 2014).

In light of this evidence, it is apparent that women’s needs are dependent upon a variety of factors such as age, race, ethnicity, culture socio-economic status, ability, gender, sexual orientation as well as other points of identity (Laing, Humphreys, & Cavanagh, 2013). Thus, any response that has a hope of being effective should be tailored to meet the individual needs of each woman, rather than applying a ‘one size fits all’ approach. Collaboration seeks to address the wide range of women’s needs by bringing together multiple agencies to facilitate a seamless and comprehensive response to domestic violence, which aligns well an intersectional framework. The following section offers a definition of collaboration as well as a model for collaboration, which helps to understand how service providers can facilitate collaborative partnerships and engage with each other to improve sexual assault and domestic violence service provision for women who have experienced violence.
Collaboration Theory

Historically, it was socially desirable for researchers and educators to concentrate their efforts, specializing in one particular area of study and become an expert in that field. This resulted in fragmentation and disintegration of our theoretical knowledge, disabling our ability to effectively address complex social issues plaguing our society today (Mariano, 1989). Presently, human service professions are being confronted with social problems that are so complex that no single discipline has the ability to respond effectively to these issues alone (Mariano, 1989). Hesselbein and Whitehead (2000) assert:

We live in a time when no organization can succeed on its own...As we look around us in a new century, we realize that businesses and non-profits in today’s interconnected world will neither thrive nor survive with visions confined within the walls of their own organizations. They need to look beyond the walls and find partners who can help achieve greater results and build the vital communities to meet challenges ahead (foreword).

Increasingly, collaboration is being promoted as the best practice to address a vast array of complex social problems, including; homelessness, illiteracy, drug and alcohol abuse, poverty, school violence as well as domestic violence (Gray, 1989; Gajda, 2004; Allen, 2006). The history of collaboration theory is unclear. Scholars from a variety of disciplines have examined collaboration, but none have coined a general theory of collaboration. Barbara Gray (1989, 1991) is a prominent scholar on collaboration who specializes in organizational behaviour. Collaboration is a multidisciplinary theoretical framework, and scholars from an array of disciplines including: organizational and management theory, microeconomics, linguistics, epistemology, democratic theory and education have contributed to the literature in this area (Wood & Gray, 1991; Chrislip & Larson, 1994).
Defining collaboration.

The concept of collaboration is difficult to grasp, primarily because its definition is “elusive, inconsistent and theoretical” (Gajda, 2004: 66). Collaboration lacks a universal definition. Rather, there are a welter of definitions, each offering something valuable, but none that are satisfactory on their own (Wood & Gray, 1991). Wood and Gray (1991) examined common elements of various definitions of collaboration. They found that the definitions of collaboration rely on implied assumptions, some of the elements are abstract and unnecessary and they disregard at least one central element. Wood and Gray (1991) assert that a satisfactory definition of collaboration must address the following questions “who is doing what, with what means, toward which ends?” (146). In Gray’s book, Collaborating: Finding Common Ground to Multiparty Problems (1989), she defines collaboration as “a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible” (p. 5). Further, Gray adds collaboration is “a process of joint decision making among key stakeholders of a problem domain about the future of that domain” (p. 11). Gray’s definition of collaboration was later revised with Wood to encapsulate the questions they felt were critical to a comprehensive definition. They assert “collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms and structures, to act or decide on issues related to that domain” (Wood & Gray, 1991:146). In other words, collaboration is an interdisciplinary approach, which involves independent stakeholders from various sectors with differing perspectives, utilizing common rules, norms, and structures to develop a holistic response.
to address a multifaceted social problem. The term “stakeholders” refers to an individual, group or organization with a vested interest in the issue being addressed through a collaborative approach (Gray, 1989; Shepard & Pence, 1999). Further, the process of collaboration facilitates the achievement of collective short and/or long term goals that would otherwise not be attainable when individual entities act alone (Gajda, 2004). For the purposes of this thesis, this research will rely on Wood and Gray’s definition of collaboration because it is the most commonly cited definition within the literature and captures the essence of the concept adequately.

Coordinating councils are one form of a collaborative setting that typically bring representatives together from multiple stakeholder groups that are affected by the response to a social problem (Javdani & Allen, 2011). As previously mentioned, there is no general theory of collaboration. Thus, in an effort to better understand collaboration and how it occurs practically, between multiple stakeholder groups, the following section outlines a model for collaboration.

A Model for Collaboration

There is no universal model for multi-agency collaboration (Hague, 2001; Hague, 1997). Instead, each collaborative initiative has developed their own model with varying structures and operational mandates (Johnson & Dawson, 2011). Many collaborative initiatives highlight the importance of greater communication among all agencies and professionals involved in a partnership to respond to domestic violence (Allen, Watt & Hess, 2008). These models commonly include the creation of a protocol or a written document (Johnson & Dawson, 2011), outlining the roles and responsibilities of each partner individually and all partners collectively. Alternatively, other models primarily
focus on collaboration and coordination among the criminal justice system and relevant community agencies to respond to cases of domestic violence (Allen, 2006; 2005; Hague, 1997; Griffiths, 1997; Clark et al., 1996; National Sexual Violence Resource Centre, 2006; Johnson & Dawson, 2011).

Collaborative models are best understood along a continuum, ranging from minimalist to maximalist approaches (Buchbinder & Eisikovits, 2008; Hague, 2001). The minimalist approach entails short-term commitment, including sharing basic information in a formal setting with minimal, if any, personal communication or commitment to the concept of collaboration. At the other end of the spectrum, the maximalist approach involves a long-term commitment to specific tasks and stages of problem solving. Additionally, a multi-disciplinary partnership emerges, committed to a shared vision and collective goals (Buchbinder & Eisikovits, 2008). Ultimately, the overarching idea underlying all multi-agency collaborative models is that “violence against women cannot be effectively responded to by one individual, agency, or sector working in isolation. Rather, communication, cooperation, and collaboration among all agencies involved with victims, offenders, or families hold the greatest potential in preventing and responding effectively to these crimes” (Johnson & Dawson, 2011: 166).

Bronstein (2003) developed a general model for interdisciplinary collaboration based on a review of theoretical and social work practice literature. Bronstein’s model fits well with the Action Committee as a group of agencies, including social workers, working together to enhance the social response to domestic violence in Guelph-Wellington. Interdependence is assumed to be occurring by agencies working together to provide seamless service to women and children who have been affected by domestic
violence. Bronstein (2003) delineates five components that are essential to optimal collaboration between social workers and others professionals: (1) interdependence, (2) flexibility, (3) newly created professional activities, (4) collective ownership of goals and (5) reflection on process, which will be discussed.

Interdependence is defined as “the occurrence of and reliance on interactions among professionals whereby each is dependent on the other to accomplish his or her goals and tasks” (Bronstein, 2003: 299). The idea is that professionals and organizations involved in a collaborative partnership cannot achieve their objectives and goals alone. Instead, they rely on each other for expertise and resources. Further, she suggests that in order to function interdependently, it is necessary that each partner has a clear understanding of their own roles as well as the roles of collaborating partners and that they use them appropriately. This will ensure that everyone has a common understanding of who is responsible for specific tasks. Spending time together both formally and informally, oral and written communication among colleagues, respect for colleagues’ opinions and input are all characteristic of interdependence (Bronstein, 2003).

Flexibility is an extension of interdependence, which is defined as “the deliberate occurrence of role-blurring” (Bronstein, 2003: 300). This is the idea that collaborative partners should be open to taking on additional responsibilities that extended beyond the purview of their defined roles that are necessary for the benefit of the problem domain in which they are collaborating. Flexibility includes the ability to reach a mutual agreement on a particular issue in the event of a dispute. Additionally, taking on new roles and thinking “outside the box” to develop new strategies when current approach are ineffective is characteristic of flexibility (Bronstein, 2003). As autonomous professionals
and organization come together guided by their own policies, procedures and goals, without flexibility collaborative partnerships will inevitably fail (Mattessich & Monsey, 1992).

**Newly created professional activities** refers to the development of “collaborative acts, programs, and structures that can achieve more than could be achieved by the same professionals acting independently” (Bronstein, 2003: 300). In other words, collaboration facilitates the development of innovative programs, activities, policies and methods for service delivery that extends beyond the confines of autonomous partners, resulting in improved service delivery and methods for addressing complex social problems. This component is particularly important because the activities that stem from collaborative efforts amplify the expertise of the collaborative partners.

**Collective ownership of goals** is described as “shared responsibility in the entire process of reaching goals, including joint design, definition, development and achievement of goals” (Bronstein, 2003: 301). In other words, professionals and organizations involved in a collaborative partnership assume collective responsibility throughout the process of attaining a shared vision. This includes accepting liability for the successes as well as failures of collaborative endeavours.

**Reflection on process** refers to “collaborators’ attention to their process of working together” (Bronstein, 2003: 302). The final component involves collaborative partners thinking about and discussing the successes and failures of their working relationship as well as the process of collaboration. Reflecting on the process of collaboration is particularly important because it allows for collaborators to offer
feedback in an effort to improve relationship among the partners involved and the
efficacy of the collaboration more generally.

Bronstein (2003) noted that “[t]rends in social problems and professional practice
make it virtually impossible to serve clients effectively without collaborating with
professionals from various disciplines” (Bronstein, 2003: 297). Although Bronstein’s
model of collaboration is only one of many, it provides a starting point to evaluate the
Protocol and perhaps even lead to the addition of new components. Theoretically,
collaboration is a promising approach to understanding and improving the current
response to domestic violence. Thus, it is necessary to examine how collaboration
impacts women and their children who come into contact with agencies that provide
services and support related for domestic violence and sexual assault.

Collaboration and Sexual Assault and Domestic Violence Service Provision

The literature review provided some evidence that women’s experiences have
improved as a result of collaboration among service providers when to responding to
domestic violence (Kulkarni, Bell, & McDaniel Rhodes, 2012; Zweig & Burt, 2007;
Zweig, Schlichter, & Burt, 2002; CREVAWC, 1999; Campbell & Ahrens, 1998; Nugent-
Borakove et al., 2006; CEVAW, 2009). A study by the London Coordinating Committee
to End Woman Abuse (LCCEWA) found high consumer satisfaction among women who
sought assistance from formal agencies within the community for domestic violence
(CREVAWC, 1999). More specifically, the LCCEWA was successful in promoting
coordination and collaboration among relevant stakeholders through referrals, which
were followed-up by women and reported to be useful (CREVAWC, 1999). According to
Sullivan (2011), women seek to expand their knowledge about community resources
available to assist them in coping with their experience of violence, which is necessary to facilitate collaboration. In another study conducted by Zweig and Burt (2007), it was concluded that the level of interaction among service providers is correlated to women’s perceptions about the services they received. Women reported that collaboration between victim service agencies and the criminal justice system resulted in increased helpfulness (Zweig & Burt, 2007).

Additionally, as mentioned in the literature review, service providers have asserted that collaboration among service providers enhances the response to domestic violence for women and has more benefits than isolated service delivery. Overall, advocates perceived domestic violence services and support to be less effective without support of other community resources (Kulkarni, Bell & McDaniel Rhodes, 2012). For example, if a woman recently escaped an abusive relationship and she is staying in a woman’s shelter, she will also likely require housing assistance. If she attends counseling during this time she is unlikely to be fully engaged and mentally present because she will be thinking about where she is going to sleep at night. In this situation it is equally important for the woman to receive housing assistance as well as counseling. This is supported by the literature on women’s needs, which demonstrates their needs are interconnected rather than isolated, often require services from more than one agency simultaneously (Danis, 2003), and aligns with the tenets of intersectionality.

Case conferences have been highlighted as a significant benefit of collaboration. A case conference involves a meeting between a woman and two or more agencies to discuss her situation and develop a plan of action. Case conferencing provides consistency with the information received by agencies involved, ensuring that everyone is
on the same page (CEVAW, 2012). Additionally, it limits the number of times a woman has to retell her experience of domestic violence and attend meetings (CEVAW, 2012). Funding for domestic violence and sexual assault initiatives are often limited and resources are scarce. Collaboration eliminates replication of programs and services when agencies work together. This allows funds and resources to be redirected, resulting in improved services and support (Shepard & Pence, 1999).

Every woman’s experience of domestic violence and/or sexual assault differs and their needs are shaped by their social position within society, derived from historical and structural inequalities and impacts their ability to access services and support. Intersectionality and collaboration are complementary theories and are most useful for the current study because they provide an understanding of the importance of unique and individualized service provision for women who have experienced violence. Intersectionality recognizes that women’s diverging identities interact concurrently and impacts their experience of violence and their ability to rebuild their lives. Collaboration theory offers an understanding of how collaboration among agencies across diverse sectors enhances service delivery for women and children who have experienced violence and is more beneficial than isolated service provision. The next chapter outlines the methodological orientation used to guide the current research study, as well as the data collection methods and data analysis process.
Chapter Three: Methodology

This community engaged research (CEnR) study was conducted in partnership with the Guelph-Wellington Action Committee on Sexual Assault and Domestic Violence (the Action Committee). The Carnegie Foundation for the Advancement of Teaching (n.d.) defines community engagement as “collaboration between institutions of higher education and their larger communities (local, regional, national, global) for the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity.” Community engaged scholarship requires the researcher to be fully engaged in a mutually beneficial partnership with the community partner, guided by the needs of the community (Maurana et al., 2001; Israel et al., 1998). Methodologically, the research is best described as community engaged evaluation research. Evaluation research is beneficial for community organizations because it can lead to the development of new strategies and initiatives (Akintobi et al., 2013). However, community based organizations often do not have the resources to conduct evaluation research, limiting their ability to effect change (DiFranceisco et al., 1999; Richter et al., 2000). Moreover, academic researchers seek to gain trust and credibility in the local community by developing or reestablishing relationships with community partners (Blumenthal, 2006; Corbie-Smith, 1999; Freimuth et al., 2001). Academic and community partners have much to gain from each other working together collaboratively. Collaboration between academic and community partners produces practical and rigorous results, eliciting effective change to respond to a community-identified problem.

A community-engaged research (CEnR) framework was used to conduct this evaluation research and facilitate an equitable partnership between academic and
community partners. Broadly speaking, CEnR refers to a set of principles that are compatible with participatory action research (PAR) and community-based research (CBR) methodologies (Minkler 2005; Community-Based Research Canada, 2008; Strand et al., 2003; Wellesley Institute, 2008; Israel et al., 1998). Community engaged research (CEnR) is the broader umbrella under which this research was conducted. In contrast, CBR and PAR are two approaches underneath CEnR, which were used to guide this evaluation research. This study relied on CEnR, PAR and CBR principles to carry out this research through a community-university (CU) partnership to respond to a community-identified need, which aligns with the principles of these research methodologies. The process by which collaboration occurs between researcher(s) and the community is fundamental to the methodology of community engaged scholarship (Calleson, Jordan, & Seifer, 2005). There are seven principles of community engaged scholarship (CES)\(^6\) that informed the process:

1. Relationship building
2. Open communication
3. Collaboration/partnership and co-learning
4. Mutual respect and trust
5. Mutual benefit/Negotiated reciprocity
6. Socially responsive purpose/social change
7. Sustainability

A research study guided by principles of CES will influence the decision-making process, while still allowing for the use of quantitative and/or qualitative research methods in accordance with academic methodological rigour (Shalowitz et al., 2009). The current

\(^6\) The principles of CES were drawn from a compilation of sources (Strand et al., 2003; Israel et al., 1998; Community-based Research Canada, 2008; Roche, 2008; Minkler & Wallerstein, 2003a; Minkler & Wallerstein, 2003b).
chapter outlines the methodological orientation and methods employed to carry out this research study. The chapter will begin with a discussion of CEnR, CBR and PAR, including how these complementary methodologies were employed within the current research study. Next, the chapter will provide background about the development of this CU partnership. Subsequently, the chapter will shift to a discussion of the methods and the data analysis procedures. Finally, the chapter will conclude with a reflexive account of the research process as well as challenges of CEnR for the community partner(s) and the researcher(s) involved in this project.

Community Engaged Research (CEnR)

Institutions of higher education were founded with a civic mission requiring faculty, students, and staff to use their knowledge and resources to respond to community identified needs. Recently, educational institutions have made a concerted effort to renew their commitment to civic engagement by engaging in innovative efforts to partner with communities to conduct research (Stanton, 2008). Increasingly, universities are supporting CEnR through the establishment of interdisciplinary centers, such as the Institute for Community Engaged Scholarship at the University of Guelph. Engaging in CEnR has also become popular among researchers and community agencies because of funding requirements (McKenna & Main, 2013). Nation et al. (2011) define CEnR as:

a collaborative approach to research that democratically involves community participants and researchers in one or more phases of the research process. Partners share responsibilities and leverage their unique strengths to enhance understanding of the target of research (often a social or cultural dynamic of the community) and integrate the derived knowledge with action to improve the well-being of community members (p. 90).
In essence, CEnR is a research approach that emphasizes an equitable and consensual partnership at select phase(s) of the research process. The diversity of the partnership offers an improved understanding of the issue under study, which can translate into action leading to improvements in social life.

**Dimensions of CEnR.**

Stanton (2008) outlines three primary dimensions of CEnR – purpose, process and product, which are necessary for working within a CEnR framework. First, those engaging in CEnR must have a deliberate public purpose directly or indirectly benefiting the local, national and/or global community. The purpose of CEnR differs from traditional research because it creates knowledge for a public purpose – improving social life, whereas traditional research creates new knowledge for the sake of advancing knowledge. However, research conducted relying on the principles of CEnR should still be comparable to the quality and rigour of traditional academic research (Gibson, 2006). Second, process refers to the methods employed by researchers to carry out research with a public purpose and the degree to which their approach is collaborative and involves input from the community partner(s) at various stages throughout the research process (Stanton, 2008). Proponents of CEnR assert that increased collaboration between community and university partners leads to better scholarship and service to the community (Benson, Harkavy, & Hartley, 2005; Benson, Harkavy, & Hartley, 2007; Minkler & Wallerstein, 2003b). Finally, product refers to the outcomes of the CEnR research. Product includes contributions to knowledge, publications, as well as other academic products, but also refers to benefits for the community such as improvements in social life. There is disagreement among proponents of CEnR about the degree to which
those engaging in CEnR must follow these dimensions. Stanton (2008) recommends that faculty members at universities engage in conversation with their department and disciplines to determine guidelines and establish clarity around CEnR and the degree to which they must follow these dimensions to be considered genuine CEnR.

**CEnR principles.**

Community-engaged research (CEnR) principles guided the broader development of this research study. Since the Protocol was in place in Guelph-Wellington for over five years, there were discussions at the Action Committee table about its effectiveness and whether it led to improvements in service delivery for women and children who have experienced violence. The Action Committee was particularly interested in hearing from women about their experiences accessing services, which fueled the development of this research. This research genuinely served a public purpose – addressing the questions that surfaced at the Action Committee table about the effectiveness of the Protocol. The Chair of the Action Committee is committed to amending the Protocol based on the findings of this research, in an effort to improve service delivery for women and children who have experienced violence. Community-based research (CBR) and PAR are complementary methodologies that align well under the broader framework of CEnR. The principles of CBR and PAR were used to guide this evaluation research, which are discussed below.

**Community Based Research (CBR)**

Community-based research (CBR) emerged in the late 1960s as a result of criticisms launched against institutions of higher education for being inequitable and insufficiently responsive to the needs and issues experienced by local communities. Additionally, CBR was an effort to minimize the distrust and lack of respect that
commonly existed between researchers and community members (Strand et al., 2003; Israel et al. 1998; Kidd & Kral 2005; Shalowitz et al., 2009). The W. K. Kellog Foundation (n.d.) defines CBR as:

a collaborative process that equitably involves all partners in the research process and recognizes the unique strengths that each brings. [CBR] begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and eliminate disparities (n.p.).

This has become a widely cited working definition of CBR and referenced across academic disciplines (Wellesley Institute, 2008).

Community-based research (CBR) shifts away from the “traditional” research orientation characterized by a top down approach towards an equitable collaborative approach in which the researcher(s) work alongside the community to formulate and carry out research (Hartwig, Calleson, & Williams, 2006; Centre for Community-Based Research, 2008). CBR differs from traditional academic research because it blurs the distinction between “the researcher” and “the researched,” rather everyone is perceived to be a researcher and learner, dually (Strand et al., 2003; Community Based Research Canada, 2008; Wellesley Institute, 2008; Israel et al., 1998).

**CBR principles.**

Throughout the process of conducting this evaluation research, the research team relied on a number of CBR principles, resulting in a strong partnership with a rigorous method. According to the principles of CBR, the necessary “first step” to initiating a CBR project is finding a way to engage the community partner(s) to form a partnership (Shalowitz et al., 2009; Ochocka, Moorlag, & Janzen, 2010). In addition to discussions at
the Action Committee table that inspired this research, the Action Committee carried out a previous evaluation in 2009, but the findings did not provide valuable feedback. The research asked service providers about their knowledge and use of the Protocol. Generally, it was revealed that many service providers did not have knowledge of the Protocol and were not using the Protocol in their work (Guelph Wellington Action Committee on Sexual Assault and Domestic Violence, 2009). This project is genuinely CBR in the sense that it came from the community, rather than the community trying to fit their needs with the interests of an academic researcher to form a mutually beneficial partnership. This also aligns with the dimensions of CEnR, which requires research to be conducted for a public purpose, by responding to a community identified need.

Frequently, the next step requires the researcher(s) and community partner(s) to exchange dialogue and experiences with the research team. Throughout the course of the project the research team met regularly, often bi-weekly from September 2012 through May 2014 to develop the pieces of this research study. Meeting regularly was part of a collaborative and co-learning process and was key to ensuring open communication in an effort to build trust and respect between academic and community partners. Regular meetings also helped to foster relationships among the members of the research team, resulting in a strong CU partnership. A consensus approach was used at every stage, ensuring equitable control over all of the phases of the research process, building trust and mutual respect between academic and community partners, as well as community members that were involved.

A project using CBR as a methodological approach requires the community partner(s) and researcher(s) to be committed and invested in the project to facilitate
exchange of knowledge and sustainability, which were both required to carry out a CBR study (Israel et al., 1998; Bushouse, 2005, Shalowitz et al., 2009). Taking on evaluation research can be especially challenging for community nonprofit organizations with limited funding and scarce staff resources (Bushouse, 2005). The Action Committee coordinator was a core member of the research team and her role as the coordinator is a part-time position, which averages 10 hours per week. The Action Committee coordinator found this evaluation research to be challenging at times, especially during the report writing stage. The Action Committee coordinator was required to perform her regular duties related to the Action Committee and take on additional projects, while also being involved in this research project, which was ongoing for approximately two years. The Action Committee coordinator was also a counsellor at Women in Crisis, which is one of the Action Committee agencies. The PI experienced similar challenges since it was her intention to have a peripheral role. However, due to the complexity of the CU partnership, the supervision requirements of the University of Guelph students, the project parameters, and the principles of CU partnerships, the PI ended up being heavily involved in all stages of the research process. The PI balanced her obligations as a pre-tenured faculty member, while she was heavily involved in this evaluation research project. Previous research has noted the heavy workload for faculty as an institutional barrier to CEnR partnerships (Schwartz, 2010), which is further compounded by the limited funding available for CEnR research (Savan, 2004).

**Participatory Action Research (PAR)**

Similar to CEnR and CBR, PAR requires the researcher(s) and community partner(s) to engage in a collaborative partnership. PAR is “the creation of a context in
which knowledge development and change might occur – much like building a factory in which tools may be made rather than necessarily using tools already at hand… PAR may be seen as a macro method, as setting the stage for the development of a research project” (Kidd & Kral, 2005: 187). Green et al. (1995) describe participatory research as “systematic investigation with participation of those affected by an issue for purposes of education and action or affecting social change” (p. 4). PAR has a dual objective “to produce knowledge and action directly useful to a group of people through research, adult education or sociopolitical action” and “to empower people at a second and deeper level through the process of constructing and using their own knowledge” (Reason, 1998: 71). A study guided by principles of PAR requires the inclusion of those most affected by the research involved throughout the entire research process, from refining the research topic to dissemination of findings (Kidd & Kral, 2005; Whyte, 1991).

**PAR principles.**

Women who have experienced SADV in Guelph-Wellington and disclosed their experience to one or more of the Action Committee member agencies are affected by the Protocol and the research findings that emerge from this study. In accordance with PAR objectives, women who have experienced SADV and had contact with at least one Action Committee member agency were involved in select stages of the research process acting as both research partners and participants. For example, a draft of the interview questions were distributed to five women by Action Committee representatives for review and feedback. We received feedback from four women. Women who have experienced SADV were also research participants because they participated in face-to-face interviews. This research study aligns partially with the principles of PAR because
women who experienced SADV and disclosed their experience to one or more of the Action Committee member agencies were only involved in select stages of the research process, primarily reviewing the data collection tool, participating in data collection and verifying preliminary research findings. Women who have experienced SADV in Guelph-Wellington and disclosed their experience to one or more of the Action Committee member agencies were not involved throughout the entire process from development to dissemination, which is generally the expectation for PAR. The current section discussed how CEnR, CBR and PAR principles were employed in the current project. The next section provides background on how the partnership between the community and academic partners developed.

**Community University (CU) Partnership Development**

This CU partnership began with The Action Committee, and was the community partner for this community engaged evaluation research. The Action Committee initiated this research study and invited a community based researcher, Dr. Mavis Morton, Assistant Professor in the Department of Sociology and Anthropology at the University of Guelph, to work with them to develop and conduct evaluation research. Dr. Morton was the Principal Investigator (PI) of this research study as well as the advisor for this researcher’s Master’s thesis. At the same time the project was developing, this researcher was looking for a community partner to develop a community engaged research project related to violence against women that would also fulfill her graduate degree program requirements. From there, Dr. Morton reached out to the Institute for Community
Engaged Scholarship/Research Shop\(^7\) at the University of Guelph for assistance and support for this evaluation research. The Institute for Community Engaged Scholarship offered the support of a PhD student in Applied Social Psychology and consultation with the Knowledge Mobilization coordinator.

Throughout the process of conducting this research study, a number of people from various organizations and educational institutions were involved in the planning development, execution and dissemination of this research study. This specific collaborative partnership is referred to as a community-university (CU) partnership and aligns with the principles of CES. A collaborative partnership developed in which mutual benefit and co-learning were sought and experienced. The core partners who contributed to this research project include: (1) The Action Committee and (2) The University of Guelph (See Appendix B for Research Team profiles and roles). Community-university (CU) partnerships are unique because they blend diverse perspectives with expertise from academia and the community to elicit a culturally relevant solution to a locally defined problem (Wellesley Institute, 2008). In concert with the principles of CES, specifically open communication, negotiated reciprocity, and mutual respect, the research team negotiated roles for everyone that contributed to this project based on a variety of factors including; their interest in the project, background/position, experience conducting

\(^7\) The Research Shop is affiliated with the University of Guelph and acts as a portal connecting community and university research needs. The Research Shop facilitates partnerships of faculty and students working with community organizations and individuals to identify and address social problems and develop strategies and policies promoting positive social change. The Research Shop focuses on working together with collaborations within the Guelph-Wellington community fostering community based research, placing students for service learning and knowledge mobilization. The vision of the Research Shop is “a community of engaged citizens who create and use research knowledge and experience to achieve positive social change” (http://www.theresearchshop.ca/about).
research and time availability (Israel et al., 1998), which was essential for sustainability of the research team and the current research study.

The chapter has offered a detailed discussion of the methodological framework and principles that were employed to conduct the current research study. The next section begins with a demographic snapshot of Guelph-Wellington to provide a contextual understanding of the community in which the research was conducted.

**Demographic Snapshot of Guelph-Wellington**

Guelph-Wellington is comprised of the City of Guelph, two towns and five townships (Wellington-Dufferin-Guelph Public Health, 2012). According to the 2006 Census, the population of Guelph-Wellington was approximately 200,000. More than half of the population (55%) in Guelph-Wellington is married or in a common-law relationship. Immigrants comprise 17% of the population of Guelph-Wellington (Wellington-Dufferin-Guelph Public Health, 2012).

The majority of the population in Guelph-Wellington (58%) has completed post-secondary education. The unemployment rate across Guelph-Wellington (4.5%) is lower than the provincial average (6%), and women (3.5%) are marginally more likely to be unemployed in contrast to their male (2.5%) counterparts (Wellington-Dufferin-Guelph Public Health, 2012). The proportion of low-income individuals is lower in Guelph-Wellington (8.5%) compared to the rest of Ontario (14.7%). Women are more likely to head a single parent household (9%) compared to men (2.5%), which is consistent across the province. Additionally, households with a single female parent are dramatically more likely to be low-income (23%) in contrast to single male parent households (12%) (Wellington-Dufferin-Guelph Public Health, 2012).
Since 2007, there has been a significant increase in Social assistance (Ontario Works) caseloads across Guelph-Wellington. There were approximately 275 Ontario Works cases in Wellington county in 2007, which jumped to 400 by 2010. Similarly, in 2010, there were roughly 1500 Ontario Works cases in the City of Guelph, which spiked from 900 cases in 2007 (Wellington-Dufferin-Guelph Public Health, 2012). Moreover, since 2007, the number of families on the wait-list for affordable housing has increased dramatically (71%) in Guelph-Wellington (Wellington-Dufferin-Guelph Public Health, 2012).

Methods

The current study involved collection and analysis of primary data collected via qualitative interviews by three graduate student researchers. The interviews sought to understand women’s experiences accessing services and seeking support from Action Committee member agencies and how the current system response to violence against women can be improved. The interviews were transcribed verbatim using ExpressScribe software for data analysis purposes. This research study was approved by the Research Ethics Board at the University of Guelph. Data were securely stored on encrypted computers used by the research team. Identifying information was removed from the original data to ensure confidentiality of the research participants.

Sample.

The population of the current study consisted of adult women who have experienced SADV and disclosed their experience to one or more Action Committee member agencies since the first version of protocol was implemented in 2006 (“service users”). It was critical to select appropriate language to refer to the research participants.
The interview included a question asking women what term they preferred. The research team thoughtfully selected “service user” in consultation with women as a neutral term, moving away from the contentious and loaded language that has been used to refer to this population such as “victim,” “survivor,” and “abused woman,” while still capturing the focus of their role as a consumer of SADV services. The research team developed an exclusion criteria for specific contacts between a woman and service provider. There were some situations in which it was unclear if the relationship between the woman and service provider was a service user/service provider relationship. For example, a woman may come into contact with a service provider from one of the Action Committee agencies in a volunteer position. In this case, it would be not be a service user/service provider relationship. If a woman came into contact with one of the Action Committee member agencies in a volunteer position or a similar capacity, that encounter between the woman and service providers was excluded from this research study. Additionally, there were some situations that were unclear whether the service provider a woman had contact with was mandated by the Protocol in their position. For example, some women that participated in this research study had contact with an employee of a large organization such as the University of Guelph, but it was not clear whether all employees of that organization is mandated by the Protocol. Since the Director of Campus Community Police, Fire Prevention and Parking Services represents the University of Guelph at the Action Committee table, only women that had contact with staff under her supervision were included as part of this research.
Recruitment.

Service users were recruited from the community throughout Guelph and Wellington County (Fergus, Elora, Rockwood, Puslinch, Aberfoyle, Mount Forest, Arthur, Palmerston) through a variety of sources. Flyers for the current research study were posted in public locations throughout the Guelph-Wellington community including: public libraries, grocery stores, coffee shops, laundromats, community centres, medical offices, employment centres, downtown shops, mailboxes, university campus as well as the member agency locations (see Appendix C for service user recruitment poster). Advertisements were circulated in a local newspaper as well as online classifieds (Kijiji, Craigslist) and social networking websites (Facebook). This technique is referred to as nonprobability sampling, a nonmathematical random process to select research participants, commonly used by qualitative researchers (Fitzgerald & Cox, 2002; Tewksbury & Ehrhardt Mustain, 2004). In an effort to access rural women in Wellington County, the research team revised and redistributed the recruitment posters. The revisions specified that we were looking for women in Wellington County and that interviews were available in the County (see Appendix D for recruitment poster).

Research participants were screened by an administrative staff person at Guelph-Wellington Women in Crisis who had experience working with this population. Research participants were screened to ensure they met the eligibility criteria for the current research study. Eligibility requirements for the current research study were specified in the recruitment poster. Recruitment resulted in a total of 33 interviews being conducted between December 2012 and May 2013, but only 26 interviews were included in the analysis of this research study. The current research study excluded cases of family
violence because it is qualitatively different than violence between intimate partners. Additionally, SADV disclosures to an Action Committee member agency that occurred before 2006 were also excluded because the Protocol had not been implemented. The analysis presents data from 26 cases of intimate partner violence in which the woman disclosed her experience to one or more Action Committee member agencies after 2006. The women received $25 as remuneration for participation and they were compensated for transportation and childcare.

**Semi-structured interviews.**

Qualitative data were collected via face-to-face semi-structured interviews with service users. This researcher conducted and transcribed eight of thirty-three interviews that were conducted for this research study. Semi-structured interviews are particularly valuable for exploratory research because they allow research participants to dictate the findings and elicit responses the researcher may not have anticipated by “probing for more detail” (Dantzker & Hunter, 2006; Neuman, Weigand, & Winterdyk, 2003). The interview questions were created in collaboration with the Action Committee coordinator, the PI, a graduate student intern from the Research Shop and this researcher, as part of a collaborative and co-learning process, which is consistent with dimensions of CEnR and principles of CES (See Appendix E for interview questions). The research team consulted a variety of sources to develop the interview questions including; the Protocol document, academic research and grey literature surrounding coordinated responses to violence against women as well as sexual assault and domestic violence service provision.

Integrated interview training was provided by the PI and the Action Committee coordinator based on their education and experience in the field. The PI has been
researching violence against women for more than twenty-five years and had previous experience conducting interviews with women who have experienced domestic violence. Additionally, the Action Committee coordinator completed her Masters of Social Work degree and worked with women who have experienced violence in her position as a counselor at Women in Crisis. In addition, the student researchers consulted literature provided by the PI on feminist interviewing techniques (Campbell et al., 2009; Lavis, 2010; Campbell et al., 2010; Tang, 2002). Training was particularly important for this research study to ensure consistency because the interviews were conducted by three student researchers. Two of the graduate student researchers had prior experience conducting qualitative face-to-face interviews with participants on sensitive research topics.

The interviews were approximately 1-2 hours in duration. They took place in a private meeting room at Women in Crisis and the University of Guelph. Prior to conducting the interview, the researchers briefly explained the study to participants, discussed confidentiality and the limits of confidentiality and reviewed the consent form (see Appendix F for service user consent form) and then proceeded with the interview. The interviews were recorded using audio recording equipment and later transcribed verbatim for analysis. Participants were provided with a list of community resources at the end of the interview. They were also asked if they wanted to participate in a focus group to offer feedback on preliminary research results, referred to as member checking (Deprince, Priebe, & Newton, 2001) and if they wanted to receive a copy of the research findings.
Data Analysis

The research team valued shared decision-making throughout the research process, including data analysis, consistent with dimensions of CEnR and CES principles. The research team met frequently to develop data analysis procedures and process, as part of a collaborative and co-learning partnership. There is disagreement within the literature in terms of how to perform data analysis. Data analysis is an individualized process and there is no right or wrong approach (Bradley, Curry, & Devers, 2007). There is agreement within the literature that an ongoing, iterative and flexible process is important for analyzing qualitative data (Bradley, Curry, & Devers, 2007; Flick, 2014). We found that a flexible research process was necessary, especially because we engaged in team-based analysis. A flexible process was critical to facilitate co-learning through collaboration and negotiation between members of the research team since the academic and community partners did not have extensive experience with data analysis.

Initially, coding was conducted as a team to ensure consistency and that the research team members were familiar with the coding process. The research team began the coding process by choosing two interview transcripts, which were reviewed by all members of the research team individually as a way to become comfortable with the data. Then the research team met and discussed emerging patterns and the codes we came up with. This researcher was primarily responsible for coding the service user interview data because it was the focus of her Master’s thesis. Coding involves “naming segments of data with a label that simultaneously categorizes, summarizes, and accounts for each piece of data” (Charmaz, 2006: 43). Subsequently, each interview transcript was coded by at least two research team members to ensure intercoder reliability (Creswell, 2014).
There is debate within the literature regarding Qualitative Research Teams (QRTs) compared to data analysis by a single researcher. Some argue that QRTs are beneficial because they have the potential to increase inter-reliability via member checking (Denzin, 1978; Mays and Pope 1995, Patton, 1999; Pope, Ziebland, & Mays, 2000), while others argue that data analysis derived from a single interpretation by one researcher elicits better quality findings (Morse, 1994; Morse & Richards, 2002; Janesick, 2003). A single interpretation of the data analysis is inconsistent with principles of CEnR. As a result, the research team opted to engage in team-based analysis. The research team was involved in the coding of the interviews as well as preliminary data analysis. This researcher primarily focused on analysis the service user interview data, because it was the focus of her Master’s thesis. However, she consulted with the research team regularly, consistent with principles of CEnR. There were benefits and drawbacks of both approaches, but we found ways to manage this tension using features of the qualitative software program and regular communication among all members of the research team.

The research team met periodically to discuss codes and emerging themes. The data was analyzed using thematic analysis, which is a method for identifying, analyzing, and reporting patterns, or themes (Braun & Clark, 2006). The analytic approach involved both deductive and inductive coding. Deductive coding is theoretically driven and relies on pre-existing theories or preconceived ideas, whereas deductive coding allows the data to guide the findings (Braun & Clark, 2006) to answer the research questions and identify additional themes. We created deductive codes for each of the Protocol objectives (See Appendix G for list). Interviews were coded using qualitative data analysis software
(NVivo 10), which was useful for facilitating a team-based thematic analysis of the data. Qualitative data analysis software was also particularly helpful for data management, which can be challenging for a research team with large amounts of data (Roulston, 2014).

The purpose of the current research study was to conduct evaluation research on a sexual assault and domestic violence protocol implemented in Guelph-Wellington by the Action Committee, from the service user perspective. Broadly speaking, this research study examined the extent to which the Protocol objectives are being met, service users’ satisfaction of their service provision experience and whether the Protocol meets the needs and issues facing women who have experienced violence (see Chapter 1 for detailed research questions). It was important during the data analysis process to keep the research questions close by, otherwise it was easy to lose focus and get lost in the data. Finally, when the initial coding was completed, the research team organized full-day data analysis meetings to compare themes as well as interview transcripts (Braun & Clark, 2006), and refine, reorganize and collapse/expand codes to make it manageable.

Once all of the interviews were coded and the themes were synthesized and agreed upon, we began analyzing the data. Practically, analyzing and making sense of the data involved skimming through the codes and noting major recurring themes. Data analysis also involved thinking about how the codes and themes related to each other and how and whether they addressed the research questions.

Additionally, the women were specifically asked whether service providers attended to and performed the interventions outlined in the Protocol for a “consistent, caring and effective first response.” The responses to these questions were entered into a
quantitative data analysis program (SPSS) to obtain quantitative statistics about the frequency in which service providers explained confidentiality, performed a risk assessment, offered safety planning and provided follow-up and support. These results are provided in the research findings (See Chapter 3).

**Reflecting on the Research Process**

**Reflexivity.**

Consistent with community engaged, qualitative and feminist research principles and perspectives, it is valuable to reflect on the research process (Israel et al., 1998). Reflexivity is common practice among qualitative researchers, and it is best described as “self-criticality among researchers” (Kidd & Kral, 2005: 187). Moreover, it is a method “use[d] to legitimize, validate and question research practices and representations” (Pillow, 2003: 175). Reflexivity is the “process of examining both oneself as [a] researcher, and the research relationship” and involves reflecting on the research process as a whole, and at various stages (Hsiung, 2010). There have been many occurrences of reflection throughout the process of conducting this research. Distributing recruitment posters throughout the community for this research remains a memorable experience. Many locations had a community notice board or a dedicated place to display advertisements, with approval by an employee. Most individuals were happy to display the recruitment poster for this research study, but some were dismissive and unpleasant. Initially, it was upsetting that some individuals had no qualms about declining to display the recruitment poster for this research study and others justified their position and said felt the content was inappropriate. However, after taking a step back and reflecting on this experience, it was apparent that this is a larger systemic issue. It was evident that
individuals still have an “out of sight, out of mind” mentality when it comes to violence against women and still believe that it is a private matter. The actions of the individuals also demonstrated a greater need for public education around violence against women.

In another vein, it was intimidating to interview women about a sensitive topic without any previous experience conducting interviews or interacting with this population. However, women expressed appreciation for the opportunity to participate and offer feedback, and they were supportive of the research. The interviews gave women a chance to reflect on their service provision experience, which many women had never done. Experiencing violence and coping with the aftermath of the violence is often a trying time for women. The women rarely had time to themselves, let alone time to reflect on their experience and think about what was helpful and supportive as well as unhelpful and what could be offered to improve service delivery. It was rewarding to see the women reflecting on their experiences. Many of the women that participated in the current research study had both positive and negative experiences with various service providers. However, the women expressed gratitude for the services and support they received from the Action Committee agencies, as these women share:

I think it’s important for [the Action Committee] to know what [they’re] doing is working. All these... organizations, like I saw how many different ones over the last two years?... They all have an important [role] to play... I needed every one of them in order to get through the crisis...I’m just thinking what would [I] have done if I didn’t have even one of those? – Woman #11

I feel very surprised and very, I’m gunna use the word delighted to know that all of these services that I’ve accessed have really helped me... you go from one service and then you go to the next service and you don’t realize that “holy crap” there’s so many out there and each of them have their own entity that helps in different positions and I think because I did do that [accessed multiple services], I survived... if I didn’t do that I don’t know how I could have done it... having all these services in place have helped me to feel so strong, like just so validated as a person. – Woman #20
Moreover, the opportunity to engage in a CEnR project has enhanced this researchers’ Master’s degree and has been rewarding on many levels. This researcher has built relationships with the Action Committee member agencies, which represents more than 25 agencies in the Guelph-Wellington community. The breadth of this research project has also provided her with practical experience conducting interviews on a sensitive research topic as well as analyzing qualitative data using computer software program. The skills and experience she has gained through this community university partnership is unparalleled, and greatly improves the prospect of employment post graduation. Skill development and increased employment prospects have been noted in previous research as a benefit of CEnR research for students (Schwartz, 2010).

The current section outlined the methodological orientation guiding the current research project and offered a reflexive account of this researcher’s experience. The chapter will now shift to a discussion of the study purpose, research design including the methods and data analysis employed to conduct this evaluation research.

**Challenges of doing community engaged research.**

Engaging in CEnR often presents challenges for the community and university partner(s). Time commitment was identified as a common challenge among the research team, which is also echoed in the literature (Davidson & Bowen, 2011; Sadler et al., 2012; Israel et al., 1998; Community-Based Research Canada, 2008; Strand et al., 2003). As Davison and Bowen (2011) note, “it is imperative to recognize the time investment required for this type of work and to honor[u]r the unfolding of the collaborative relationship… it is also a long-term relationship for the community organization (p. 315).
The opportunity for the Action Committee to conduct evaluation research is rare. Thus, it was important that the research team took their time to ensure a rigorous process yielding reliable results. This was particularly challenging for the Action Committee coordinator because service providers often attribute more value to the results of evaluation research and less to the process, whereas the university partners placed equal value on the process and the results. The Action Committee coordinator was often anxious to get the data collection tools finalized, whereas the university partners held back allowing more time to finalize the tools and obtain input from service users and service providers, consistent with a CEnR framework as well as CES and PAR principles. The Action Committee coordinator was understanding and accepting of the timeframe required for a rigorous engaged process.

Initially the Action Committee Coordinator was apprehensive about engaging in a CEnR project because she was concerned that the university partner(s) would take over the process. This was a legitimate concern of the community partner, and part of the history of community-university partnerships (Israel et al., 1998; Buchanan, 1996; Dockery, 1996; Plough & Olafson, 1994; Cosier & Glennie, 1994; Altman, 1995; Israel et al., 1992; Barnett, 1993).

Our study attempted to equalize power and foster an ongoing collaborative partnership characterized by an equitable process, which is consistent with dimension of CEnR and principle of CES. This was achieved by open communication, meeting regularly and ensuring that everyone “touched everything.” In other words, all of the documents created as part of this research evaluation (i.e. recruitment posters, interview questions, research report) were written by one member of the research team and then
edited by all members of the research team. As an example, the interview questions went through numerous drafts because the first draft was sent out to all members of the research team for comments and then the research team met, discussed and finalized the interview questions collaboratively. While a collaborative process was time consuming, it facilitated community-university trust. Additionally, the PI always made an extra effort to ensure that the Action Committee was satisfied with decisions that were being made. It was important that the university partners were mindful of the hesitation of the community partner and made every effort to explicitly value their expertise, wisdom and relationships they brought to the research. The collaborative process also allowed the PI to mentor this researcher and other student researchers who were involved in this CEnR project.

A personal challenge for this researcher was negotiating a thesis topic. From the outset this researcher knew she wanted to do a CEnR project related to violence against women. However, the challenge was finding a community partner with similar interests/needs. After a lot of patience and careful consideration, this researcher finally settled on this project 11 months into her program. It was unsettling for this researcher not knowing her thesis topic for nearly a year into her program. However, she was fortunate that she did not have to negotiate her research interests and she was able to be involved in a project responding to a community identified need. In addition, it was challenging to complete this research within the allotted program timeframe. Similar concerns were expressed by students who completed a CEnR course as part of their degree requirements (Schwartz, 2010). Other researchers have identified time constraints
and curriculum inflexibility as a challenge for this type of research (Hyde & Meyer, 2004; Mulroy, 2004).

**Strengths and limitations of this research study.**

Qualitative research is invaluable because it allows researchers to obtain a comprehensive understanding of the topic of study from the perspective of those with lived experience (Dantzker & Hunter, 2012; Creswell, 2014; Tewksbury & Ehrhardt Mustain, 2004). Feminist research methodology literature suggests that interviews are most beneficial for discussing a sensitive topic such as sexual and domestic violence. Interviews are most beneficial because it allows the researcher to develop a rapport with the participants, which is essential to obtain an in-depth understanding of the research topic (Barribell & White, 1994; Kraska & Neuman, 2011, Driscoll & McFarland, 1989). Feminist interviewing is also favourable because it facilitates the deconstruction of hierarchal relationships that are often present (Bell et al., 2004; Campbell et al., 2010; Oakley, 1981). Researchers are often in a position of privilege and possess power relative to their research participants, so there is an unspoken hierarchy that is present when feminist researchers interact with research participants. Face-to-face interviewing helps researchers to build a rapport with participants and break down that hierarchical relationship.

Qualitative research is not without limitations. Conducting qualitative research is often not feasible for an M.A. student because it requires the researcher to invest a significant amount of time and it can be costly (Dantzker & Hunter, 2012; Neuman, Weigand, & Winterdyk, 2003; Tewksbury & Ehrhardt Mustain, 2004). This researcher had previous experience with CEnR and was prepared to dedicate more time than
required for a traditional M.A. thesis for the practical experience she would gain through her involvement with this evaluation research. Researchers employing a qualitative research design, especially in the field of sociology/criminology may find it difficult to recruit participants because they are trying to access hard to reach populations, which often requires non-probability sampling (Tewksbury & Ehrhardt Mustain, 2004), as this study did. Partnering with the Action Committee was beneficial for recruitment because many of the women that participated in the current research study were recruited through one of the Action Committee member agencies. Displaying posters in the community and circulating advertisements for this research study through online classifieds and social media were less successful. Although, a qualitative research design is fraught with limitations, the current study sought to minimize the impacts of these as much as possible relying on a CEnR framework.

This chapter discussed how the research team employed dimensions of CEnR, as well as principles of CES CBR and PAR to engage in a CU partnership to conduct evaluation research. The chapter offers a reflexive account of this researchers experience. Subsequently, the chapter outlined the research design including; research participants utilized for this study, data collection methods and data analysis procedures. Last, the chapter concluded with the challenges of CEnR experienced by the community and university partner(s) involved in this research as well as strengths and limitations of this research study. The following chapter will unveil the research findings of the current study.
Chapter Four: Research Findings

This chapter presents the research findings from both the quantitative and the qualitative data. The research questions guiding this study sought to examine the Action Committee’s sexual assault and domestic violence protocol and to ask about barriers and challenges experienced by women accessing and receiving SADV services. This study will contribute to the sociological literature surrounding sexual assault and domestic violence service delivery via coordinated responses from the service user perspective specifically. The following chapter presents service users’ socio-demographic profiles to give a snapshot of the women that were interviewed. Then the chapter unveils the research findings in the form of themes and sub-themes addressing each of the research questions using data from the semi-structured interviews.

Service Users’ Socio-demographic Profile

Service users were asked to report their socio-demographic characteristics. Women reported their area of residence, age, race/ethnicity, first language, country of birth, education, marital status, annual income and the number of children they have (See Appendix H for figures displaying service users’ socio-demographic characteristics).

A total of 33 women were interviewed as part of this research study. However, data from only 26 participants were included in the analysis based on the eligibility criteria.⁸

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⁸ Participant data related to the Protocol objectives were excluded if the disclosure took place before 2006 because the Protocol was not implemented. Additionally, only women that experienced violence by an intimate partner were included. Intimate partner violence includes violence between dating, married/common-law as well as legally estranged (separated and divorced) partners.
Table 1. Descriptive Statistics (n = 26)

<table>
<thead>
<tr>
<th>Place of Residence</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Guelph</td>
<td>96</td>
</tr>
<tr>
<td>Wellington County</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education Level</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than highschool</td>
<td>4</td>
</tr>
<tr>
<td>Completed some highschool</td>
<td>15</td>
</tr>
<tr>
<td>Completed highschool</td>
<td>12</td>
</tr>
<tr>
<td>Some college/university</td>
<td>19</td>
</tr>
<tr>
<td>College Diploma</td>
<td>23</td>
</tr>
<tr>
<td>University undergraduate degree</td>
<td>23</td>
</tr>
<tr>
<td>University graduate degree</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-24</td>
<td>11</td>
</tr>
<tr>
<td>25-34</td>
<td>8</td>
</tr>
<tr>
<td>35-54</td>
<td>61</td>
</tr>
<tr>
<td>55-64</td>
<td>15</td>
</tr>
<tr>
<td>65-74</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birth Place</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Canada</td>
<td>92</td>
</tr>
<tr>
<td>Outside Canada</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Language Spoken</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>96</td>
</tr>
<tr>
<td>English &amp; Lithuanian</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>69</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>8</td>
</tr>
<tr>
<td>Mixed</td>
<td>8</td>
</tr>
<tr>
<td>South Asian</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Separated/Divorced</td>
<td>46</td>
</tr>
<tr>
<td>Single</td>
<td>27</td>
</tr>
<tr>
<td>Married/Common-law</td>
<td>27</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>72</td>
</tr>
<tr>
<td>No</td>
<td>28</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $20,000</td>
<td>79</td>
</tr>
<tr>
<td>$20,000-$39,000</td>
<td>8</td>
</tr>
<tr>
<td>$40,000-$59,000</td>
<td>8</td>
</tr>
<tr>
<td>$60,000-$79,000</td>
<td>4</td>
</tr>
</tbody>
</table>

The vast majority (96%) of service users lived in the city of Guelph (n= 25) and 4% lived in the county (n= 1). Service users had diverse education levels. Of the women that participated, 4% (n=1) had less than high school, 15% (n= 4) completed some high
school, 12% (n=3) completed high school, 19% (n= 5) completed some college and/or university, 23% (n=6) received a college diploma, 23% had a university undergraduate degree (n= 6), and 4% (n=1) had a university graduate degree (See Appendix H figure 3).

The majority (61%) of service users were between 35 and 54 years old (n=16), 11% (n= 3) were 18-24, 8% (n= 2) were 25-34, 15% (n= 4) were 55-64 and 4% (n=1) was 65-74 (See Appendix H figure 1). Of the women who participated in this research, 24 were born in Canada, and 2 were born outside of Canada. Twenty-five service users spoke English as their first language and one participant spoke English and Lithuanian. The majority (69%) of service users identified as “White” (n=18), 8% identified as Aboriginal (n=2), 8% were Mixed race (n=2), 4% identified as South Asian (n= 1), 8% identified as Other (n= 2) (See Appendix H figure 2).9 Service users were comparable across marital status. Nearly half (46%) of service users were separated/divorced (n=12), 27% (n=7) were single, 27% (n=7) were married/common-law (See Appendix H figure 4). The majority (72%) of service users had children (n= 18), while 28% did not have children (n= 7).10

Children’s ages ranged from 7 months to 42 years. Finally, a large majority (79%) of service users were low income and reported a total annual income of less than $20,000, 8% reported an annual income of $20,000 to $39,000, 8% had an annual income of $40,000 to $59,000 and 4% reported an annual income between $60,000 to $79,000.11

Although the Protocol focuses on sexual assault and domestic violence, the majority of the women interviewed experienced domestic violence, encompassing physical, emotional, psychological, sexual, financial and spiritual violence, and is reflected in the

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9 One participants’ race/ethnicity was unknown
10 One participant did not answer
11 Two participants did not provide their annual income.
research findings. The following section presents the findings of the current research study related to the Protocol objectives.

**Inconsistent and Irregular Performance of Protocol Objectives**

The first research question asked whether the Protocol was being implemented as written. The Protocol outlines steps to a consistent and caring first response, which include three primary interventions:

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

Overall, the findings reveal that only some of the Protocol objectives were implemented according to the written Protocol, specifically explaining confidentiality, the limits of confidentiality and obtaining informed consent. Offering safety planning, performing a risk assessment and providing follow up and support are not being performed regularly or consistently across all Action Committee agencies. Moreover, service users reported that they could benefit from increased coordination and collaboration among service providers. Findings related to each of the interventions to a consistent and caring response are discussed in detail below.

**Care is key.**

A major finding of the current research study challenges the structure of the Protocol, which assumes that the “first response” is most important and reveals *how* service is delivered, is equally as important as the content of the service. Care was
defined by the women using a range of qualities including; attentiveness, accommodating, compassionate, respectful, empathetic, non-judgmental, patient, understanding and validated women’s experiences. The importance of care was echoed throughout all of the interviews with service users. This finding was unveiled through a series of questions women were asked about their experience with each service provider they had contact with to provide a more complete picture of their experience (See Appendix E Question 13). The findings reveal that the manner in which women were treated by service providers and how they felt was often remembered, and was critical to shaping their service provision experience. In fact, we also asked women for feedback on the interview experience and the interview questions and one woman suggested that we should have asked women how a service provider made them feel. This finding is interesting because the final paragraph of the Protocol reads:

[The Protocol] cannot replace the most important quality we can all bring to our work – our understanding and empathy. It is not only what we say or do that will be remembered, but also how we make a person feel when he or she comes to us for help that will be remembered (based on quote by Carl W. Buechner) (p. 23).

Despite the content of the paragraph, the placement of the quote within the Protocol document speaks to the importance of the quote and suggests that it may not be as paramount in terms of the focus for service providers as the quote eludes. The placement of the paragraph also makes it easy to overlook. However, the findings of the current study corroborate the sentiment of the paragraph.

Women were asked what service providers did to make them feel supported and what they found to be helpful for them, and they repeatedly mentioned care, as these women share:
To be honest, like just a listening ear. Somebody that cared, you know. Like they said they cared about me kind of thing and made me feel better about myself. That was the most important thing to me right then and there. – Woman #2

They just made me feel like I was the only one that mattered. And I know that I’m not and I know that they deal with, you know hundreds, probably thousands of people, but they made me feel that way. They made me feel like I was all that mattered, and that’s important to me. – Woman #11

The most prevalent theme was the importance of feeling heard and believed, demonstrated by the following quotes:

Interviewer: Was there anything else that you found supportive?

Participant: Just the listening, just that and validating the fact that, no you’re not losing your mind, you’re not crazy, this is a serious thing. Ya, just being heard. – Woman #28

The big thing for me was nobody’s ever believed my experiences. They’ve never believed that I’ve gone through these traumas. I felt, not totally, but I felt [worker], she was believing me. I just needed to come and talk to her some more and some more and some more. – Woman #7

Interviewer: Was there anything that was said or done that was supportive or is there a way that [service provider] could have been more supportive?

Ah…made me feel that I was being listened to would be nice […] Not like being so distracted with other things, like you know…like if somebody is talking to you […] pay attention and not…maybe even just take them somewhere where they can talk privately or don’t keep getting interrupted by people. You know? – Woman #1

Women reflected on positive service delivery experiences and how service providers demonstrated care. The woman quoted below shares how the school staff were accommodating to her children:

They were really good actually, because the school was combined. It was over capacity, and they weren’t allowed any more students, especially ones that didn’t live in the school district, and [the principal] actually called the superintendent and he got special permission based on compassion for my sons to return to that school…And it was, just unbelievable. – Woman #16
This woman recalls how the officer was patient and made an effort to make her feel comfortable:

The officer that I spoke to made me feel very comfortable. Didn’t push to get details… I remember one instance where we were trying to get some information and it was just all so fresh and everything was just such a turmoil that I couldn’t remember exactly what was said and [the officer] said “calm down, relax. Take a deep breath you know talk about it and it might come back to you sort of thing. Like she was very encouraging and supportive that way… It was more like take your time. Relax. You know I know this is a hard time and you know, very supportive that way. – Woman #10

Finally, this woman shares that validation and understanding were ways in which service providers made her feel supported:

Interviewer: What was said or done that was supportive?

Participant: They just validated how I was feeling and said that it wasn’t my fault…and they just made me feel not so ashamed of the whole situation. – Woman #3

In contrast, women felt unsupported and reported negative experiences when service providers did not demonstrate caring qualities:

The other school, the new school that [my son is at, the principal is] all about the legal and phoning my lawyer and getting everything you know, completely legal, which I get, but the personal part is out of it, the like caring and giving a shit – it’s gone. – Woman #20

No, no emotional support was there…it was just very…it just felt very business like, right. You know [the service provider – Legal Aid Ontario] didn’t want to hear the intimate details… [service provider] was more interested about, you know how much money I made and my income and things like that. – Woman #11

**Which door to choose?**

In addition to a caring response, the Protocol aims to implement a consistent response among all the Action Committee agencies, ensuring that there is “no wrong door” (the Action Committee, p. 5). Providing a consistent response was not uniform
among workers from the same agency or across workers from different agencies. Women commonly had interactions with more than one worker at the same agency. These women contrast their experience with different workers from the same agency:

I had two different workers and so they’re very extreme. Like to me, one was very nice but not investigative enough and the other one is, you know, she’s more like strict… and very understanding of abuse like so… she gets it. Like she sees what’s happening so, the second woman I found a lot more helpful in the way that she could understand what I was going through ‘cause the first woman, we never touched on any of that. – Woman #20

... my one negative complaint with them [the police] – one of the officers was fantastic, one was not great and one was mediocre. – Woman #5

… some women at the shelter are amazing at listening, amazing at giving advice and they just go well with your personality, or somebody else’s and sometimes it just doesn’t work and some people just don’t give good advice, it’s just the way it is. – Woman #17

There was great disparity in terms of how women experienced the police. Specialization in domestic violence and sexual assault in combination with the individual officer’s personality had implications for women’s experiences with the police. Women that had contact with the Domestic Violence Coordinator from Guelph Police Service all shared positive experiences as the following quotes demonstrate:

Guelph Police, the – that one officer he was…absolutely spectacular. I would recommend [Guelph Police Domestic Violence Coordinator] to anybody! Answers his cellphone any time a day, no word of a lie, even if it’s just to bitch because the asshole is hacking your Facebook account again... – Woman #17

I just feel like this [Police officer] gets it…he’s so helpful, he listens to the woman’s point of view and doesn’t take anything outside of that... You feel like “oh, finally someone gets it”… he’s got a sense of humour, but he’s very strict too, like he’s the kinda person who’s got such a beautiful balance – you know very strong and firm, but also human. He’s just so great, he listens and he understands the male mentality, the controlling abusive mentality…he knows how they operate right, and you know it’s just second nature to him. - W# 20
Conversely, women that had contact with first line responder police officers that did not specialize in domestic violence and/or sexual assault primarily shared negative encounters with the police, as the following quotes reveal:

…when I first arrived [the police] kind of were hesitant to even help me for a bit, like they…asked me like did he have nudes of me and that’s what I was concerned about…but after I started – like explained the situation to them then they knew it was serious…I just want to make it clear at the beginning I kinda didn’t like how it started off ‘cause I just kind of felt off put by it all…like I came in with a serious matter…I felt uncomfortable at the beginning… - Woman #18

The police….they could have offered me a glass of water and some Kleenex because I was balling my eyes out and I had snot running down my face. – Woman # 9

Finally, there was variability in the clinical skills of the individual service providers women encountered. This woman recounts her experience with a service provider and she was not confident the worker had the skills to calm her down during a time of crisis:

When I was in [service provider’s] office, it was not the most calming experience. It wasn’t the best experience and I remember thinking during the whole time, I remember every time I looked at her and I could see the look on her face changing even more to a frustration level. She couldn’t get me to stop crying enough to answer her questions. I wasn’t able to, and she wasn’t very accepting of that. She wasn’t very responsive to that thing and…in the meantime I felt like I was going into the black hole. I felt like I was just – this woman is not getting what I am trying to say to her. Is it really my imagination? I kept on doubting myself from the look on her face and the tone of voice she was using with me as the appointment went by. So looking back on it, it was a negative experience. – Woman #7

The findings provide evidence that “a consistent and caring response” proved to be paramount for women and was largely dependent on the individual worker at a particular agency, as well as their skill and experience.
Confidentiality and its limits consistently explained.

Explaining confidentiality and limits of confidentiality is performed as a “best practice” by service providers across sectors and it is commonly included as part of agencies’ formal processes and legal requirements. This objective requires service providers to inform women what can be held in confidence and what cannot. Typically, service providers have a duty to report to appropriate authorities, such as a child welfare agency and/or the police, if an individual discloses knowledge of abuse occurring against a child\textsuperscript{12}, that the person is going to injure herself or another person.\textsuperscript{13}

Overall, confidentiality and the limits of confidentiality were explained to women 87\% of the time.\textsuperscript{14} Women revealed some scenarios in which service providers did not explain confidentiality, for example if they disclosed in a support group. A woman may join a support group for sexual and/or domestic violence, and it may be the first time she discloses experiencing abuse. This is a situation in which confidentiality was not explained to women. Additionally, confidentiality was not explained to women if she disclosed over the phone to a crisis line. In these cases service users said that confidentiality was assumed on their behalf, even if it was not explained to them.

Service users expressed confusion about their rights related to confidentiality with certain service providers. Some service providers that come into contact with women who have experienced SADV, specifically Family and Children’s Services, Guelph Police and Ontario Provincial Police take on an investigate role rather than provide

\textsuperscript{12} See Section 72(1) of the Child and Family Services Act for legislation mandating the duty to report abuse perpetrated against children.
\textsuperscript{13} See Section 40(1) of the Personal Health Information Protection Act for legislation mandating the duty to report reasonable beliefs of serious bodily harm to a person or group of persons.
\textsuperscript{14} Statistic is based on overall number of contacts with service providers for all of the women that disclosed experiencing SADV to an Action Committee member agency since 2006.
support to women per se, due to their agency mandate. For example, the role of the police is to uphold public safety and security on behalf of the state (Guelph Police Service, n.d.). Thus, if a woman discloses that she has experienced physical abuse and there is evidence of abuse the police are required by legislation to charge. Women who contact the police are often unaware of pro-charging policies that police are working under prior to disclosing abuse. Therefore, if the police fail to inform women about their limits pertaining to confidentiality during initial contact she may disclose experiencing abuse without fully understanding the implications of sharing that information with police. This undermines her ability to make informed decisions about what or what not to disclose to the police because once the police have grounds to lay charges they are mandated to proceed, regardless of the woman’s wishes. This woman shares the importance of explaining the implications of disclosing experiencing violence to the police:

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

In a similar vein, child welfare agencies are mandated to protect children from physical and emotional abuse and/or neglect (Family and Children’s Services, 2014). Child welfare agencies often place the onus on the woman to protect her children in cases of domestic violence (Hester et al., 2007). Consequently, if there is domestic violence occurring in the home and the woman does not leave her partner to ensure safety of her child(ren) this may result in removal of the child(ren) from the home and restricting parental access. Similar to the police, if a child welfare worker does not inform a woman
that if she discloses experiencing violence at home she will be required to leave her abusive partner and her decisions will have implications for access to her child(ren). If a woman does not have this knowledge, she may disclose without understanding the repercussions of sharing this information with a child welfare worker. The mandates of the police and child welfare agencies differ from the other Action Committee agencies because they are legislated to act if a woman discloses experiencing violence in a way that other agencies are not. Conversely, agencies that provide support to women place greater priority on women making informed decisions and are not in the same position to act upon certain disclosures.

Generally, service providers are required to keep all information about a file confidential unless a disclosure meets the criteria for the duty to report. If a worker wishes to discuss a client file with another service provider they are required to obtain informed consent from the woman to share her information. Informed consent is written permission from a client giving permission to share information about her file with another service provider. Women we interviewed were unclear about the limits of confidentiality under the Child and Family Services Act (1990), which outlines parameters for sharing information with other service providers. Generally, service providers prefer to obtain informed consent from a woman to share information among service providers, as opposed to proceeding through the court system to obtain permission. In some cases child welfare workers may need to proceed through the court system to obtain consent to share information, if the woman is not cooperative, in order to protect the children. The following quote highlights confusion experienced by one woman:
My [Family and Children’s Services] worker was like... calling in [to another agency] and wanted to talk to them or whatever. So I just remember them saying... wanting me to sign a form for her to [release information]... and then I said well what if I don't want to sign it? Because they said if I sign it she can get all my files from whatever. And they said “if you don’t sign it she could go to court and they could get all your files instead... they could go back forever.” So I kind of felt like I was forced into signing something. Because I feel like “well we’re Children’s Aid” right, because if you don’t sign stuff... then they can force you to do it. So there is confidentiality but not really. - Woman #2

In this case the worker attempted to obtain informed consent, and the woman questioned her rights. However, the Family and Children’s Service worker did not clearly explain confidentiality and informed consent to the woman under the Child and Family Services Act (1990), and the woman felt compelled to provide consent to share information related to her file with another service provider, although she may not have wanted to. This left a negative impression with the woman. These findings highlight the importance of service providers clearly explaining confidentiality and the limits of confidentiality to service users during initial contact and ensuring they understand the implications of disclosing their abuse. This is especially important for the police and child welfare agencies because they take on an investigative role rather than a solely supportive role.

Privacy.

A related Protocol requirement is that service providers should “meet with a woman in a place that is private and safe” when disclosing SADV (the Action Committee, p. 5). We asked women whether their disclosure with each service provider they had contact with took place in a private setting. Overall, women reported that they disclosed experiencing SADV to a service provider in a private place 81% of the time. A woman’s first disclosure did not always take place in a private or clinical setting as prescribed by the Protocol, but did most of the time. There were situations in which
women felt they were not afforded privacy to feel comfortable or talk openly about their experience of SADV. Women reported that their disclosure was not private if it took place in a waiting room, over the phone, in a public place or public areas of an agency or in their home if the police were called. This woman recounts the lack of privacy when she receives a phone call from a service provider:

Woman: Uhm…it was, well no it wasn’t [private], it was on the bus because they were calling me. This was for the… sexual assault. Once [perpetrator] was released actually, [worker] called [me] before he was released from… or the day of his release or something like that. I guess whenever he got a parole… she called right away but I was on the bus and I wanted to talk to her. So I ended up talking on the bus about everything that happened. So no, it wasn’t private at all… [service provider] did ask if I wanted to come in and I said it was okay just to talk on the phone… It wasn’t – I don’t even know if she knew I was on the bus. – Woman #11

There was one I can’t remember which service she was with…and she needed to talk to us about something… we had to talk separately and she called [the home phone], we were still in the house together me and [abusive partner] after the police left and [service provider] had called… We were supposed to do an interview each [participant and abusive partner]… and I had phoned [service provider] to do that which [was a] major barrier. Where else am I going to phone? I’m in the house. He can walk in any minute. Privacy goes out the window. You’re watching your words, it just did not work… and again business hours. Well [in the evening] I’ve got the kids and I’m not going to talk about that in front of the kids so there just seemed to be these barriers that come up. – Woman #5

Many of the women we interviewed that had contact with the Welcome-in Drop in Centre commented on the lack of privacy and confidentiality of this agency due to the layout of the space. Generally, if a woman did not feel she was afforded privacy she reported this aspect of service delivery negatively. There was a disjunct between women disclosing SADV and service providers recognizing it as a disclosure. For example, a woman may meet with a service provider without the intent of disclosing SADV, but
throughout the course of their conversation the woman may elude to the fact that she is experiencing violence by an intimate partner or there may be physical evidence of abuse occurring. This is especially common for medical professionals as this woman recalls, but in this case the ER doctor screened her for domestic violence:

…the time that I actually had to go to the hospital was ‘cause, I don’t know if he punched me in the face or I think or it might have been a blow dryer that he hit me in the face with, it cracked open my chin… [my friends] took me to the hospital right away to get stitches, and at first I was just – I just told the doctor, like I went to the ER, I just told the doctor… I fell on ice or something, but then like all the other bruises started appearing on my body and [the doctor asked] “did you really fall?” and I just like started balling, I’m like “no” and then he called – I guess the, sexual assault or domestic violence unit within the hospital and they took me away to another part of the hospital and then started documenting and all that stuff from there. – Woman #23

Service providers may not recognize a disclosure or understand how significant it can be for women. This is problematic because women may not be treated according to the Protocol, or with the care and compassion that they deserve and that is so critical to SADV service provision. Despite how a disclosure of SADV may occur, it is often challenging for women and can be further compounded if she is not afforded privacy and confidentiality.

**Limited safety planning offered to women.**

Safety is of the utmost importance for women who have experienced violence and is the cornerstone to a collaborative and coordinated community response. Safety planning is common practice for service providers that provide services to women who have experienced abuse (Hester et al., 2007; Goodkind, Sullivan & Bybee, 2004), and is a primary focus for SADV service provision. It involves service providers devising strategies with women to keep herself and her children safe from further abuse by their
perpetrators. Safety planning is done on an ongoing basis and requires revision when circumstances change. The goal of safety planning is to empower women and provide greater protection for herself and her children (the Action Committee, 2010). As the Protocol is currently written, there is an expectation that all service providers will offer safety planning to every woman who discloses experiencing SADV. Service users revealed that safety planning is not being done by all agencies. Overall, service users reported that the majority (64%) of service providers talked to them about their safety, while a smaller proportion (41%) reported that service providers made clear safety plans with them. This finding is somewhat surprising since safety is a paramount element of SADV service provision. However, there are a variety of agencies from diverse sectors that are members of the Action Committee, and each has their own mission and mandates. In addition, many of the agencies have limited staff resources and funds. The results suggest it may not be realistic to expect all Action Committee agencies to perform safety planning with every woman who discloses SADV. Feeling safe and developing a safety plan was helpful and supportive for women experiencing ongoing abuse or a recent incident of abuse, as these women share:

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

…specifically their [Women in Crisis] safety planning has been really, really good…I don’t know what my husband’s going to do. I don’t know what his triggers are going to be that are going to make him go off. And so I… fear for
my safety and the safety of my son. So they have helped incredibly and been incredibly supportive in managing that fear. – Woman # 10

Moreover, the findings revealed that safety planning may not be necessary for all disclosures. A woman may share a historical experience of SADV with a service provider and may not require safety planning because the abuser no longer poses a danger to her. This finding is notable because the Protocol, as it is currently written, assumes that safety planning is always necessary for every woman that discloses SADV. However, the findings reveal that this is not the case and the Protocol should note that not all situations require safety planning, as the following quote reveals:

   Interviewer: Did [service provider] talk to you about your safety?
   Participant: Well they let me know about the distress line and things like that. I wasn’t with my ex-husband anymore. He wasn’t even in the city so I didn’t have to worry about that. – Woman #24

   Interviewer: Do you remember if [service provider] made a safety plan with you?
   Participant: I don’t know if it was applicable because [abusive partner] can’t find me [he doesn’t live in the same city]. – Woman #33

Although safety planning is not essential for all disclosures, it is helpful for women deemed at risk. Women are often at risk for future abuse if they choose to stay in the relationship because domestic violence is typically recurring (Johnson & Dawson, 2011; Hester et al., 2007). A woman’s risk persists even if she decides to separate from her abuser (Fleury, Sullivan & Bybee, 2000) and has been found to be risk factor for lethal violence (Jaffe, Dawson & Campbell, 2011). Thus, safety planning is critically important for women who have recently experienced abuse, whether they choose to stay or end the relationship.
Women commonly relied on two agencies – Victim Services and Women in Crisis, for safety planning. This finding is not surprising because some agencies are more suited to offer safety planning to women, while others are not based on their agency mandate, mission, resources and funding. Instead, it might be reasonable to expect specific agencies who specialize in SADV to perform comprehensive safety planning, while the remaining Action Committee agencies check in with women to ensure that they have a safety plan in place, and that it is being updated as necessary.

**Was risk assessed?**

Assessing a woman’s level of risk using a risk assessment tool has been common practice for SADV service provision for decades (Kropp, 2008). Risk assessments are used by service providers to manage dangerous situations and provide greater protection for women and children affected by violence (Hoyle, 2008). A risk assessment is a checklist of questions service providers ask a woman who has experienced violence to predict future violence and lethality, including frequency and severity. There are various risk assessment tools used across agencies and sectors (Kropp, 2008; the Action Committee, 2010). The Protocol outlines that a risk assessment should be performed by the first service provider a woman has contact with, or by referral to specific agencies, including Women in Crisis, The Sexual Assault and Domestic Violence Care and Treatment Centre at Guelph General Hospital, Guelph Police Service or Ontario Provincial Police and Victim Services. If a risk assessment has been completed, service providers should ask women whether there have been any changes in circumstances, which would require another risk assessment.
Service users reported that they were aware service providers were asking them questions to determine how much danger they were in more than half (63%) of the time. However, only 28% of women reported completing a formal risk assessment with the service providers they had contact with. It was evident from the interviews that women were unsure what a risk assessment was and whether service providers had completed a formal risk assessment with them or not, as the follow quotes demonstrate:

Interviewer: Was a risk assessment or screening tool form filled out by you or on your behalf?

Participant: Uhm, not that I know of, but they did ask me a lot of questions...So they probably did fill something out on their end because they asked me all kinds of similar questions to what’s on there [referring to sample risk assessment]...But not that I know of so...but I am sure they had to do some sort of assessment. – Woman #11

I don’t know that they really assessed or gave me direction about the danger I was in, and from their [service provider’s] perspective I don’t really think there’s been any proof of the emotional abuse that continues… - Woman #21

**Risk assessment tools as a source of validation.**

Assessing a woman’s risk proved to help validate women’s experiences, and thereby was paramount for women disclosing SADV because their experiences are often minimized or not believed. Beyond using a risk assessment to determine risk, women reported that it was educational and helped them to identify and appropriately label their experiences as abuse and understand their level of risk as the following quotes demonstrate:

"Yeah, it’s good to do that [fill out a risk assessment] just even for yourself to look at the page and go “what?” Do you know what I mean? Like that’s what made me leave my relationship because I did an assessment, a control assessment and I couldn’t believe how many I checked off." – Woman #20

I found [the risk assessment] helped me more than them realize the type of abuse that I had experienced...They ask you questions, you know, “has he ever raped
you” and you know I said “no.” They said “well has he ever had sex with you when you said “no” or you didn’t want him to and he did it anyways” and I said “yes.” But at the time I didn’t, I didn’t see that, right, so I was really trying to protect the abuser still, I was still in that frame of mind. So they were very helpful, the questions that they asked were…very helpful questions, they were very specific. It’s almost like they knew what they were looking for by asking those questions. – Woman #17

A risk assessment may not be necessary for a woman because the service provider has asked questions and determined she is safe based on the information she has provided and the service provider’s experience and intuition. However, a risk assessment can serve multiple purposes, which are helpful to women. The findings suggest service providers should be open and transparent with women about performing a formal risk assessment so that they understand what the service provider is doing when they complete a formal risk assessment. Regardless of what the Protocol mandates, our findings suggest that performing a risk assessment is necessary for every woman so that service providers can respond appropriately. Completing a risk assessment helps service providers determine whether they need to escalate a situation and take further steps to ensure her and her child(ren)’s safety. It is also helpful for service providers to get an understanding of a woman’s level of risk because it will be useful for informing safety planning strategies. The findings suggest that service providers should clearly explain why they are completing a risk assessment and provide an opportunity for women to ask any questions they might have. This would help to clarify any miscommunication or confusion women might have about risk assessment. It is also important for women to know a risk assessment is being done so they understand the danger they might be in. This would help women to make informed decisions about their next steps, in consultation with service providers. In addition to the reasons mentioned, ensuring a woman knows a risk
assessment is being completed serves an educational purpose both her and the service provider, and helps to validate her experience, which women expressed were important when the gain the courage to disclose SADV.

**Inconsistencies of coordination and collaboration.**

Coordination and collaboration are the cornerstone of sexual assault and domestic violence service provision, and are touted as the “gold standard” for improving women’s experiences (Allen, 2006; Campbell et al., 2012). Beyond the primary interventions of a “consistent, caring and effective first response,” a secondary purpose of the Protocol is to facilitate coordination and collaboration between Action Committee agencies in an effort to better serve women. The second research questions asked whether the Protocol has assisted in facilitating coordination and collaboration between service providers to improve service delivery. On average, women had contact with 4 service providers related to SADV. The minimum number of contacts was one and the maximum number of contacts with service providers was 13. Despite collaboration and coordination being a central component of a community’s response, service users largely shared experiences of isolated service delivery. Two examples of the way in which collaboration and coordination are evident come from referrals between agencies, and case conferences. Case conferences help to facilitate coordination and collaborating by bringing multiple service providers together with a woman who has experienced SADV to develop a plan of action. Of the 26 women, only two women said they participated in a case conference. While few of the women participated in a case conference, the vast majority said it would have been helpful, as this woman shared:

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

**Follow up: The importance of a differential response.**

Every woman who experiences SADV is affected differently, and their experience and needs are impacted by their social location within society. Factors impacting women’s needs include: age, socio-economic status, ability, citizenship status, children, addictions and mental health issues. Follow-up as it is outlined in the Protocol refers to service providers employing a differential response by offering women choices and options to stay in an abusive relationship or leave her abusive partner. A differential response also stipulates that service providers will employ an individualized approach assessing the unique circumstances and needs of every woman and ensuring that all women have access to services and supports offered within the community. For example, a woman living in the county might need access to transportation to attend an appointment. One woman we interviewed was a young, single mother receiving social assistance and had Aboriginal status. The criminal trial of her abusive partner took place outside the city of Guelph and she was required to travel to attend court in addition to other appointments for services and support to deal with the aftermath of the abuse she endured. She talks about how the abuse has impacted her financially and caring for her child:

I had to pay $100 dollars to have my son in daycare for the evening before and the day of trial and [service provider] sent me a refund but they didn’t send me a refund of what I was supposed to be refunded... I was told that when I went on the trial date that, that morning on the trial date I would get my money for my childcare expenses for that day and travel costs for that day as well as travel costs and childcare expenses for my pretrial appointment, which I hadn’t yet gotten, they said “we’ll deal with it all on the day of trial and you’ll get it in cash that day.” I went up to get it... they stand there and tell me “well it’s over $100, we are going to have to send you a cheque in the mail, is that okay?” I - that was my
breaking point at that point in the day and I just said, I started balling my eyes out
I’m like “I just spent my last $100 on daycare and you’re asking me if it’s okay,
you’re not giving me a choice, are you? Are you going to give it to me in cash
today” [service provider says] “well no” [woman responds] “well why are you
asking me if it’s okay then, what’s the purpose? You’re not doing me any good…
I mean you can’t be put in a position where you pay for daycare or you feed your
child, you pay for daycare to put his father away so that your son’s no longer in
danger or do you put him in diapers and feed him? That’s a really tough position
to put them under, really tough… and it shouldn’t be that way… at all! – Woman
#17

The quote above demonstrates how the aftermath of abuse can impact a woman and is
influenced by her social positioning within society. Thus, it is important that service
providers employ a differential response with each woman and are cognizant of the
barriers and challenges they may experience accessing and receiving services.

Relatedly, victim blaming is a common experience among women who have been
abused and has implications for service provision (WHO, 2001). The findings reveal
evidence of victim blaming and instances of women being judged and consequently
denied services. Some women reported that they were not believed and were judged
based on their appearance, addictions, low income, employment status and mental health
conditions, as the following quotes reveal:

I think when people have drug addiction problems and their mental health it’s
different because people look at them different…It, it just is and they maybe
don’t believe them or act different towards them than if I was somebody
that…was in a business suit and came in and said the same thing…you can’t [tell
service providers] you’re an addict and you’re not… people aren’t – they don’t
believe you. – Woman #2

I remember this police officer… he intimidated me during the conversation and
[he] said I think you’re using your post-traumatic distress disorder as an
excuse…like when this police officer said [that to me] I lost a lot of faith in the
police right there because if he had the liberty to even come out and say that then
that means they had formed an opinion of me where they – where I wasn’t really
believed. – Woman #22
In these cases, women needed a service provider to advocate on their behalf to obtain the assistance and support they required. However, if they were unable to get this support, for many women it meant that they did not receive services and/or support they needed.

**Referrals do not guarantee further service provision.**

Experiencing domestic violence and sexual assault affects every woman in profound ways. Women may seek services and support from various service providers to help them cope and rebuild their lives. Currently, the system is set up in such a way that requires women to fragment their needs based on the social problem apparatus. In other words, women are required to go to various locations for each individual issue they are experiencing. Seeking and accessing services is often raised as a challenge by women who have experienced violence. Sexual assault and domestic violence services are not well advertised, making it difficult for women to find out about what services are offered in her community as these women share:

…unless you’ve been through this or unless you’ve looked for this type of thing you don’t know what’s available to you and even when you do, perhaps you’re trying to survive certain elements of it, you don’t even have your ears and eyes open to other potential helpful services or programs…” Woman #21

…there needs to be more information out there. Women need to know there’s a safe place for them to go quietly…Women don’t know. If they’re not getting hit, they don’t think. And because you’re so beaten down emotionally you feel too stupid to get out of it…” Woman #32

In addition, when women do find out about services available, they may experience difficulties engaging with or accessing that service provider. However, availability of services is not the only barrier for women. Women are often unaware of the full range of services offered and rely on referrals from service providers they come
into contact with to inform them of different services and supports offered by other agencies and to connect them with those service providers. Referrals are an important intervention of service provision. Women reported that service providers frequently referred them to other SADV related services in the community such as Women in Crisis, Family Counselling and Support Services, Victim Services, Victim Witness Assistance Program and Legal Aid Ontario. However, the findings unveiled that providing a referral does not always ensure that the woman will follow through and access that service. In some cases women felt that the referral was not appropriate or they did not have the time or energy to make contact with a new service provider, and were reasons women cited for not following through with a referral. This woman explains she did not access the hospital after a violent attack by her abuser because she was afraid, overwhelmed and exhausted:

Honestly, I was afraid to go outside. One of the reasons...I mean within the first 24 hours you get contact with all these service providers and these are just Guelph, I had to deal with Toronto as well. And dealing with my family, my exes family and raising a baby all by yourself. All of a sudden you wake up one morning and you’re a single mother. I had a lot goin’ on...I just didn’t have the time or the energy to - my son had pneumonia at the time, I had pneumonia at the time so it was a lot at one time and trying to deal with all of this the right way so that I could keep my son safe, there just wasn’t enough time in the day. – Woman #17

Service users shared that advocacy and accompaniment such as making a phone call to schedule the first appointment with a new service provider, attending the first appointment and maintaining contact with other service providers on their behalf were ways in which service providers made them feel supported and helped to connect women with a new service provider. Advocacy and accompaniment was appreciated by the women and helped them to attain results that they could not achieve on their own.
Did [Service provider] listen to you in a way that made you feel heard?

Participant: No, not the first time, but when my worker from Women in Crisis came [worker] was – she was attentive…I felt that [service provider was more thorough] when my worker from Women in Crisis came that it was more supportive – Woman #18

Accessing certain agencies and systems was more difficult for women than others. Women expressed intimidation of the police, court systems and child welfare agencies because of their power and authority. Child welfare agencies hold a lot of power because they can remove children from a home and restrict a woman from seeing her children if she does not comply with the requested plan. Similarly, the police may charge a woman if there is evidence of mutual violence or violence perpetrated by the woman in self-defence. The woman quoted below was arrested by the police because she threatened to kill her abusive partner. She endured various forms of abuse for more than 10 years and finally he withdrew all the money from her bank account while she was overseas, leaving her with no money and isolating her financially. Her abusive partner reported her to the police and said that she was armed and dangerous, she recalls her experience being arrested by the police:

When I was arrested – so it was in a parking lot and my husband had tricked me into meeting with him and I was surrounded [by the police]… he had told them I was armed and dangerous… they had guns pointed at me. Like it was – they were in bullet proof vests… that’s very intimidating for someone who’s never been in trouble before… I actually shut down [when the police were arresting me]… – Woman # 11

This woman vividly remembers the police arriving at her home the night of a violent incident:

[The police] were all males, which I found very offensive… Salt in the wounds and of course you’re not in a position to feel the strength to say “go back and get
a woman…so being interviewed in my bedroom by a male in my pajamas was not… I did not appreciate that. That really… it still bothers me that of course there’s four men now in the dining room talking to [abusive partner] and here’s me all by myself with two little babies… So then of course they all banded together I felt like. It just felt like that. – Woman #5

Women either appreciated or wished they had a service provider to advocate and/or accompany them when interacting with these agencies and systems, as this woman comments:

So I do think like you know what, they do have a hard job or whatever because people are clearly traumatized… I feel like if you know, if someone’s telling you they’re scared to go to the police station and they’re saying to go to the police station… would you not go with them or send somebody with them? I know they have those services, but I was unable to advocate for myself and say look you guys [I] need [you] to help me. I couldn’t do that at the time. – Woman #2

…they seemed to do everything that was needed and they were like, even when the judge asked me to come to court, I didn’t have to, but he wanted me to be present that day because he was going to read it so even they were like, they all showed up, like they were there to support me. [Service provider] was sitting right behind me, so they were a great help. – Woman #31

Women appreciate and rely on referrals to other agencies. Advocacy and accompaniment are also important elements of SADV service provision, and helped transition a woman to a new service provider.

**Service Providers Not being held Accountable to the Protocol by Service Users**

Beyond the objectives of the Protocol document, one of the research questions asked to what extent service users are satisfied with their experience of service providers as they are mandated by the Protocol? It was our sense that the women we interviewed did not have knowledge of the Protocol or that the service providers they had contact with were members of the Action Committee and are therefore mandated by the Protocol. This provides some evidence that service providers are not being held accountable to the
Protocol by women since they do not have knowledge of it. Thus, it is difficult to gauge whether service users’ satisfaction or dissatisfaction with service providers is directly attributable to the Protocol. However, the findings reveal important elements of SADV service provision that matter and impact women’s experiences accessing services.

**Comprehensive service delivery matters.**

The Protocol states “An effective first response to the disclosure of sexual assault and/or domestic violence cannot be underestimated. It lays the groundwork for successful intervention and potential prevention of further violence” (the Action Committee, p. 5). The assumptions of the Action Committee were that the “first response” or initial interaction with a woman is a key aspect of service provision. This influenced the focus of the research and was the reason for specifically asking women about their “first response” experience with service providers. However, the data suggests otherwise, and reveals other aspects of service delivery are more important for women, which are discussed throughout this chapter. As we conducted the interviews we realized there was a lot of ambiguity surrounding when the “first response” occurs because the Protocol does not outline any quantifiable parameters. It was unclear whether the “first response” occurs the first time a woman has contact with a service provider and discloses SADV, or whether it is the first two to three times a woman has contact with a service provider. Overall, the findings of the research revealed that a woman’s overall service delivery experience is more important than the “first response.” One woman commented when asked to provide feedback about the interview:

That was one of the things I found in the initial contact, you’re not all there, you’re really in a different headspace, you’re kind of – you’re there but you’re not and you’re not really taking in all of the information… Initial contact, that’s a little question, like you need to know what’s happened [during] the initial
contact, but… [there] needs to be more conversation about what happened as a whole with that organization – Woman #17

Women were asked a series of questions about their experiences with each service provider they had contact with (See Appendix E Question 13). Many women were unable to answer some questions because they could not recall the specific details. However, women tended to reflect on their overall impression and shared anecdotes of their experiences with service providers, regardless if it was during initial contact or not. It is notable that women were able to recall specific positive and negative experiences over the course of their contact with a service provider. This is additional evidence of the importance of a woman’s comprehensive service delivery experience. This woman recalls her experience with a criminal justice service provider and makes the point that she remembers this specific encounter even though it was in the distant past:

Okay, well like even though that was two years ago I still remember [the worker’s] comment and it just makes me so upset. She said after I told her everything – and by the way he was Afghani from Afghanistan. So [the worker] says to me “well, he comes over to this country” – by the way he was born here, his parents immigrated – “he comes over to this country and he’s never given a chance, he’s never given a chance and now this happens to him” and I just kind thought you know what – obviously you can tell I’m angry right now even over that […] she kept kind of, saying like the way it was coming off to me was I shouldn’t have reported [the abuse]… - Woman #18

There was some evidence that the “first response” mattered, although it was not a major theme and was not the most critical aspect of service delivery for women. The woman quoted below was diagnosed with concurrent disorders as a result of her experience of violence. She wanted to attend two support groups for her mental health conditions, but the agency only permitted her to apply for one group. She precisely recalls her experience and feeling re-victimized during initial contact with the intake
worker at the agency. She further expresses her desire not come into contact with that individual worker in the future:

Whereas I found… when I got diagnosed with PTSD and was told that there’s a group there [mental health agency]… I actually felt more victimized the way [the intake worker] handled it… the interview… it was like make a choice…here’s the paperwork you have to fill out to see if you qualify for the group, but it’s make a choice and she was very cold, and there was no empathy, there was no compassion… this is the way it is… and I thought I never want to see this person again… ever. For anything. I didn’t feel taken care of at all. – Woman #24

Additionally, this woman shared that her poor experience during initial contact led her to withdraw her request for service completely. After meeting with a worker at an agency for counseling services she left feeling like she was dismissed and was denied the service she was seeking:

Participant: When I had that one counseling session with that woman [when the session was over] she’s like “okay, we’ll see you later and I was like - well I was going there thinking that I was going to have some ongoing [counseling] and then she was like, it’s kinda like she put it at me like I don’t need to go back kinda thing, like she didn’t wanna see me again. It was kinda like she felt…

Interviewer: That you didn’t need any help?

Participant: Yeah! And then she said “you know it’s because I thought you were really strong” and this and that and I’m like “yeah, but I went there for a reason.” Yeah, like you can still be strong and still be hurting inside, right like I mean, I don’t know. I just…[she] wasn’t sensitive.

Like, see I keep jumping to the different situations like do you [mean] with my son, or do you mean just me? Because I keep focusing on the, the one really bad experience [when I met with a counsellor was felt dismissed after our first meeting] I had, so…And I did try to deal with it, and I rectified myself, like okay just don’t go back there right. As much as I tried to work it out with [the service provider] I still never would feel comfortable again. – Woman #20

Although the “first response” was not the most important aspect of service provision for women, the findings reveal that initial contact matters and has implications for whether a woman will continue contact with a service provider. Ultimately, a
woman’s overall experience of service delivery proved to be significant and remains impressionable.

**Service Users’ Needs and Issues**

**Basic needs are essential.**

There has been a lot of attention within the literature on coordinated responses as a vehicle to improve service delivery for women who have experienced violence. However, since the emergence of the battered women’s movement, women have indicated that basic needs are essential to cope with the aftermath of violence and move forward with their lives after abuse (Allen, Bybee & Sullivan, 2004; Postmus et al., 2009; Hart, 1995; Gondolf & Fisher, 1988). Women reported that practical and tangible assistance and resources were one of the most helpful things offered by service providers. Service users received a variety of practical and tangible assistance and resources including: bus tickets/taxi fare, grocery store vouchers, housing support, child care services/financial assistance for child care, thrift store vouchers, clothing, personal emergency alarms and educational resources (i.e. books, pamphlets, “purple cards”). This form of support was integral for women coping with their experience of violence and rebuilding their lives.

Interviewer: Looking back on the situation, what were the most helpful things that service providers were able to offer?

Participant: Shelter, some food…things for your basic needs like shampoo, towels, that sort of thing I felt helpful…All those pieces like anything like Maslow’s hierarchy of needs, those basic needs. Anything like that I felt was helpful in those moments. – Woman #12

And then my doctor helped me, she helped me with like…grocery cards and stuff like that ‘cause I went in there and I was just a mess and [mimics crying] “I have no money, I have no food.” I just broke down. So she was really, she really helped me, it was nice. – Woman #20
They got me welfare right away, which turned around and got me housing right away, like everything went boom, boom, boom, I got my home...And my apartment got fully furnished from the community...because I had nothing but the clothes Sister Christine gave me. – Woman #33

This finding is particularly important to understand within a patriarchal society in which women are socially, economically and politically disadvantaged. Offering basic material needs to a single woman escaping abuse is an individualized solution. However, if coordinating committees desire to achieve long-term sustainable change for all women they need to work at tackling the larger converging systems of oppression that women must navigate to escape abuse and live violence free lives.

**Institutional and systemic issues.**

In addition to research questions that asked specifically about the Protocol objectives, it was important to hear about whether there were issues women faced beyond the Protocol that needed attendance. The final research question asked to what extent do the current protocol objectives meet the needs and issues facing women and children who experience sexual and/or domestic violence? The current Protocol objectives partially meet the needs and issues facing women and children who have experienced SADV. However, service users identified larger systems issues as well as gaps in services that impact their experiences with service providers and their ability to cope and rebuild their lives.

**Increase public knowledge of sexual assault and domestic violence and services available.**

Despite nearly 40 years of public education about violence against women, service users indicated that public knowledge about SADV is still lacking in the
community. Women did not always identify or label their experience as abuse, particularly if it was non-physical or sexual in nature. There has been an ongoing struggle to include emotional abuse and other non-physical forms of domestic violence treated as worthy of attention by the system. Criminal law is particularly restrictive, and only physical forms of domestic violence are chargeable (Perreault & Brennan, 2009; Tam et al., 2013), suggesting that only physical violence in the context of an intimate relationship matters. However, the findings of this study indicate that this is not the case. It is critical to focus our attention beyond physical abuse and condemn emotional and other non-physical forms of violence perpetrated by men against women in intimate relationships to send the message that all forms of violence against women are unacceptable. This woman primarily experienced emotional and psychological abuse, she shares:

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

Another woman shares that she did not understand part of her experience as abuse:

I’d been on my own and this fricken knight in shining armour rides into my life […] it was a lot of emotional abuse, which I didn’t realize it was at the time. […] And I didn’t realize over the course of three, four years how mind fucked […] I don’t know how else to describe it…how mind fucked I was, to the point where we actually, we went to the doctor one day because there was something seriously wrong with me and it just went on and on. The violent part, I didn’t think it was – I didn’t know any different. – Woman #16

This woman could not conceptualize her experience as abuse because she was married to her abusive partner:
Sexual abuse, I don’t know how to say that in a marriage, you know, forcible blow jobs and things like that...you can’t really report that, it’s like people would say “well it’s just kinky sex. – Woman # 32

**Court system challenges.**

Previous research has documented the barriers and challenges experienced by women experience accessing the criminal (Dichter et al., 2011; Bennet, Goodman & Dutton, 1999) and family court systems (Cross, 2012). It is not surprising that these court systems continue to be a stumbling block for women who have experienced gender based violence. Some women that encountered the criminal and family court systems expressed frustration. The criminal court system is often unable to directly address SADV because non-physical violence is not chargeable under the *Criminal Code* (Perreault & Brennan, 2009; Stewart, Langan, & Hannem., 2013; Tam et al., 2013), although it can have a significant impact on women’s and children’s lives as the interviews revealed. Additionally, some justice professionals presiding in the family and criminal courts may not understand the complexity of domestic violence, leaving women feeling like it is another avenue in which the abusive partner continues to abuse her.

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

Prior to engaging in contact with the court systems, it would be beneficial for women to be informed and understand the constraints of these systems. This would allow women to make an informed decision whether they want to proceed or possibly seek an alterative resolution outside the court systems.
Gaps in services for children.

Women highlighted the lack of services available in the community for children who have witnessed violence or been a victim of violence. Parenting support was also identified as a gap in services.

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

Similarly, women identified a need for greater financial assistance with child care since many were in a low income bracket and cannot afford to pay for a child care provider, making it difficult to deal with the aftermath of abuse while also caring for children.

In summary, the typical profile of women who accessed SADV services in Guelph Wellington were White, English speaking middle aged low income Canadian born, educated women living in the city and have children. The findings of the current study reveal that the Protocol is not being implemented exactly as written according to women we heard from. The findings also highlight that a woman’s overall impression and experience of a service provider was integral to positive service delivery experience. How service is delivered proved to be one of the most important elements of SADV service delivery and was memorable for women. Basic needs continue to be essential for women who have experienced abuse. The objectives of a “consistent, caring and effective first response,” are not being complied with consistently across all Action Committee agencies. Service providers are explaining confidentiality regularly and consistently, while offering safety planning, performing a risk assessment and providing effective follow-up and support is sporadic, according to service users. This research also
identified broader systemic issues and gaps in services in Guelph-Wellington beyond the scope of the Protocol including public knowledge of SADV, challenges related to involvement with the court systems and lack of services and support related to children. Service providers need to be more accountable to the Protocol if we want to assess its impact on service delivery. This chapter illuminated the findings from the current research study. The discussion section will connect the findings from the current research study to past academic research, highlighting the consistencies and disparities.
Chapter Five: Discussion

The primary objective of this research study was to examine the Protocol from the service user perspective by hearing about women’s experiences accessing and receiving services in Guelph-Wellington. The current research study contributes to existing academic literature through the inclusion of women’s voices as service users, which has largely been neglected. The current chapter draws connections between existing literature and the research findings, unveiled in the form of qualitative themes. This chapter offers a discussion and critical analysis of the key findings of the current research study and offers recommendations based on the findings of this research. Subsequently, the chapter discusses theoretical and policy implications. Finally, the chapter concludes with a discussion of limitations of this research study and suggestions for future research.

Protocol Objectives

The current research study sought to determine whether the Protocol implemented by the Action Committee to improve service delivery for women is being executed as written. The Protocol seeks to offer a consistent, caring and effective first response to every woman who discloses SADV to any one of the Action Committee member agencies. The Protocol objectives are to offer a consistent, caring and effective first response by: (i) explaining confidentiality and obtaining informed consent (ii) offering safety planning and performing a risk assessment, and (iii) making appropriate referrals and providing follow-up and support. The following section highlights key research findings and how they relate to relevant academic literature.
Providing a caring response.

The current research study found that demonstrating care and how service providers made a woman feel was a significant aspect of her service delivery experience. Women talked extensively about the manner in which service providers treated them, which was evidently more important than whether service providers attended to the Protocol objectives. Consistent with existing literature, service users defined care using a range of verbs including; feeling heard/attentive listening, empowering, respectful, empathetic, patient, non-judgmental, validating and understanding. Women felt supported and empowered to make positive changes in their lives when service providers treated them with care. Moreover, prior research has found that women who report positive encounters with service providers are more likely to have greater confidence in their ability to change their situation (Waldrop & Resnick, 2004). This finding provides evidence that a positive service delivery experience is a key ingredient to helping women who have experienced abuse make positive changes in their lives.

Seeking formal support from service providers for SADV is daunting for many women. Women commonly experience feelings of fear, shame and embarrassment, preventing them from seeking formal support (Montalvo-Liendo, 2009; Erez, Adelman & Gregory, 2009; Fugate et al., 2005). Campbell et al. (2001) assert “[w]hen women go public with their stories of rape, they place a great deal of trust in our social systems as they risk disbelief, scorn, shame, and refusals of help. How these interactions with system personnel unfold can have profound implications for victims’ recovery” (p. 1253). In a study conducted by Bell and Kulkarni (2005) service users agreed that having a poor attitude and prejudice can act as a barrier preventing women from seeking services. The
manner in which service providers treat women is important to break the cycle of dependency on the system and abusers through empowerment as opposed to victimization (Postmus & Hahn, 2007). This finding provides an opportunity for service providers to think about valuable ways that agencies can use the feedback that they are mandated to collect from services users in a way that would make women feel cared for, and result in a positive service delivery experience as way to bring research and practice together to benefit women.

Many social service agencies that provide assistance and support to women and children who have experienced SADV receive funding in the form of grants from the provincial and federal governments. Social service agencies are commonly obligated by funders to obtain feedback from service users and evaluate the services they provide (Riger & Staggs, 2011). Evidently, there is a disconnect between what prior research has identified is important for service provision and what occurs in practice. There is extensive research indicating that how women are treated is a paramount aspect of service provision, yet service providers are not making a greater effort to ensure that service users coming through their doors have a positive experience.

**Confidentiality.**

Overall, service providers across all Action Committee member agencies consistently explained confidentiality to women. Prior research has found that confidentiality is important to women (Kulkarni, Bell & McDaniel Rhodes, 2012; Simmons et al., 2011; Hester et al., 2007), which is not surprising since it is often interconnected with safety. The findings of the current research study also highlighted the importance of the police and child welfare agencies ensuring that women understand the
legislation that they are working under so that they can make informed decisions about what to disclose, or not. Without an understanding of the implications of sharing information that would require an arrest, women’s autonomy is compromised and she may become entangled in the criminal court system against her wishes. Women shared rare situations in which service providers did not explain confidentiality due to the circumstances of their encounter. Although, confidentiality was not explained in some situations, the women said it was assumed. Moreover, women revealed that privacy was important to facilitating a SADV disclosure. In some cases, women disclosed in public areas of agencies because they were not offered a private space. Women who did not feel a sense of privacy did not feel comfortable disclosing their experience of violence, which is congruent with previous research (Bacchus, Mezey & Bewley, 2002; Bates et al., 2001; Shipway, 2004). A disclosure is the first step to seeking formal support, and privacy plays a critical role during the initial contact. It is important that when women gain the courage to disclose SADV they are offered a private space to talk, in an effort to ensure that they feel safe and comfortable to share their experience. A lack of privacy can act as a barrier preventing a disclosure, which can have negative repercussions for a woman. This finding suggests that agencies should review their intake process to ensure that service users are afforded privacy and comfort, which has been found to be an important element for facilitating a SADV disclosure.

Risk assessment and safety planning.

Safety is central to domestic violence and sexual assault service provision. Since the emergence of the battered women’s movement, service providers have been using risk assessment tools (Kropp, 2008) and safety planning strategies (Davies, Lyon &
Monti-Catania, 1998) to increase women’s and children’s safety. As discussed in the literature review, risk assessment tools are primarily beneficial for service providers (Campbell, 2010; Abrams, Belknap, & Melton, 2001; Roehl & Guertin, 2000; Websdale 2000a; Weisz, Tolman & Saunders, 2000). Overall, the findings of this research study found that many of the women were unsure whether service providers conducted a formal risk assessment with them or not. Although only one quarter (28%) of women said that service providers completed a risk assessment with them, the findings revealed that performing a risk assessment with a woman as part of a participatory process has value for her as well. Specifically, completing a risk assessment with a woman can educate her on the dynamics of abuse and it can help to validate her experiences of violence. Validation was particularly important for women who have experienced violence because they frequently reported that they were not believed or that their experiences of abuse were minimized. Performing a risk assessment demonstrates to the woman that her concerns are being taken seriously. The benefit of performing a risk assessment for women is a unique finding, which has not been documented in the existing literature. It is important that service providers clearly explain to women that they are performing a risk assessment so that women can reap the benefits that have been identified by the current research study.

The results of a risk assessment help service providers to devise appropriate safety planning strategies. Consistent with prior research (Bell & Kulkarni, 2006; Harris et al., 2001; Weisz, 2005), women reported that safety planning helped them to feel safe and manage their fear. Safety planning strategies help prepare a woman for an escape in the event that she is in immediate danger. Safety planning is critical for women who are
experiencing violence and although “no one can know everything about every risk or reduce every risk” (Davies, Lyon & Monti-Catania, 1998, p.102), safety planning can help divert a woman or alert the police if she encounters a dangerous situation. Not all women will come into contact with traditional agencies that regularly encounter women who have experienced SADV and typically perform risk assessments and offer safety planning. Campbell (2004) stresses the importance of ensuring that nontraditional service providers are confident performing a risk assessment and offering safety planning, as well as traditional agencies, in an effort to reach as many women as possible. Some women in the current research study only had contact with one service provider. Since safety is a primary concern for this population, it would be beneficial for agencies to think about implementing a mechanism to ensure that every woman who comes into contact with the formal system completes a risk assessment and that she discusses safety planning strategies in an effort to keep herself and her child(ren) safe. Moreover, it has been noted that it is not necessary for all service providers to conduct a risk assessment with every woman. Rather, it is important that all service providers are cognizant of safety and issues related to risk assessment and safety planning, and they ensure that there is a continuous and coordinated approach in place so that any changes in circumstances will be accommodated (Ministry of Public Safety and Solicitor General, 2010). In other words, all agencies that may encounter a woman who has experienced SADV should be comfortable conducting a risk assessment and offering safety planning, but a woman does not need to do safety planning and conduct a risk assessment with every service provider she has contact with.
Limited coordination and collaboration between service providers.

There is strong theoretical support within the academic literature for CCRs to respond to sexual assault and domestic violence, but empirical evidence is lacking (Allen, 2006: 2005; Gamache & Asmus, 1999; Griffiths, 1997; Hague & Malos, 1998; YWCA, 2009; Greeson & Campbell, 2013). As noted in chapter two, evaluation of CCRs is still in developing and not much is known about their effectiveness and whether they have led to improvements of service delivery experiences for women. Service providers assert that collaborative service delivery is necessary to meet the full range of women’s diverse and interconnected needs (Kulkarni, Bell & McDaniel Rhodes, 2012; Zweig, Schlichter, & Burt, 2002; Zweig & Burt, 2007; Campbell & Ahrens, 1998; Allen, Bybee, & Sullivan, 2004; CEVAW, 2009; CREVAWC, 1999; Nugent-Borakove et al., 2006). However, the current study found limited evidence of coordination and collaboration occurring between service providers. In fact, women primarily shared experiences of isolated service delivery. Case conferences are one way in which service providers may coordinate and collaborate their services. The vast majority of women that participated in this research study did not participate in a case conference, but felt that it would have been helpful.

Bronstein’s (2003) model for interdisciplinary collaboration is useful for the current research study because it provides a framework for facilitating collaboration among multiple service providers from different agencies to improve service delivery for women who have experienced violence. Bronstein (2003) delineates five components as part of her interdisciplinary collaboration model, although only those components that align with aspects of service provision that women in this research study suggested would be beneficial are discussed. The first component of Bronstein’s collaboration model is
interdependency, which refers to service providers relying on each other to achieve their own tasks and goals. Interdependency requires service providers to have a clear understanding of their role and responsibilities as well as the roles and responsibilities of other collaborating partners (Bronstein, 2003). Women that participated in the current research study reported that interdependency among Action Committee member agencies is lacking since service providers were often unaware or had limited knowledge of the roles and responsibility of other service providers as well as services offered by other agencies. A lack of interdependency often means that service providers are not offering all possible relevant referrals to women. Moreover, the women in the current research study revealed that some service providers did not have a good understanding of barriers and challenges they experienced in their attempt to access services, limiting their ability to offer appropriate referrals to women. Participants in the current research study identified offering appropriate referrals as an important element of service provision since they were often unaware of agencies that offer domestic violence and sexual assault services and that they are reliant on service providers to provide appropriate referrals when they do make contact. With a greater understanding of roles and responsibilities among service providers involved in a coordinated response, interdependency will lead to service providers offering all appropriate offer referrals to women and ensure that her needs are being met.

Newly created professional activities is another component of Bronstein’s collaboration model, which refers to the development of collaborative activities, programs and structures by multiple agencies to address a social problem (Bronstein, 2003). Women that participated in the current research study identified how the current
response to violence against women can improve through new collaborative activities
between multiple agencies. For example, women in this research study discussed how
decisions made by the criminal court may be in conflict with outcome of family court
proceedings, putting them and their children at greater risk, which is also identified by
previous research (Campbell, 2010). Increased communication between service providers
is necessary for women involved in the criminal and family court systems to ensure that
decisions by the courts are not contradictory and do not compromise women and
children’s safety. Women also identified the need for consistency with service providers.
In many cases, women encountered multiple service providers from the same agency as
well as across agencies, resulting in fragmentation. In an effort to improve consistency,
greater collaboration among service providers a woman encounters is essential to
improve women’s experiences accessing and receiving services. Newly created
professional activities is an important element of collaboration because coordinated
responses have greater power, expertise and resources collectively to address gaps in
services and improve service delivery for women.

The final component of Bronstein’s model of collaboration involves reflection on
the process, which involves members of a coordinated response to engage in discussions
about what is working and identify issues that need attendance (Bronstein, 2003).
Practically, employing the final component of Bronstein’s model of collaboration would
mean that CCR members take some time to engage in conversation about the successes
and failures of their partnership and how it can improve and better service women and
lead to greater improvements in the efficacy of the coordinated response.
The term “collaboration” is used extensively within the academic literature on CCRs, but researchers and multi-agency collaboratives lack a common understanding of what is meant by collaboration, let alone how to evaluate it. It is unclear whether researchers and service providers are talking about the same thing when they refer to “collaboration.” Chapter two revealed inconsistencies in the way that collaboration is conceptualized and understood across the academic disciplines (Wood & Gray, 1991; Gadja, 2004). It is difficult to evaluate multi-agency collaboratives without a common understanding of what is meant by collaboration.

The limited coordination and collaboration occurring among Action Committee agencies is evidence of how difficult it is to engage in multi-agency collaborative work because of the barriers cited within the literature including: competing philosophies/mandates (Greeson & Campbell, 2012; Campbell & Ahrens, 1998; Clark et al., 1996; Wendt, 2010), role confusion (Greeson & Campbell, 2012; Campbell & Ahrens, 1998; Clark et al., 1996; Wendt, 2010), power dynamics (Allen 2006; Allen, 2005 Giacomazzi & Smithey, 2001; Hague 1997; Hague & Malos 1998) and turfism (Giacomazzi & Smithey, 2001; Griffiths, 1997; Hague 1997; Greeson & Campbell, 2012; Campbell & Ahrens, 1998; Uekert, 2003). Moreover, the findings of the larger research study which sought feedback from service providers as well as service users, asked service providers about coordinating and collaborating with other Action Committee member agencies. The findings of the larger study revealed barriers and challenges impeding coordination and collaboration including; time, inaccurate understanding of each others roles, differing/competing philosophies and mandates, limits related to confidentiality, lack of trust (Morton et al., 2014). Gamache and Asmus (1999) argue:
The adoption of a council structure should not be viewed as the solution to coordination problems. Although some communities are developmentally ready to formalize existing cooperative relationships, in too many communities, much energy has been wasted in repeated attempts to bring everyone to the table in the face of considerable resistance from a number of key players in the system. Instead a more effective strategy would devote these scarce resources to the building of linkages among those agencies willing to initiate collaborative problem solving efforts and later use these successes to persuade other agencies to participate. The creation of some type of coordinating structure along, whether a council model or the DAIP [Domestic Abuse Intervention Program] approach, will accomplish little unless the cooperating agencies are willing to hold themselves accountable not only to each other but ultimately to the victims in their community (p. 86-87).

Although collaboration among service providers is assumed to be a crucial ingredient for improving the local response to violence against women, the findings of this study offer little evidence of how collaboration benefits women.

**Referrals.**

Referrals are helpful for women because they are often do not have knowledge of available services or how to access them, or they may be too traumatized to know what to do (Ministry of Public Safety and Solicitor General, 2010). Overall, women reported that they often received referrals from the service providers they encountered. Generally, women followed up with referrals that were offered to them by service providers. However, in some cases a woman did not follow up with a referral because she felt that the referral was not applicable or because she was feeling overwhelmed and did not have the energy to contact another service provider. A study conducted by Krasnoff & Moscati (2002) found that nearly half of the women did not follow through with the referral provided by the hospital emergency department crisis services advocate. Referrals are an important element of coordinating and collaborating sexual assault and domestic violence services which is needed to attend to women’s multiple interconnected needs. It is
important that service providers are cognizant that they are the gatekeepers of information to sexual assault and domestic violence related services and women rely on that information, which is integral to help women cope and rebuild their lives after abuse. The literature found that some service providers do not have knowledge of the services available in the community (Hester et al., 2007; Campbell et al., 2010; Kulkarni, Bell & Wylie, 2010; Gamache & Asmus, 1999) and even their own agency (Wendt, 2010). The lack of knowledge among service providers highlights an area in which some service providers may need to improve if they are committed to improving sexual assault and domestic violence service provision.

Navigating the complex systems that women become entangled in has been found to be the greatest challenge for women leaving abusive relationships. Further, women are often unaware of the complexity of the systems until they gain first-hand experience, which might be while they are contemplating their future steps, during or following the process of leaving her abusive partner or even after she has begun to rebuild her life (CEVAW, 2012). Consistent with existing research (Kulkarni, Bell, & Wylie, 2010), service providers are often privy to information, allowing them to navigate the system easier. The current study revealed that advocacy and accompaniment were ways in which service providers helped to facilitate a referral and made women feel supported, and was appreciated. Women also reported that when service providers accompanied them or advocated on their behalf, and helped women achieve results that they would not achieve on their own. Women particularly appreciated support via accompaniment when dealing with the police and child welfare. It may seem like a small feat for a service provider to help a woman navigate the system because they fail to understand how challenging it can
be. However, if a woman ends up feeling frustrated because she continuously encounters barriers accessing services she may give up, and feel trapped in an abusive relationship. Feelings of entrapment can be heightened if a woman does not have informal support from family and/or friends.

**Service User Satisfaction**

Beyond the primary interventions of a consistent, caring and effective first response, the current study sought to assess how satisfied women are with their experiences of service providers as they are mandated by the Protocol. The researchers were interested in whether the Protocol was attending to the needs and issues facing women who have experienced violence.

**Comprehensive service delivery.**

The Protocol outlines steps to a “consistent, caring and effective first response” to a SADV disclosure. As the Protocol is currently structured, the initial contact between a woman and service provider is the focal point of SADV service provision. The findings of the current research study largely reflect women’s overall impression of service delivery and their experience with service providers, which proved to be more important to women than the first response. This finding is significant because it challenges the current framework of the Protocol. Existing literature does not explicitly distinguish between “first response” and overall service delivery experience. The literature on sexual assault and domestic violence service provision focuses on multiple aspects of women’s service delivery experience at various points of contact. The limited literature on initial contact within the service provision literature may be an indication that a woman’s
overall experience is more important, and lends support to the findings of this research study.

**Tangible assistance and resources.**

Meeting women’s basic needs is vital to helping them cope, rebuild their lives and become self-sufficient (Gondolf & Fisher, 1988; Hart, 1995; Allen, Bybee, & Sullivan, 2004; Bell & Kulkarni, 2006; Lein et al., 2001; Postmus et al. 2009). Service providers’ attendance to women’s needs demonstrates to them that their needs were taken seriously and it is appreciated (Kulkarni, Bell, & McDaniel Rhodes, 2012). The findings of the current study are congruent with prior research, which has found that tangible assistance and resources are helpful and appreciated by the women (Kulkarni, Bell & McDaniel Rhodes, 2012; 2010; Bell & Kulkarni, 2006; Allen, Bybee, & Sullivan, 2004). As mentioned in chapter two, women’s basic material needs cannot be adequately understood without attention to the social, legal and political contexts in which women live. The individualized approach to supporting women through the system fails to address the larger institutional structure in society that supports and perpetuates violence against women, specifically their access to financial security (Postmus & Hahn, 2007). In a study conducted by Lein and colleagues (2001), service providers and women who had experienced violence reported that women’s concerns revolved around their financial insecurity and that women needed assistance seeking and securing employment that would give them benefits that would meet their families’ needs long-term. These findings reveal that above all, women need basic resources, which is fundamental to a feminist analysis. Collaboration will offer little benefit to women if they do not have basic resources.
There was variability in the tangible assistance and resources needed by each woman, which is indicative by the number of service providers each woman had contact with as well as the different agencies they encountered. The variation in needs among the women can be explained using an intersectional analysis which posits that “women who experience domestic violence are not the same and do not have the same experiences, nor do they respond to their circumstances in the same way” (Josephson, 2002: 16). The Protocol uses an intersectional analysis, but uses different language. The Protocol refers to a “differential response,” which is important for understanding women’s social location within society, which is necessary for understanding and addressing their needs as well as barriers and challenges they may be experiencing accessing and receiving services. Existing research has also noted the importance of simultaneously addressing the multiplicity of problems women experience because the issues are often interconnected, as opposed to isolated (Zweig, Schlichter, & Burt, 2002; Kulkarni, Bell, & Wylie, 2010). The interconnectedness of women needs provides evidence that collaboration among service providers is necessary to improve service delivery for women who have experienced violence, and demonstrates that an integrated theoretical framework combining intersectionality and collaboration is necessary to understand how to improve sexual assault and domestic violence service provision. In addition to the Protocol objectives, the current study revealed important findings about larger systems issues accessing and receiving services, which are discussed below.
Beyond the Protocol

**Naming the problem – sexual assault/domestic violence.**

The current study found that some women did not conceptualize their experiences as abuse, which has been found by other researchers (Bell & Kulkarni, 2006; Fanslow & Robinson, 2010). For some women, abuse within the context of their intimate relationship is normalized (Petersen et al., 2004). Women may also minimize the seriousness of the violence they are experiencing (Ministry of Public Safety and Solicitor General, 2010). It can take awhile before women begin to understand their experiences as abuse and realize the severity, impacting their ability to seek assistance and make positive strides in their lives. Prior research found that receiving educational materials and information about domestic violence helped women “open [their] eyes and see what’s really going on and make a move” as one participant stated and led women to seek formal support (Petersen et al., 2004: 69).

When women are ready to seek formal support, they often do not know what services are available in their community (Simmons et al., 2011; Fugate et al., 2005; Du Mont, Forte & Cohen, 2005; Ministry of Public Safety and Solicitor General, 2010) or how to access them (Ministry of Public Safety and Solicitor General, 2010; Fugate et al., 2005). Fugate et al. (2005) asked women about barriers to accessing domestic violence services. Women cited not knowing whom to contact, where to go and how to contact an agency or counselor as reasons for not seeking formal support. Women’s lack of knowledge about domestic violence and sexual assault related services and may help to explain low utilization of domestic violence and sexual assault services (Simmons et al., 2011; Du Mont, Forte & Cohen, 2005). Campbell (2004) found that a large majority of
the women who were victims of attempted femicide or were killed by their intimate male partners had not accessed a shelter or domestic violence advocacy system in the year preceding their death. This highlights a need for agencies to increase advertisement of sexual assault and domestic violence related services to ensure that if a woman is experiencing abuse she knows where to go. Chang et al. (2005) asked women what advice they would offer service providers. Women said that a disclosure should not be required before service providers offer information about violence against women, counseling and resources, it should be readily available. It might be the case that a woman is not ready to disclose to a service provider at that time when she sees her family physician, but she might want to take materials and seek out her options later. Public libraries have been identified as a single site in which women who have experienced violence can access information on sexual assault and/or domestic violence as well as services and resources available in the community (Westbrook & Gonzalez, 2011).

Women often turn to informal supports and confide in family and friends about their experience of violence (Fanslow & Robinson, 2010; Du Mont, Forte & Cohen, 2005). This finding highlights the importance of educating the general public on violence against women and how to support someone who has experienced violence, as well as advertising services and resources available in the community supports (Laing, Humphreys, & Cavanagh, 2013: 62) so that if a woman discloses to a family member or friend, they can be directed to sexual assault and/or domestic violence related services for formal help. Offering education on domestic violence and information on services available are essential to empowering women who have experienced abuse because they are often isolated and intimated into seeking help.
**Lack of services for children.**

Despite previous beliefs that children are peripheral and unaffected by violence between their parents, domestic violence can have a profound impact on child witnesses including behavioural, physical, emotional and psychological effects (Hester et al., 2007; Holt, Buckley & Wheelan, 2008; Chiodo et al., 2008). Literature examining domestic violence service provision has noted the limited availability of services for children who witness and/or experience domestic violence (Bell & Kulkarni, 2006), congruent with the findings of the current study. One woman contrasts the availability of SADV related services for women and children in the community:

**Interviewer:** Did you feel that [agency] provided you with support?

**Participant:** Not when it came to my son – not at all – zero. When it came to me, it was a different story right... If I come [to agency] we don’t ever talk about – I mean we’re working on myself, but... so they don’t really have a lot of services for the kids [at agency], but [agency] was awful. – Woman #20

The consistency in literature and this research study related to the lack of services available for children is troubling given the detrimental impact of domestic violence can have on children. The limited availability of services suggests that perhaps children are forgotten victims of domestic violence.

**Moving Forward: Recommendations for Improved Sexual Assault and Domestic Violence Service Provision**

The current section highlights this researcher’s recommendations for addressing violence against women and improving sexual assault and domestic violence service provision within a community response model, which are informed by the findings of the current research study.
1. Increase state funding to address women’s basic needs, such as housing, transportation and financial assistance, to ensure that all women have access to services and supports which we know is an important part of violence prevention, as well as safety and the management of violence against women. It is important that service providers understand that women’s experiences of violence do not occur in a vacuum, rather their experiences are impacted and managed within larger social, legal and political contexts. Thus, addressing women’s basic needs will help women focus on coping and managing violence and navigate the system with greater ease.

2. Agencies who respond to women who have experienced violence must develop institutional ways to integrate the importance of a caring response via staff training and meetings so that service providers do not lose sight of demonstrating care.

3. Examine and address staff burnout, which is common among service providers that offer social services, and can help reduce a non-caring response by service providers when interacting with women who have experienced violence.

4. Agency developed and implemented (internal) audits, can be used systematically as a way to collect and respond to feedback from service users.

5. Reevaluate agency intake processes to ensure that service users are afforded privacy in order to make them feel more comfortable disclosing experiences of violence.

6. Service providers should be transparent with women about completing a risk assessment. In other words, it is important that service providers clearly explain the purpose of a risk assessment so that women’s experiences of violence can be validated, which was identified by the current research study as a benefit for service
users and cannot be realized unless the woman understands the purpose of performing a risk assessment.

7. Ensure that all service providers can offer basic safety planning strategies and, if necessary facilitative an active referral for in-depth safety planning. An active referral may involve calling a new service provider on behalf of the woman or accompanying her during her first appointment with a new service provider.

8. Service providers offer active referrals to other service providers to ensure that women are connected with services and supports to address their interconnected needs. Active referrals help connect women to other service providers, which may include making a phone call to a new service provider or accompanying a woman to her first appointment with a new service provider.

Implications

Sexual assault and domestic violence service provision.

The findings of the current study have implications for the way in which service providers can improve service delivery for women. First and foremost, the findings of this research revealed that it is necessary to understand the broader context in which women live to comprehend and appreciate their experiences of violence. Penning-Zoellner (2009) assert “the current focus on individual women does not address or even begin to eliminate the institutional structures in society that support intimate partner violence against women particularly barriers to women’s economic security” (p. 542). Increased government funding is needed to attend to women’s basic needs such as: housing, food, access to transportation, childcare subsidies, allowing women to focus on coping and rebuilding their lives after abuse. Second, how a woman is treated is a key
component of combating violence against women at the local level. Women’s experiences of service provision were found to be largely contingent on how they are treated by a service provider and can impact her willingness to continue accessing and receiving services. Positive experiences were found to be empowering for women. This is an important finding and is a simple way that agencies can guide their staff on how they can improve the delivery of domestic violence and sexual assault services. Third, privacy, advocacy and accompaniment, and referrals were appreciated by the women and are additional ways in which service providers can improve a woman’s experience accessing and receiving services. Finally, feelings of disbelief after a disclosure of SADV are common among women who have experienced violence. Existing research has documented the benefits of performing a risk assessment for service providers. However, the findings of this study found that completing a risk assessment was beneficial for women because it helps to validate her experience. This finding challenges service providers to think about the purpose of performing a risk assessment beyond their own benefit. This evaluation research provides insight into what women need and what matters to them when seeking formal support related to their experience of sexual assault and/or domestic violence.

**Sociological and criminological literature.**

The current research study contributes to the sociological and criminological on domestic violence and sexual assault service provision through the inclusion of women’s voices. Existing research on risk assessment has predominantly documented the purpose and benefits of performing a risk assessment for service providers. The current study found that conducting a risk assessment has benefits for women. Performing a risk
assessment with a woman helped her to recognize and label her experiences as abuse and it helped to validate women’s experiences of abuse. Moreover, the findings of the current study contribute to the limited evaluation research on CCRs, specifically from the perspective of the service user. The women revealed that there is little evidence of coordination and collaboration between members of the Action Committee. The findings suggest that it might not be enough to have a coordinated response in place, and perhaps members of coordinated responses need to make more of a concerted effort to collaborate to improve the social response to violence against women at the local level.

Finally, this research study offers a theoretical framework for understanding domestic violence and sexual assault service provision. Theoretically, collaboration has been touted as the “gold standard” for improving domestic violence and sexual assault service provision, despite the limited empirical evidence. This research study employed an integrated theoretical framework using feminist intersectionality and collaboration to better understand women’s experiences accessing and receiving services and the need for inter-agency collaboration because women’s needs are interdependent, rather than isolated. Feminist intersectionality and collaboration theories work well as an integrated approach to understand how to improve service delivery. However, there is a disconnect between our theoretical understanding of women’s experiences of violence and the operation of the current social response, which is referred to as the “social problem apparatus” (Walker, 1990). The social problem apparatus refers to the fragmented response to violence against women, which requires women to go to multiple service providers to address each need individually, assuming that women’s needs are isolated (Walker, 1990). Thus, the system response to violence against women is set up in a way
that is not conducive to coordination and collaboration. In fact, the current social response to sexual and domestic violence counters a collaborative model of service delivery, and it is not surprising that coordination and collaboration is lacking among service providers. Although an integrated theoretical framework combining feminist intersectionality and collaboration theories offers an understanding of how to better respond to women, it will not work the response currently in place.

**Community engaged research (CEnR).**

The current research study employed a CEnR framework and relied on principles of CES, CBR and PAR to respond to the needs of the Action Committee, which was to evaluate the Protocol. The Protocol was implemented to improve service delivery in Guelph-Wellington for women who have experienced sexual assault and/or domestic violence. The Action Committee was interested in hearing about women’s experiences accessing and receiving services from the Action Committee member agencies. Conducting this research study in partnership with the Action Committee provided the research with authenticity, which would not have been possible without their participation. Moreover, this research study fostered relationships between the Action Committee and the University of Guelph, which future faculty and students may benefit from. Few students in the departments of Sociology and Anthropology, and Political Science at the University of Guelph have explored CEnR. This study provides evidence that research conducted through community-university partnerships can be beneficial for graduate students, while also providing valuable data to community organizations who often do not have the funding or resources to conduct rigorous academic research. More specifically, this evaluation research provided this researcher with various scholarship
opportunities including: conference presentations, publications on the process, findings and community engagement for graduate students, a knowledge mobilization video as well as a Master’s thesis. The mutual benefit for faculty, students and community partners engaging in CEnR provides a rationale for promoting and continuing to conduct collaborative research studies.

Limitations

The findings of the current research study contribute to the sociological and criminological literature on CCRs as well as sexual assault and domestic violence service provision. However, the findings should be considered in light of the study’s limitations. First, despite a concerted effort by the research team to recruit women from the county, only a small number of rural women participated in this research study. Thus, the overall findings of this research study may not reflect the unique barriers and challenges experienced by women who reside in rural regions. Second, due to the small and non-representative sample, the findings cannot be generalized to a larger population. Third, the sample of women that participated in the current research study primarily experienced domestic violence by an intimate partner and may not accurately capture experiences of women who have been victimized by sexual violence. Fourth, the graduate student researchers that conducted interviews with service users had limited knowledge of the Action Committee member agencies and did not have knowledge of the larger systems women may encounter. It was important that the interviewers were perceived by research participants to be impartial and disconnected from the Action Committee and the member agencies so that participants felt comfortable sharing their experiences.
Future Research

The current research study has provided useful information about one Ontario community’s sexual assault and domestic violence protocol, which guides the work of service providers of a VAWCC. This study also provided insight into women’s experiences of sexual assault and domestic violence service provision. Further research is needed to conceptualize quality sexual assault and domestic violence service provision (Bell & Kulkarni, 2006) in an effort to offer a greater understanding of elements of service delivery that are important to women. Moreover, it would be useful to examine service user’s utilization of sexual assault and domestic violence services as well as factors that increase effectiveness and help to support women to survive and move forward with their lives. Further research on utilization and effectiveness of domestic violence and sexual assault services would help to improve service provision and lead to more effective intervention for all women (Postmus et al., 2009).

Moreover, as mentioned in chapter two, evaluation research on DVCCs and SARTs is lacking. Evaluation research on CCRs is needed because DVCCs and SARTs have proliferated across North America and the United Kingdom based on theoretical assumptions, which is not a valid premise to proceed. In light of the limited evaluation research on CCRs, there is limited empirical research to suggest that DVCCs and SARTs are in fact improving service delivery for women. Additionally, it is necessary to collect data from women who have encountered service providers involved with the coordinated response to understand their experiences from their perspective. Much of the research on CCRs are single site studies, it would be useful to for future research to conduct multi-site studies and compare CCRs across jurisdictions and the extent to which they are
coordinating and collaborating. Given the extensive literature on barriers and challenges to multi-agency collaborative work it makes it easy to accept the poor coordination and collaboration occurring between service providers that are members of a CCR. Instead, it would be beneficial to research facilitators of coordination and collaboration between multiple service providers.
References


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Appendices

Appendix A: Action Committee Member Agencies

- HIV/AIDS Resources and Community Health (ARCH)
- Canadian Mental Health Association Waterloo Wellington Dufferin (formerly Trellis Mental Health and Developmental Services)
- Care and Treatment Centre for Sexual Assault and Domestic Violence – Guelph General Hospital
- Child Witness Centre
- Community Torchlight Wellington/Dufferin
- County of Wellington Social Services
- Crown Attorney's Office for Wellington County
- Family & Children's Services of Guelph and Wellington County
- Family Counselling and Support Services for Guelph-Wellington
- Guelph Community Health Centre
- Guelph Humane Society
- Guelph Police Service
- Guelph-Wellington Women In Crisis
- Homewood Community Addiction Services (CADS)
- Immigrant Services
- John Howard Society of Waterloo-Wellington
- Legal Aid Clinic
- Legal Aid Ontario
- OPP, Wellington County
- Parkwood Gardens Church
- Probation and Parole Services, Guelph and Wellington County
- Sanguen Health Centre
- University of Guelph
- Upper Grand District School Board
- Victim Services Wellington
- Victim / Witness Assistance Program
- Welcome In Drop-In Centre
- Wellington Catholic District School Board
- Wellington-Dufferin-Guelph Public Health Services
Appendix B: Research Team Profile and Roles

Danielle Bader

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

Linzy Bonham

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

Sara Crann

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

Melissa Horan

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

Mavis Morton

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

Ashley is a registered community social worker. Ashley is a recent graduate from the University of Windsor where she obtained a Masters of Social Work. She is passionate about community social work, feminist issues, and advocating for individuals with a developmental disability. Ashley was a graduate student researcher for this research study.
Appendix C: Service User Recruitment Poster (Guelph)

Are you a woman who has experienced domestic violence, sexual abuse or sexual assault?

We want to hear from you about your positive or negative experiences receiving services in Guelph and Wellington County.

We are looking for research participants who:
- Are women over 18
- Have had your first contact with counselling agencies, the police, shelters, the courts and/or other social services since 2010 for sexual or domestic violence
- Are interested in doing a confidential, one hour face-to-face interview

To express your interest in this research, please contact us at 519-836-1110 x222.

Interview participants will receive $25.

Arrangements for transportation, interpreters, and childcare can be made.
Appendix D: Service User Recruitment Poster (Wellington County)

Are you a woman in Wellington county who has experienced domestic violence, sexual abuse or sexual assault?

We want to hear from you about your positive or negative experiences receiving services in Guelph and Wellington County.

We are looking for research participants who:
- Are women over 18
- Have had your first contact with counselling agencies, the police, shelters, the courts and/or other social services since 2010 for sexual or domestic violence
- Are interested in doing a confidential, one hour face-to-face interview

To express your interest in this research, please contact us at 519-836-1110 x222.

Interview participants will receive $25.

Interviews are available in Wellington county.
Arrangements for transportation, interpreters, and childcare can be made.
Appendix E: Service User Interview Questions

I would like to start by asking you some questions about yourself:

**Demographic Information**

1. What area of the city or county do you live in?

<table>
<thead>
<tr>
<th>City of Guelph</th>
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<tbody>
<tr>
<td>Wellington County</td>
</tr>
<tr>
<td>• Minto</td>
</tr>
<tr>
<td>• Wellington North</td>
</tr>
<tr>
<td>• Central Wellington</td>
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<tr>
<td>• Mapleton</td>
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<td>• Puslinch</td>
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2. What is the highest level of education/school you have completed? If currently enrolled, highest degree received.

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<thead>
<tr>
<th>Less than highschool</th>
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<tbody>
<tr>
<td>Some high school, no diploma</td>
</tr>
<tr>
<td>High school graduate</td>
</tr>
<tr>
<td>Some college (no diploma)</td>
</tr>
<tr>
<td>College diploma</td>
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<tr>
<td>Some university (no degree)</td>
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<tr>
<td>Undergraduate degree</td>
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<tr>
<td>Masters degree</td>
</tr>
<tr>
<td>Professional degree</td>
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<tr>
<td>Doctoral degree</td>
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3. What is your age?

<table>
<thead>
<tr>
<th>Age Range</th>
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<tbody>
<tr>
<td>18-24 years old</td>
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<tr>
<td>25-34 years old</td>
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<td>35-44 years old</td>
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<tr>
<td>45-54 years old</td>
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<tr>
<td>55-64 years old</td>
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<tr>
<td>65-74 years old</td>
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<td>75 years or older</td>
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4. Where were you born?

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<tr>
<th>Location</th>
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<tbody>
<tr>
<td>In Canada</td>
<td></td>
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<tr>
<td>Outside of Canada (specify country)</td>
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5. What is the language you first learned in childhood and still understand?

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<tr>
<th>Language</th>
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<tbody>
<tr>
<td>English</td>
<td></td>
</tr>
<tr>
<td>French</td>
<td></td>
</tr>
<tr>
<td>Outside of Canada (specify country)</td>
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</tbody>
</table>
6. What race or ethnicity do you identify as?

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<thead>
<tr>
<th>Race/Ethnicity</th>
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<tbody>
<tr>
<td>White</td>
<td></td>
</tr>
<tr>
<td>Chinese</td>
<td></td>
</tr>
<tr>
<td>South Asian (East Indian, Pakistani, Sri Lankan, etc.)</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td></td>
</tr>
<tr>
<td>Filipino</td>
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<tr>
<td>Latin American</td>
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<tr>
<td>Southeast Asian (e.g. Vietnamese, Cambodian, Malaysian, Laotian, etc.)</td>
<td></td>
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<tr>
<td>Arab</td>
<td></td>
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<tr>
<td>West Asian (e.g. Iranian, Afghan, etc.)</td>
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<tr>
<td>Korean</td>
<td></td>
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<tr>
<td>Japanese</td>
<td></td>
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<tr>
<td>North American Indian/Aboriginal</td>
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<tr>
<td>Metis</td>
<td></td>
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<tr>
<td>Inuit</td>
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<tr>
<td>Other</td>
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7. What is your marital status?

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<tr>
<th>Marital Status</th>
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<tbody>
<tr>
<td>Single</td>
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</tr>
<tr>
<td>Legally married</td>
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<tr>
<td>Separated</td>
<td></td>
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<tr>
<td>Divorced</td>
<td></td>
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<tr>
<td>Widowed</td>
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</table>
8. Do you have children? If so, what are their ages?


9. What is your total annual income?

<table>
<thead>
<tr>
<th>Income Range</th>
<th></th>
</tr>
</thead>
<tbody>
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<td>Under $20,000</td>
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<tr>
<td>$20,000-39,000</td>
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<tr>
<td>$40,000-59,000</td>
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<td>$60,000-79,000</td>
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<td>$80,000-99,000</td>
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<tr>
<td>Over $100,000</td>
<td></td>
</tr>
</tbody>
</table>

Main Survey
Now I am going to ask you some questions about what led you to have contact with one of the Protocol agencies.

10. Can you please briefly describe the situation or experience of abuse or assault that led you to seek assistance from service providers?

   a. What type(s) of abuse/violence would you say you experienced during this time?

<table>
<thead>
<tr>
<th>Type</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Emotional</td>
<td></td>
</tr>
<tr>
<td>Verbal</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td></td>
</tr>
<tr>
<td>Financial</td>
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<tr>
<td>Sexual</td>
<td></td>
</tr>
<tr>
<td>Spiritual</td>
<td></td>
</tr>
</tbody>
</table>

   b. What was your relationship to the person who abused you?

11. What service providers in Guelph or Wellington County have you told about your experience of domestic or sexual violence? (SHOW LIST OF PROTOCOL AGENCIES)

12. Have you had INVOLUNTARY contact with service providers related to sexual and/or domestic violence such as the police, Family and Children Services, crown attorney, victim services, hospital? If so, which ones?
13. *Now I would like to ask you some questions about EACH of the protocol agencies you said you had contact with because of the experience of abuse/assault you talked about.*

Please answer the following questions based on your early involvement (e.g. first few times you met with or talked to them) with each of the service providers you had contact with once you told them that you were experiencing or had experienced domestic or sexual violence:

Q. 13 Each protocol agency with which the woman had early contact:

<table>
<thead>
<tr>
<th>Question</th>
<th>Agency</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Was the location private? Where was it?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>b. Did agency ___ clearly describe their services or mandate?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Did agency ___ clearly describe the type of assistance that you might want and/or need?</td>
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<tr>
<td>d. Did agency ___ explain confidentiality and the limits to confidentiality to you?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>e. Did agency ___ ask you questions about the person who had abused/assaulted you to help you and them understand how much danger you were in?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>f. Was a Risk Assessment/Screening Tool form filled out by you or on your behalf? <em>(show example)</em></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>g. Did agency ___ talk to you about your safety? Did they help you to make clear safety plans?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Did agency ___ listen to your story in a way that made you feel heard?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. Did agency ___ make you feel comfortable?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. Did you have an opportunity to ask questions?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>k. Did you feel as though your questions were answered to your satisfaction?</td>
<td></td>
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<td>---</td>
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<td></td>
</tr>
<tr>
<td>1.</td>
<td>Was agency ___ respectful?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Did agency ___ inform you about some of your choices and options? E.g. That you might decide to stay or leave your current relationship or you may or may not want to get a lawyer, go to counseling, have a sexual assault kit done etc?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>If you answered yes to the previous question, did agency ___ outline the potential implications of these choices and options?</td>
<td></td>
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<tr>
<td>4.</td>
<td>Did agency ___ refer you to any other service providers for other types of assistance and/or support?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>If yes, who?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Did you ever make contact with the referrals that were given to you? If yes, what happened? If no, why not?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Did you feel that agency ___ provided you with support? What was said or done that was supportive?</td>
<td>Specify:</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Overall, how did agency ___ help/not help? Were there any needs/issues that you experienced at that time that they did not help with?</td>
<td>Needs/Issues?</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Using a scale of 1 to 5 where 5 means very helpful and 1 means very unhelpful, how helpful agency ___ was at that time?</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
14. Regarding ALL THE SERVICES that you used were there any barriers or challenges in accessing or receiving services?
   a. If so, what were they?

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

15. Did the different service providers you were working with ever talk to each other with your permission to coordinate their services?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
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<td></td>
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</tbody>
</table>

16. Did the service providers ever meet together with you in a case conference or community consultation? If so, was it helpful? Why? If not, would this have been helpful for you?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
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<tbody>
<tr>
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</table>

17. When you look back on this situation, what were the most helpful things that the service providers were able to offer? The least helpful things that were provided?

<table>
<thead>
<tr>
<th>Most Helpful</th>
<th>Least Helpful</th>
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<tbody>
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</table>

18. Were there other or related issues/needs you had at the time that were not addressed? If so, what were they? (e.g. financial, housing, food, childcare, employment, transportation etc.)

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
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</table>
19. What could have been done/offered or done differently that you think might help another woman in this situation?

<table>
<thead>
<tr>
<th>Done/offered such as?</th>
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<tbody>
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<td></td>
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</table>

Concluding Questions
20. How did you find out about this research?

21. Why did you want to participate? What did you think it might do?

22. What was this interview experience like for you? Would you make any changes to the questions we asked or the way we asked them?

23. Would you like to be contacted when the research is further along to give feedback on the findings? This would be done in a focus group with other women who have also completed interviews.

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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</table>

24. What term do you prefer to refer to yourself for the purpose of this research?

<table>
<thead>
<tr>
<th>Term</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service User</td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td></td>
</tr>
<tr>
<td>Survivor</td>
<td></td>
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<td>?</td>
<td></td>
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</tbody>
</table>
25. Do you have any other comments or suggestions?

THANK YOU VERY MUCH FOR TAKING THE TIME TO GIVE US YOUR FEEDBACK.
Appendix F: Service User Consent Form

COLLEGE OF SOCIAL AND APPLIED HUMAN SCIENCES
Department of Sociology and Anthropology

SERVICE USER CONSENT TO PARTICIPATE IN RESEARCH

RESEARCH PROJECT TITLE: First Response Protocol Evaluation

You are asked to participate in a research study conducted by Dr. Mavis Morton, Assistant Professor, Linzy Bonham, Action Committee Coordinator, Guelph-Wellington Action Committee on Sexual Assault and Domestic Violence, Danielle Bader, Masters student, Department of Sociology and Anthropology, University of Guelph, Ashley Murphy-Kilgar, Masters student, University of Windsor, Sarah Crann, Intern, The Research Shop, University of Guelph, Dr. Anne Bergen, Postdoctoral Fellow, Institute for Community Engaged Scholarship/Research Shop, University of Guelph.

If you have any questions or concerns about the research, please feel free to contact Dr. Mavis Morton, Assistant Professor, Department of Sociology and Anthropology at mortonm@uoguelph.ca or by calling 519-824-4120 x52576.

PURPOSE OF THE STUDY

The purpose of the current proposed project is to evaluate whether or not the Protocol is working well in our community from a service provider and service user perspective. The Protocol’s purpose is to facilitate a consistent, caring first response and effective follow up and support for women and children. The protocol evaluation will examine the extent to which the protocol objectives are being met, and to what extent the current protocol objectives meet the needs and issues facing women and children who experience sexual and/or domestic violence.

PROCEDURES

If you volunteer to participate in this study, we would ask you to do the following things:

a) Interested service users will consent to be screened for eligibility upon contacting the researchers. This will be a short set of questions which will help ensure we hear from women who have experienced domestic violence and/or sexual assault between 2010 and 2012 and who have used services from at least one protocol member agency.

b) Sign and return the attached consent form or verbally agree after receiving a copy.

c) Participate in a face to face interview which will take approximately 60 minutes. The interviews will be digitally recorded and transcribed.
The findings of this evaluation will be published as a report for the Action Committee member agencies and on the Action Committee website, an online report in the document repository at theresearchshop.ca, and may be distributed in other forms, including, but not limited to, grant proposals, scholarly publications, and policy reports. Research findings will be available to participants who are interested at a time to be determined by the investigator.

**POTENTIAL RISKS AND DISCOMFORTS**

There may be some psychological and/or social risks and discomforts associated with participating in this research project. Specifically, the interview may cause participants to recall experiences of sexual and/or domestic violence which may be upsetting or uncomfortable. Participants may also be concerned about someone seeing them in a space like Women in Crisis for the interview. These potential risks will be managed by using the following procedures:

a) The participant will not be anonymous but the information provided will be kept confidential. Access to raw data will be limited to authorized researchers from the University of Guelph and the Action Committee. Although the face-to-face interview means the research is not anonymous, your name will not be associated with any comments.

b) Participants will be assigned an identification code and confidential information will be kept separate from any identifying information of the participants. Identifying information will be removed from service user comments before using this in any publication or dissemination materials.

c) Original audio-recordings will be securely erased from the audio-recorder after the interviews are saved on encrypted media.

d) All hard copies of research obtained will be kept under lock and key at the Institute for Community Engaged Scholarship/Research Shop or with the Primary Investigator.

**POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY**

Service users will have an opportunity to provide valuable feedback to service providers in the community about their experiences and how services can be improved. Service users are also able to share their stories of experiencing violence and of how they coped or are continuing to cope with these experiences. Sharing stories of survival can be an empowering experience for women and we aim to honour the women’s voices in the presentation of the research.

This research will allow Protocol member agencies of the Guelph-Wellington Action Committee on Sexual Assault and Domestic Violence to reflect on their services, ongoing barriers to service and room for improvement. By evaluating the First Response Protocol, we aim to understand how the Protocol is working or not working in our community. This information will allow us target our improvements to services for those who have experiences domestic or sexual violence in Guelph and Wellington County.

**PAYMENT FOR PARTICIPATION**

Participants will be offered $25.00 for participation.
CONFIDENTIALITY

Service user interviews will be face-to-face, and therefore these data will not be anonymous. However, all data will be treated as confidential by the researchers. Specifically, participant confidentiality will be maintained as participant names and contact information will be kept separate from participant data, which will be identified only through an ID code. There will be no way to match ID codes to names of participants. You will not be identified individually as a participant in this research. Your name will not appear in the interview notes or recording.

PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. During the study, you may choose not to answer any question. After the study is complete, your data cannot be withdrawn as it will be impossible to distinguish individual responses from the responses of the other participants. However, you may refuse to answer any question and still remain in the study. The investigator may withdraw you from this research if circumstances arise that warrant doing so.

RIGHTS OF RESEARCH PARTICIPANTS

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. This study has been reviewed and received ethics clearance through the University of Guelph Research Ethics Board. If you have questions regarding your rights as a research participant, contact:

Research Ethics Coordinator
University of Guelph
437 University Centre
Guelph, ON N1G 2W1

Telephone: (519) 824-4120, ext. 56606
E-mail: sauld@uoguelph.ca
Fax: (519) 821-5236
SIGNATURE OF RESEARCH PARTICIPANT

I have read the information provided for the study “First Response Protocol Evaluation” as described herein. My questions have been answered to my satisfaction, and I agree to participate in this study. If I participate in a telephone interview, I give permission to be audio-taped. I have been given a copy of this form.

Name of Participant (please print)

Signature of Participant

Date

SIGNATURE OF WITNESS

Name of Witness (please print)

Signature of Witness

Date
Appendix G: Deductive and Inductive Codes for Qualitative Analysis

Deductive Codes

- Consistent and caring response
  - Confidentiality
  - Privacy
  - Safety Planning
  - Risk Assessment
- Coordination/Collaboration
- Service User Needs

Inductive Codes

- Barriers Accessing Services
- Fear
- Gender solidarity
- Hesitation to disclose
- Implications of Service Use
- Inconsistency with workers from same agency
- Information and knowledge about services
- Involuntary Contact
- Lack of Social Capital/Isolation
- Non disclosure of sexual violence
- Medicalization/Psychologizing/Pathologizing
- Organizational Structure
- Personal Agency
- Questions about the Interview
- Resourcefulness
- Service Provider environment
- Service Delivery
- Service Provider Skills

- Sexual and domestic violence (experiences/impacts)
  - Understanding Abuse and Impacts
- Suggestions for Improvement
- Support for child

- Supportive/Helpful
  - Accomodating
  - Advocacy/Accompaniment
  - Attentiveness/Dismissiveness
  - Being heard, believed, accepted
  - Building Skill
  - Caring
  - Empathy
  - Judgment
  - Knowledgeable
  - Overwhelmed
  - Responsibilization
  - Tangible Assistance/Resources
  - Understanding
  - Validation
Appendix H: Service User Demographic Profile

Figure 1 – Service User Age

Figure 2 – Service User Race/Ethnicity
Figure 3 – Service User Education

- University graduate degree
- University undergraduate degree
- College Diploma
- Some college/university
- Highschool
- Some highschool
- Less than highschool

Figure 4 – Service User Marital Status

- Single 46%
- Married/Common-law 27%
- Separated/Divorced 27%

Figure 5 – Service User Annual Income

- Under $20,000 8%
- $20,000-39,000 8%
- $40,000-59,000 4%
- $60,000-79,000 79%