Evaluation of the Green Valley Domestic Violence Service (GVDVS)

Final Report – April 2005

Author: Dr Lesley Laing

with assistance from Associate Professor Jude Irwin and Cherie Kennaugh, School of Social Work and Policy Studies, University of Sydney

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Acknowledgments

This project could not have been competed without the generosity and expertise of many people. I gratefully acknowledge: the unique contribution to this project by the fourteen women who shared their stories and expert understandings of the type of assistance that women need to move towards lives free of violence and abuse; the staff of the GVDVS who were committed to receiving feedback on the progress of the development of the service, in order to continue to refine and improve it; the Steering Committee members and others who provided insights into the development of the service and the interagency response to domestic violence in Green Valley; the service providers in the organizations in the Liverpool area who participated in interviews about the role and impact of the GVDVS; research assistant Cherie Kennaugh for her hard work in conducting and transcribing interviews; and Associate Professor Jude Irwin for taking the lead role in the file audit. The methodology was informed by similar research into coordinated responses to domestic violence that was conducted under the Federal government's Partnerships Against Domestic Violence (PADV) initiative by Keys Young. The survey guides used in this project were based on those developed in this PADV initiative.

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Executive Summary

Green Valley Domestic Violence Service (GVDVS)

The GVDVS is a pilot project, funded as one of a number of Integrated Case Management (ICM) projects within the NSW Government's Community Solutions and Crime Prevention Strategy. It was initially funded for two years to October 2004, and subsequently extended to December 2005.

The GVDVS is an innovative approach aimed at improving the response to women and children experiencing domestic violence, through a partnership between NSW Health, the Department of Community Services, Police, Housing and a range of non-government agencies. Health is the lead agency. The development of the GVDVS builds on previous community development and regeneration projects in Green Valley.

Key features incorporated into the design of the GVDVS are:

- A 'Fax-back' system to facilitate referrals from Police to the GVDVS.
- The provision of counselling and support services by specialist personnel.
- The inclusion of a DoCS casework specialist within a domestic violence team based in the Health sector, as part of the Health/DoCS partnership
- The inclusion of Health staff with expertise in child protection and AOD issues, because these issues commonly intersect with domestic violence.

Aims of the GVDVS

The GVDVS aims to:

- improve the service system's capacity to respond to domestic violence in Green Valley
- improve the wellbeing of women, children, young persons and families
- promote community awareness about domestic violence

Staffing and resources

The GVDVS team comprises:

- Three positions funded by Community Solutions: 2 domestic violence counsellors (Health – 1.8 FTE) and one full time DoCS child protection casework specialist (vacant for approximately 12 months)
- Additional positions funded by SWSAHS: Part-time counsellor, alcohol and other drugs (AOD) and counsellor located with the Child Protection and Family Support (CPFS) team, who takes referrals from the GVDVS.
- The team also has brokerage funds to enable the delivery of a flexible service (e.g. assistance for women with removal expenses).
- The GVDVS reports to the manager, CPFS.
- The project is overseen by an interagency group, commonly referred to as the Steering Committee, with the formal title of Child and Family Multi-disciplinary Team Steering Committee.

The GVDVS model

In comparison with other Australian efforts to develop coordinated responses to domestic violence, the GVDVS is a modestly resourced model, with efforts directed primarily at the *service delivery*, rather than at the policy level1. In this sense it is a 'ground up' model, with the interagency response driven by a specialist domestic violence service. This is similar to one of the longest established coordinated responses in Australia, the Gold Coast Domestic Violence Integrated Response (GCDVIR). It stands in contrast to the other Australian well-established coordinated response, the ACT Family Violence Intervention Program (FVIP) where the stimulus for interagency coordination is at the policy level, via a statutory Domestic Violence Prevention Council which developed the policy framework for the implementation of the ACT FVIP.

Most Australian specialist women's domestic violence services have staff and programs specifically working with children exposed to domestic violence. The inclusion of a member of the CPFS team in the GVDVS is consistent with this approach. However, the inclusion of a statutory child protection worker is a novel feature of the GVDVS approach.

The evaluation

The School of Social Work and Policy Studies at the University of Sydney was contracted to undertake this evaluation by South Western Sydney Area Health Service (now Sydney South West Health). The evaluation commenced in May 2004 following approval from the SWSAHS Ethics Committee and the agreement of contractual arrangements. An interim report was submitted in August 2004. The evaluation was completed in March 2005.

Methodology

The methodology was developed to be responsive to a number of factors:

- The aims of the GVDVS
- The need to try to capture the developmental and evolving nature of the GVDVS.
- The dynamics of domestic violence which shape domestic violence service delivery and research
- The need to balance making women survivors' voices central to the research with the ethical requirement to consider women and children's safety when participating in research.
- The uncertain timeframe available for the evaluation project
- Consistency with the methodologies used in recent Australian evaluations of co-ordinated, interagency responses to domestic violence

Because of the developmental and evolving nature of the GVDVS, a 'formative' or 'process' evaluation was regarded as most appropriate. This involved the collection of data from a range of sources:

1 These terms are used in the Evaluation of the ACT FVIP by Keys Young (2000), and are used here to enable comparison with other Australian evaluations of coordinated responses.

- semi-structured interviews with women clients of the GVDVS
- semi-structured interviews with staff of the GVDVS about the process of service development and the barriers and opportunities for enhanced interagency cooperation
- semi-structured interviews with 'Key Informants' – senior representatives of participating interagency partners, and/or participants on the GVDVS steering committee
- semi-structured interviews with service delivery personnel from human services agencies in contact with those affected by domestic violence in the Liverpool area
- a review of data collected by the GVDVS, both with respect to its direct client service activities (file audit), and its service development, community education and training activities.
- Participation at some steering committee meetings, the Steering Committee Planning Day in February 2005 and participation in the staff interview with urbis keys young as part of the wider ICM evaluation.

The context of the evaluation

The findings of this evaluation have been placed within the context of the current research on good practice in:

- coordinated responses to domestic violence
- service provision to women and children affected by domestic violence
- improving collaboration between statutory child protection and specialist domestic violence services.

Since this is a pilot project located within the Health sector, an important part of the context for these findings is the growing body of research about the impacts of domestic violence on women's physical and mental health. For example, a recent Australian study found that domestic violence is:

...responsible for more ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking. (VicHealth, 2004, p.8).

It is increasingly recognised that domestic violence intervention that increases the safety of women and reduces the physical and mental health impacts of domestic violence, can play a pivotal role in improving the social and environmental context of children's lives.

Definitions

This evaluation adopts the definition of coordinated/integrated domestic violence service provision developed by the Australian Domestic and Family Violence Clearinghouse:

Integrated service provision means: coordinated, appropriate, consistent responses aimed at enhancing victim safety, reducing secondary victimisation and holding abusers accountable for their violence. (Mulroney, 2003)

- This definition highlights that coordinated responses are a *means* to achieving the primary goal of enhancing victim safety and the secondary goal of increasing perpetrator accountability, rather than the key goal in itself.
- Also highlighted in this definition is the concept of secondary victimisation – the recognition that women and children may experience harm, in addition to the direct effects of domestic violence, if their attempts to seek help are met with inappropriate responses. Examples of responses that may cause secondary victimisation include

blaming women for their victimisation, blaming women for the harm caused to children by men's violence and abuse, providing inaccurate information about resources, and not addressing safety issues.

Findings from the research literature relevant to this evaluation

- Developing a coordinated response to domestic violence is a complex, ongoing task. For example, the best known international example (in Duluth, US) has been operating for over 20 years.
- There are few well-developed models of coordinated responses by specialist domestic violence and statutory child protection services.
- With respect to service delivery to women experiencing violence, there is strong empirical evidence available that "community based advocacy", i.e. interventions that: *"...help survivors of domestic violence navigate the systems involved in the community response as they attempt to acquire needed resources.* (Allen et al., 2004, p. 1017)", are effective in increasing women's acquisition of needed community resources, quality of life and social support and in decreasing violence experienced.
- Although no one safety strategy is effective for all women, the two strategies most likely to make the situation better are contacting a domestic violence victim service program and actually staying at a domestic violence shelter, i.e. specialist domestic violence services are an essential component of the community response to domestic violence.
- Recent Australian research identifies that good practice requires a calibration of the service response, so that the type of intervention offered matches the stage of the woman's process of dealing with domestic violence. This challenges global notions such as "early intervention" and suggests that notions of *appropriate* intervention are more useful in assessing effectiveness.

Summary of Key Findings

- The data from this evaluation provides strong evidence that the presence of a specialist domestic violence service has been the catalyst for improved interagency responses to domestic violence in Green Valley.
- This indicates that the GVDVS has been extremely successful, within the model adopted, of driving change from the *service provision* level.
- Its role in driving change has been aptly described by Key Informants as the '**hub to coordinate other agencies for sustainable outcomes**'.
- The successful partnership with the Department of Housing provides an example of how such partnerships can provide women with access to a "seamless service" that both reduces the possibility of secondary victimisation for women escaping violence and makes an important contribution to increased safety for women and their children through providing swift access to safe accommodation.
- The partnership with Police is reported by all the players to have strengthened considerably in the period since the submission of the evaluation Interim Report. The Police provide the majority of referrals to the GVDVS, primarily through the fax-back referral scheme. While the majority of these referrals result in one contact only, this is a new "entry point" for women to receive information about domestic violence and the services available.
- The GVDVS team has, in most instances, forged positive relationships with non-government agencies, particularly with agencies specializing in work with domestic

violence. This is clear example of the success of the GVDVS at building strong interagency partnerships at the service delivery level. It occurred despite strong perceptions in the non-government sector that their expertise and experience had been insufficiently recognized and utilized in the initial policy development stage of the GVDVS.

- The common factor that can be identified as contributing to improved collaboration with Police and Housing is the identification of a specified position as the link between the partner organisation and the GVDVS. In addition to building a strong link, the incumbents in these positions can build capacity within their organisations through the provision of consultation to generalist staff.
- In addition to being the major driver of improved interagency responses to domestic violence, the data from this evaluation provide strong evidence that the GVDVS has developed a model of service delivery to women and children that is consistent with good practice and provides a model of good practice in domestic violence service delivery within the health system. This practice is:
  - *woman-directed*
  - *flexible*
  - *focussed on system-wide advocacy*
  - *calibrated to the woman's stage of dealing with the violence.*
- The GVDVS was established to stimulate new ways of responding to domestic violence. In developing this model of practice, the staff have demonstrated other ways in which counsellors within health services can respond to domestic violence. This makes the GVDVS a valuable training and consultation resource for the Health system.
- The data indicate consensus that progress in achieving change at the policy level, has been slower than change driven from the service delivery level. The decision to reorient the role of the Steering Committee - to a more explicit focus on facilitating change at the inter-organisational level - reflects the recognition that change at this policy level is the next stage in the further development of the coordinated response.
- The difficulties in resolving the role of the DoCS team member is the clearest example of the lack of progress at the policy level. Although a workable solution was developed at the service delivery level, this is not an issue that could be resolved solely at this level.
- Although the structural attempt to improve services for children exposed to domestic violence by locating a DoCS specialist caseworker as part of the GVDVS team, was not successful, there was considerable evidence that child protection issues and issues of children's exposure to domestic violence are being addressed by the GVDVS.
- The employment of an external consultant with expertise in both child protection and domestic violence has been a successful strategy in developing practice that addresses the safety of both women and children.

Key achievements of the GVDVS

These are discussed in two sections, the first focussing on the teams' direct work with women and children and the second, on their role in stimulating enhanced interagency collaboration.

Direct work with women and children

Both women clients, Key Informants and front line service providers in health and human service organisations reported that the quality of intervention with women and children was extremely high. This work comprised a number of key dimensions:

Counselling and support

- The women clients interviewed were unanimous in their positive evaluation of the interventions provided by the GVDVS. Key themes in their descriptions of their contact with staff were *quality of the relationship* offered by the staff. For women who have been subjected to coercive control, the relaxed, non-hierarchical relationship offered by the staff was a different and welcome experience.
- The women reported receiving *consistent*, *non-judgemental support*, a key component of good practice in domestic violence intervention, particularly with women in the early stages of dealing with violence.
- The women reported that the counsellors *normalised and validated* their experiences and reactions and also *provided accurate information* about services, women's rights, and the nature of domestic violence, drawing on the workers' *specialist knowledge and experience.*
- The importance of the *accessibility and flexibility* of the service, was noted by many of the women interviewed, and was also noted by service providers in health and human service organisations.
- For many women, it was important that counselling and support were offered in the longer-term, when they were engaged in the process of *rebuilding a life free of violence* for themselves and their children.
- The fact that the GVDVS offered longer-term support and assistance, beyond crisis intervention, was seen as particularly valuable by other service providers.
- The women also reported that they received assistance for their children to overcome the impact of violence, either through direct work with children, or through the support that enabled them to create a safe and stable environment for their children.
- The women reported a number of important outcomes from their contact with the GVDVS, most commonly: reduced self-blame (accompanied by reassigning responsibility to the perpetrator); a sense of empowerment; freedom from the abuser's control; and improvement in children's well-being.
- These findings were supported by the data from interviews with frontline service providers, many of whom gave examples of high quality work by the team, based on the positive outcomes that they had observed for women.
- The GVDVS is receiving referrals from a broad range of agencies. This reflects its active role in interagency forums and its awareness-raising activities. This makes it a service that is accessible to women at the various phases of dealing with violence.
- The GVDVS is providing an accessible service to women from CALD communities. Although data on the cultural background of clients was not recorded for all women, 44% of those for whom this was recorded, were born overseas in a non English speaking country.

Systemic advocacy

- Dealing with violence and abuse involves women with a complex network of organisations, which may respond in ways that are enabling or that are barriers to their efforts to achieve safety. Women may be involved simultaneously, for example, with the criminal justice and civil legal systems, the Family Court, Department of Community Services, Centrelink, Housing and Immigration Departments, and more.
- The women interviewed gave numerous examples of the ways in which the GVDVS

provided assistance and advocacy to them in negotiating the complex systems involved in escaping violence and establishing a violence-free life.

- This systemic advocacy was also identified by frontline service providers as a unique and valuable component of the service offered: "…that holistic stuff, I can't rave enough about it. It really works, not just dealing with one part of what is going on. They look at the whole picture. The positive outcomes we have seen for mutual clients." (NGO respondent)
- The file audit highlighted the centrality of systemic advocacy to the interventions offered by the GVDVS. In 31% of ongoing cases, between one to three agencies worked in collaboration with GVDVS, while in 28% of ongoing cases, the interagency collaboration involved four or more agencies.

Enhancing interagency collaboration

The GVDVS has been a strong catalyst for improved interagency coordination and collaboration. One aspect to this is the day-to-day contact with agencies while providing systemic advocacy for its women and children clients, as outlined above. Through this contact, the GVDVS was reported by other serviced providers to model good practice, educate and raise awareness, and provide informal consultation and support for those working with victims of domestic violence. The other aspect to enhancing interagency collaboration involves the more formal activities of the GVDVS that are summarised here:

- The GVDVS filled the widely identified gap among service providers, for more resources to offer women and children experiencing violence and abuse. They could refer to a "one stop" service that offered both crisis and longer-term counselling and support, and coordinated a range of other needed services and resources for the client.
- In addition to providing a specialist resource for Green Valley, the GVDVS shared resources through joint work with other agencies, such as co-facilitating groups for women and for children. This enhanced the services that many agencies could offer women and children in Green Valley.
- Over an 18 month period, the GVDVS built community capacity through the provision of training on responding to domestic violence to 304 service providers in 11 agencies. In the same period, 616 service providers in 17 community based agencies in contact with children and families, were provided with training about domestic violence and child protection.
- The GVDVS staff took an active leadership role in interagency forums in the Liverpool area. Their active contribution and leadership was one of the most consistent observations about the GVDVS in the service provider interviews.
- The GVDVS has formally documented interagency policy and procedures with 6 agencies through the development of service agreements.
- The service agreement with the Department of Housing provides a model for the way in which such formal interagency policies and procedures, supported by respectful and solid working relationships, can enhance the safety of women and children escaping domestic violence at the time of greatest risk to their safety, through streamlined processes that do not further traumatise women in crisis.

The report concludes with a number of recommendations to further develop the interagency response to domestic violence in Green Valley.

SECTION 1

Introduction and Methodology

Green Valley Domestic Violence Service (GVDVS)

The GVDVS is a pilot project, funded as one of a number of Integrated Case Management (ICM) projects within the NSW Government's Community Solutions and Crime Prevention Strategy. It was initially funded for two years to October 2004, and subsequently extended to December 2005.

The GVDVS is an innovative approach aimed at improving the response to women and children experiencing domestic violence, through a partnership between NSW Health, the Department of Community Services, Police, Housing and a range of non-government agencies. The non-government agencies offer both broad welfare services and specialist domestic violence services. Health is the lead agency. The development of the GVDVS builds on previous community development and regeneration projects in Green Valley.

Key features incorporated into the design of the GVDVS are:

- A 'Fax-back' system to facilitate referrals from Police to the GVDVS. The contact details of people who consent, are faxed to the GVDVS who make contact within 48 hours. This aims to offer assistance to a group of women who may not have had previous contact with support services, a group of women who could not be responded to through existing Health services, such as community health. There is an emphasis on early intervention with women in crisis.
- The provision of counselling and support services by specialist personnel.
- The inclusion of a DoCS casework specialist within a domestic violence team based in the Health sector, as part of the Health/DoCS partnership
- The inclusion of Health staff with expertise in child protection and AOD issues, because these issues commonly intersect with domestic violence.

Aims of the GVDVS

The aims of the GVDVS, as outlined in the Service Delivery Plan, are to:

- improve the service system's capacity to respond to domestic violence in Green Valley

  One (aim) was to look at developing some systemic changes, and we know that that's very important…Even though services were out there, we weren't really coordinated in how we should be providing that service to the clients that we intended to see. So the systemic change is to do with how we view violence, what sort of training, what sort of other services are out there etc. We knew that we had to a certain extent get something into place… as far as I'm concerned, if you don't focus on making the systemic changes then nothing's ever going to change. (Staff interview)

- improve the wellbeing of women, children, young persons and families

  The second main goal was of course the actual provision of a service to the women and family members in the Green Valley area…We do that as stock items in the work that we do. So part of that service, client service provision would be individual counselling, advocacy, case management, court support, actually working with the children who present and who witnessed or who are victims of domestic violence themselves. And running groups for the clients that we have. (Staff interview)

- promote community awareness about domestic violence

  The third main goal was to actually develop community awareness because we knew that, especially in the child protection area, quite a lot of people haven't developed that awareness yet around domestic violence itself. A lot of people still have the old myth that it's just physical violence. So that was also another area that we thought we had to focus on. (staff interview)

Staffing and resources

The GVDVS team comprises:

Positions funded by Community Solutions:

- Two domestic violence counsellors (Health) – 1.8 FTE
- One full time DoCS child protection casework specialist (currently vacant and has been for approximately 12 months)

Additional positions funded by SWSAHS

- Part-time counsellor (alcohol and other drugs – AOD)
- Counsellor located with the Child Protection and Family Support (CPFS) team, who takes referrals from the GVDVS. The CPFS team is part of the state-wide network of specialist Health services dealing with the physical abuse and neglect of children.

The team also has brokerage funds to enable the delivery of a flexible service (eg assistance for women with removal expenses). Over the life of the project to date, there have been changes in personnel filling all but the 2 domestic violence counsellor positions.

The GVDVS reports to the manager, CPFS. The project is overseen by an interagency group, commonly referred to as the Steering Committee, with the formal title of Child and Family Multi-disciplinary Team Steering Committee.

The evaluation

The School of Social Work and Policy Studies at the University of Sydney was contracted to undertake this evaluation by South Western Sydney Area Health Service (now Sydney South West Health). The evaluation commenced in May 2004 following approval from the SWSAHS Ethics Committee and the agreement of contractual arrangements. An interim report was submitted in August 2004. The evaluation was completed in March 2005. Dr Lesley Laing and Associate Professor Jude Irwin are the Chief Investigators.

Interim report

An Interim Report was submitted in August 2005. It contained data from the initial round of client interviews and from interviews with Key Informants on their perceptions of the implementation of the GVDVS. Key informants are senior representatives of participating interagency partners, and/or participants on the GVDVS steering committee.

This report incorporates the findings of the previously submitted interim report. The section reporting the findings from interviews with *Key Informants* has been updated to include data from two interviews that had not been completed prior to the submission of the Interim Report. The section on *interviews with women clients* of the service has been revised to include in the analysis a further seven interviews.

New sections of this report comprise:

- The analysis of data from a series of interviews with frontline service providers in human service organisations serving the Liverpool area

- The analysis of a comprehensive file review of all referrals to the service in its initial 18 months of operation.
- Data on training and community education carried out by the GVDVS.
- A section on the progress of the implementation of the GVDVS, based on indicators of good practice in domestic violence service delivery to women and children and indicators of good practice in interagency collaboration in domestic violence service delivery.

Methodology

The methodology was developed to be responsive to a number of factors:

- The aims of the GVDVS
- The need to try to capture the developmental and evolving nature of the GVDVS.
- The dynamics of domestic violence which shape domestic violence service delivery and research (e.g. much service delivery is provided within a crisis context, where women may use the services for varying periods of time. In this context, services need to be very flexible and responsive to the woman's situation, making the design of outcome research extremely difficult.)
- The need to balance making women survivors' voices central to the research with the ethical requirement to consider women and children's safety when participating in research.
- The uncertain timeframe available for the evaluation project (initially less than 6 months but extended when the GVDVS was funded for a further 15 months).
- Consistency with the methodologies used in recent Australian evaluations of coordinated, interagency responses to domestic violence (e.g. Keys Young, 2000; urbis keys young 2001; 2002).
- The Australian and international literature on good practice in work with women and children affected by domestic violence and in coordinated, interagency responses to domestic violence. This identifies several core principles against which all interventions and system developments should be evaluated:
  - The safety of women and children is paramount at all times
  - Men who abuse are responsible and should be held fully accountable for their actions
  - All intervention is accountable to the experience of those who have been abused

Evaluation research can be either 'formative' (process-focussed) or 'summative' (outcome-focussed). Because of the developmental and evolving nature of the GVDVS, a 'formative' or 'process' evaluation was regarded as most appropriate to this evaluation.

The aims of this evaluation are:

To identify:

- data collected by the GVDVS relevant to evaluating its implementation and progress towards achieving broad service goals
- strategies adopted to enhance interagency cooperation (eg service agreements, memoranda of understanding)

To explore:

- the perceptions of women clients of the service offered by the GVDVS and its links to interagency resources
- the expectations of GVDVS of key interagency informants, and progress, barriers and opportunities for meeting these expectations
- knowledge about, expectations of, and contact with GVDVS, of personnel in human service agencies in the Liverpool area
- the experience of staff of the GVDVS in implementing a new and innovative service which focuses on interagency cooperation

Because this is a complex evaluation task, a mix of methods was employed. These include:

- Semi-structured interviews with women who have used the GVDVS – 14 interviews between May and November 2004 (See Appendices for interview guide)
- Semi-structured interviews with staff of the GVDVS about the process of service development and the barriers and opportunities for enhanced interagency cooperation - 6 interviews (See Appendices for interview guide)
- Semi-structured interviews with 'Key Informants'. Key Informants are senior representatives of participating interagency partners, and/or participants on the GVDVS steering committee - 18 interviews involving 21 respondents. These explore four broad areas: the purpose and goals of the GVDVS; interagency management processes, including initial planning and ongoing management; interagency processes; and impact of the GVDVS, including ideas for strengthening and development. (See Appendices for interview guide)
- Semi-structured interviews with service delivery personnel from human services agencies in contact with those affected by domestic violence - 25 interviews (See Appendices for interview guide)
- Review of data collected by the GVDVS, both with respect to its direct client service activities (file audit), and its community education and training activities. The file audit involved a systematic audit to collect (where recorded) data on:
  - > who is using the service - demographic details
  - > children and young people involved
  - > source of referrals
  - > contact with other services
  - > details of interventions: e.g. legal, child protection, AOD services, family support; referrals etc.
  - > outcomes (if known)
- Other data sources
  - > Participation in the Steering Committee Planning Day involving 10 Key Informants and 4 GVDVS staff in February 2005. This provided a review of progress to date in implementing the coordinated response and identification of future directions.
  - > Participation in the staff interview with urbis keys young as part of the wider ICM evaluation. This provided an update on recent service developments.

In the initial planning for the GVDVS, there was emphasis on the provision of therapeutic

interventions. This meant that there was consideration given as to whether or clinical assessment tools should be incorporated into the methodology. There are a number of arguments against this approach:

- Because of issues of client safety, it was not regarded as ethical to withhold service from some women in order to establish a control and experimental group. This provides a methodological limitation, in that any change in pre-and post-test scores on measures of functioning, cannot be attributed necessarily to the intervention of the GVDVS.
- The use of psychological assessment tools with survivors of domestic violence can inadvertently reinforce the abusive and undermining messages that are a part of much domestic violence by inadvertantly giving the impression that the woman is 'damaged' and in some way deficient and responsible for the abuse.
- The complex and multifaceted nature of domestic violence and child protection require flexible and multifaceted interventions, which are often provided by a range of agencies. Hence, standardised assessment tools, utilised in clinical settings, were regarded as inappropriate for assessing the impact of domestic violence interventions.

Given these considerations, and the desire to measure changes made by women, the evaluation team explored the possibility of using assessment tools which are 'holistic', i.e. "tools which focus on changes in the 'whole of life' rather than on a specific outcome related to each intervention" (Bullen 2003, p. 4). The 'snapshot of life' tool (worker and client versions) developed by Paul Bullen for the Family Services Association of NSW was identified as a potentially useful tool with longer-term clients (i.e. attending a service for more than 8 weeks) because these address many dimensions relevant to domestic violence intervention (strengths, children and children's issues, domestic violence, child abuse, substance abuse, services used and needed, extended family, friends, community networks).

However, after consultation with the GVDVS team, these measures were not included, because completing these comprehensive tools was judged to be too onerous for clients, especially during initial contacts with the service when women were likely to be in crisis and when engagement of women depends on woman-directed (vs. assessment-focussed) service provision.

In order to collect some pre- and post-intervention data, the GVDVS team developed a short tool, the 'Power and Responsibility Evaluation Outcome tool'. This is described and the findings discussed in section 4 of this report.

Outline of this report

Following this overview of the GVDVS and description of the evaluation methodology, Section 2 reports on the data from the interviews with clients of the GVDVS. Section 3 presents data from the interviews with human services personnel in the Liverpool area. Section 4 collates data collected by the GVDVS, both with respect to referrals received over the first 18 months of operation, and to their activities in training, community awareness raising and interagency work. The next section, five, presents data from interviews with interviews with Key Informants.

The final section brings together the findings of the evaluation to discuss the progress in development of the GVDVS, both as a specialist service to women and children and as a catalyst for the development of a coordinated response to domestic violence in the Green Valley area.

SECTION 2

Interviews with Clients

They're my lifeline, without them I'd probably be dead.

Unless I have a service such as this, I would be back with him because I wouldn't have received help from anywhere.

I'm 43 years old and I can't believe my life is starting now.

Good practice in domestic violence intervention, including research and evaluation, requires that women's perspectives are central. Hence the methodology includes interviews with women who have used the GVDVS. In accordance with requirements for ethical and safe contact with women, potential respondents were approached by staff of the GVDVS to inform them of the evaluation, to ascertain their willingness to participate and to negotiate a way in which this could happen safely.

In order to reduce the risk of re-traumatising women through their participation in the research, the interviews focussed on the women's experience of the GVDVS – with respect to their needs and the needs of their children, where appropriate – rather than requiring them to detail in depth their experiences of violence and abuse.

Seven women were interviewed and the findings reported in the interim report. A second round of interviews with a further seven women has subsequently been conducted, and the data reanalysed to incorporate the findings from the 14 client interviews. Although this is a small number of participants, it reflects the difficulty in recruiting this vulnerable population to research (urbis keys young, 2004, iv). Ethical and safe approaches to potential participants raise the possibility of selection bias, the risk that only those women who are satisfied with the service, will respond. However, interviews with key informants and service providers in contact with women who have used the service provide a way of assessing the validity of the data collected directly from women. The qualitative data from the women – using their own words where possible without risking their safety by identifying individual situations, adds richness and depth to the data collected on a wider sample of clients via the file audit.

Demographic Information

The women interviewed ranged in age from early 20s to 50s. Six women were from culturally and linguistically diverse (CALD) backgrounds and two were Aboriginal. Twelve of the 14 women have children, a total of 22 children in the sample. At the time of interview, the majority of the children (15) were aged less than 10 years: five of the children were aged under 5 years, ten were between 5 and 10 years, two were in their early teens and the remainder, young adults. In three cases, the women reported that their children had themselves been direct victims of child abuse (physical and sexual) from the perpetrator of violence towards the women. These were serious assaults involving criminal charges in two cases. This was in addition to the emotional abuse children experienced through exposure to the abuse of their mothers. A summary of descriptive data about the interview sample is provided in Table1.

Referral

The women were referred from a range of agencies: Police (4); Community Health (3); and one each from Mental Health, Department of Housing, Centrelink, Migrant Resource Centre, a marriage counselling agency and the court support service. One woman referred herself after finding information about the GVDVS in the local library.

This range of referral sources suggests that the GVDVS is well known among the many agencies to which women in the Liverpool area may turn for assistance. In some cases, the women identified themselves to the referring agency as experiencing domestic violence. In other cases, the women did not disclose violence directly but the referring agency was sufficiently aware of the dynamics of domestic violence to be able to identify it. Since women tend to define their experience differently at different stages of exposure to domestic violence – e.g. as a relationship problem or a crime – a specialist domestic violence service needs to be active in educating a wide range of agencies about domestic violence and about the service it offers. The referral pattern seen here and the findings from the interviews with frontline service providers (later in this report) confirm that the GVDVS has a strong community profile.

Nature of the abuse experienced by the women

The women were at different stages in dealing with violence in their intimate relationships. This ranged at one extreme, from two woman unready to unequivocally name their experience as domestic violence, through women who had experienced violence for over 20 years, to women whose most severe experience of violence occurred after separation.

Two of the women were still in a relationship with their partner. However, although the other women had separated from violent partners, five of the 12 women who had children, had ongoing contact with ex-partners because of child contact. For several of the women, contact between their ex-partner and their children provided the perpetrator with a context in which he could continue to abuse and threaten them:

> *…every time he comes to take his son he's cranky with me and abuses me.*

> *It's still hard, but, because he tries to intimidate me every time (at contact changeover)…*

The majority of women (12) had experienced physical violence, often severe. Three had moved states in order to escape life-threatening violence. Several women were injured seriously enough to be hospitalised. For example:

> *So I told the ambulance officer that I fell down the front steps, only because he was still in the house, but when I got to the hospital and they cut my shirt off to take x-rays, I told them he's beat the shit out of me, I couldn't tell you before because he was in the house…*

Where physical abuse occurred, it was in concert with a *range of other forms of abuse and controlling behaviours* – emotional, verbal, social, sexual and economic. One woman's experience of abuse comprised emotional abuse, verbal abuse and threats. Naming this

as domestic violence marked a turning point in this woman seeking legal protection to deal with terrifying threats on her life:

> *I guess I'd been of the opinion, all the publicity that you hear about domestic violence was always the physical stuff, the tangible stuff, the stuff that you see and…with him it's always been about intimidation and degradation and all of that kind of thing and it's gradually getting to the point where he's threatening your life. So up until that point I kept making excuses and writing it off as just bad behaviour, bad behaviour, I never termed actually it domestic violence. So up until that point, I didn't label it like that.*

Living in fear was expressed by the majority of the women:

> *…and then just some of the threats like he was gonna', like one was, "don't go to sleep and if you do, sleep with one eye open because I've only got hell to go to and I'm going to take you with me." And my son's there, so I stayed up all night.*
>
> *I had to go into hiding – to be in fear of your life, that's how bad it was.*

A common theme in the women's accounts of their abuse, was the control that the perpetrator exerted over them:

> *I was so isolated for so many years. I can't describe it, it was like a prisoner in your own home. I was virtually a prisoner in my own home. I wasn't even allowed to see a doctor… I wasn't even allowed to pick up the phone…*
>
> *…I didn't notice that he was cutting my friends off and that was a sort of control. He tried to control my money and where I went and then I realised he tried to control me from all those sides.*
>
> *He tried to cut my relationship with my mum. I kicked my mum out once because of him. And he still kept going with the violence. I thought that was it, that my mum's bothering him.*

As noted above with respect to child contact arrangements, and consistent with other research (Fleury, Sullivan & Bybee, 2000), leaving the relationship did not mean that women and children were safe from violence, harassment and abuse after separation.

> *He still threatens me every now and then. Like the threats are there. But I'm not as intimidated as I used to be. He doesn't know where I live at the moment…I still get the harassing phone calls, and this and that, the nasty messages.*

Several women described ways in which the perpetrator manipulated the intervention system to continue abusing them. For example, one woman was accused of fraud because of misinformation provided to Centrelink by her ex-partner. Another was accused in the Family Court of abusing drugs:

> *Well when I first applied to the courts, I applied for supervised access...And I end up going in and the interim orders were just completely a joke because he used the Family Courts to try and still control me to get what he wanted. Because he actually put me on drug allegations and I had to be fortnightly tested for months. So, it was unbelievable...I was the one who applied to the courts. I was the one to lose my legal aid, because I wouldn't agree to what he wanted.*

Impact of the violence on children

The women were aware of the impact that living with violence had had on their children. For example, they saw the symptoms of their children's distress:

> *…in the end he (son) had a nervous twitch and I was too afraid to take him to the doctor and it became worse so I did take him to the doctor but I didn't tell him anything. He asked me, 'Do you argue in front of him?' And I said, 'Yes.'*

> *The eldest used to yell out in bed, sweating and rolling around. She'd hardly sleep and she wouldn't eat…*

Some described the impact of their children's direct exposure to the violence:

> *The last time he actually hit me…she (daughter) was just freaked out because she was lying on her bed and he was belting shit out of me in the lounge room and she remembers the last words I was saying which was, 'Don't, you're going to kill me,' and he yelled out, 'I'm going to get a knife you bitch and stab you to death.' She heard it and the ambulance took me but I couldn't take them with me because he wouldn't let me…Yeah, the ambulance took me and she had to lay there waiting, being the eldest one. I didn't even know she was awake….*

> *He hit me in front of the child. And the child he's very withdrawn every time and sad. I don't know why but maybe it's because he sees his father hit me and every day he's cranky. My child is very sad and withdrawn.*

Two women attributed having had miscarriages to the sexual and physical violence they experienced during pregnancy.

Consistent with findings in the research literature, recognition of the impact of the perpetrator's behaviour on their child/ren, and/or direct abuse of the children, can mark a turning point in women's thinking about their situation:

> *I've got a two year old son, he's two this month, and it was 12 months ago that he seen his dad lay into me. It was so hard, and got very violent type thing. And that's how I come in contact with the police. And that's why Leanne referred me to Lisa. [Int: So was it concern for your little boy?] It was for both of us. I mean he made threats, like even when he did lay into me, (son) was in my arms and at my feet…*

> *I was thinking about my daughter...I just wanted to get out of that situation for her and myself.*

> *And that (direct abuse of child) encouraged me to think, 'Not my daughter.' If I'm going to die because I think I'd die for my husband, I cannot let my daughter go through this.*

Interventions

All the women reported high levels of satisfaction with the service provided by the GVDVS. The women reported they had been offered a range of interventions including:

Counselling and support

At the heart of their comments was the ***quality of the relationship*** offered by the staff. For women who have been subjected to coercive control, the relaxed, non-hierarchical relationship offered by the staff was a different and welcome experience. For example:

I do (feel accepted). I don't feel any different, I can laugh and tell her absolutely anything, there's nothing I can hold back from her and that's really good.

…they're just so down to earth, so normal people sort of thing. You know what I mean. Where the other counsellors I've seen are sort of not like that. They're up there and you're down here, and that's that. Which is intimidating as well.

I feel good with her. I need somebody to think with me. I can't do it alone. I have someone I can trust now. I couldn't trust no one.

They do everything. They really care. It's not like doing their job. They put themselves in your place. They try to help us find our way.

She's just so laid back. Everywhere you go it feels like authority but with her it's like she's one of us…you feel like a real person just like you can get coffee with a friend. It's not like a counsellor. Its not. Like you don't feel any different, you feel like you're on the same wave.

It is notable that the two Aboriginal clients particularly commented on their sense of ease with the counselling approach offered by the staff.

In describing their interactions with the GVDVS staff, all the women talked about being offered ***consistent, non-judgemental support***, a key component of good practice in domestic violence intervention (Patton, 2003; Queensland Department of Families, 2002):

Reflecting back on it I can see like when I started speaking with her and seeing her, like with her open mind and the approaches she took how that assisted me and how my way of thinking really did a 360 [degrees], so I found it really beneficial, I'd recommend it to anyone…Number one was probably listening to what I had to say. Open minded like I could talk to her about family issues and how that impacted and just everything that had happened and she wasn't judgmental about anything so it was really good…And she respected what I said. Because I know (that) other agencies and what have you, are very like, 'You have to leave,' but she had the understanding that it's not as easy as that. No pressure, she was very friendly…

An important aspect of the women's contact with the counsellor was the ***normalising and validating*** of women's experiences and reactions:

I'm sort of understanding more that I'm not the only one. Having people believe that you're in that situation, it's very hard. For me to talk about it, I can't even bring myself to say the things that he's done to me and that person across the room from me might think, 'Is she crazy, how did she put up with all of this? She must be the one that's crazy.'

An important part of the intervention described by the women was the ***provision of accurate information*** about services, women's rights, and the nature of domestic violence. In this respect, the fact that the GVDVS was a ***specialist service,*** was appreciated by the women, because they had talked with many other women going through similar experiences. The GVDVS was one place where they could obtain accurate information, which was not the case with all organisations.

I find that with government agencies that the information they give you is always different. They tell you one thing and then the next person tells you something else. The information's coming from the same source but it's different so what do you do?

A number of the women spoke of the importance of the ***accessibility and flexibility*** of the service, for example, the counsellor being willing to come to their home, or to drive them to appointments and court hearings. Brokerage funds were also used to assist women struggling financially. Sometimes this was related to becoming a single parent, but at others, financial pressures were part of ongoing abuse by an ex-partner, for example:

> *They needed new shoes, which their dad said he'd buy but he didn't. He didn't pay me back so I fell behind. He told the kids, 'Tell your mum to get them and I'll pay her back.' But he didn't. And they (GVDVS) ended up doing my shopping for me. And like his dentist, his specialist for his glasses, it all happened in a short period of time and I couldn't catch up. Financially I was in a panic state. And Linda came and did my shopping so I didn't have to pay for the shopping and I could pay off a few things so I could catch up.*

Some of the women also recognised that the staff understood that they may ask for assistance, yet be afraid to follow through. As their situation became more dangerous, they felt able to contact the service again:

> *I'd made an appointment but didn't come to the appointment and it wasn't until I had a bad day that I decided to contact them. I'd missed my appointment and I was a bit afraid to come in and that's when I was put on to Lisa… And she's just so patient with putting up with me because I forget appointments and she'll ring me and giggle at me because I've forgotten another appointment instead of getting angry at me like she probably should.*

> *There was no pressure, like she understood because there were a couple of times I had to cancel appointments, she understood the reasons why and what happened. It was very helpful and kind of laid-back which was good.*

For women at certain stages of their experience, for example, with severe impacts of the abuse on their confidence or who were dealing with persistent and dangerous perpetrators, the accessibility of the service was crucial:

> *I told them, I said, 'If it weren't for you I would've been dead.' They're the only ones that keep my head together, their support…I'm always on the phone when I have a panic attack, I'm on the phone and they sort of calm me.*

Good practice recognises that establishing a new, violence-free life is a long and difficult process during which women require practical and emotional support (Patton, 2003). Many women commented on the importance of the service being offered over the ***longer-term, to support them in the phase of rebuilding a life free of violence***:

> *I know that the residual fallout is a really big thing. I guess what I was trying to say was that you take such a battering physically, emotionally and spiritually that it's really hard to pick yourself up. And it's really hard to get yourself back to the person that you know that you are or the person that you know that you were. And you can have all the people in the world like your family and your friends who will say that you shouldn't feel like this, but it's not that simple.*

Women also reported being encouraged to ***overcome their isolation*** by joining social and counselling groups, taking up hobbies, experiencing self-care (e.g. massage), and taking up study.

> *Well, I'm going swimming now and I help in the canteen and next year I'm going to help more in the canteen and I'm going to get into a computer course…That lady, the*

therapist, did a massage for us and that really relaxed me for a week. I wish I could do it every couple of weeks.

The group sessions were very good. We did a lot of crying between us women. You see you're not the only one.

Systemic interventions

Dealing with violence and abuse involves women with a complex network of organisations, which may respond in ways that are enabling or that are barriers to their efforts to achieve safety. Women may be involved simultaneously, for example, with the criminal justice and civil legal systems, the Family Court, Department of Community Services, Centrelink, Housing and Immigration Departments, and more. The women gave numerous examples of the ways in which the GVDVS provides ***assistance and advocacy to women negotiating the complex systems*** involved in escaping violence and establishing a violence-free life. They had assisted women to access safe accommodation, written reports to assist women to argue for their children's safety in Family Court matters and assisted with income support (*She got me my disability pension, I just couldn't work* – woman with significant mental health impacts).

Research indicates that, without such consistent advocacy and systemic interventions, often over the longer term, 'many barriers are often encountered which, if not overcome, may result in the woman returning to her male partner.' (Patton, 2003, p. 141). This was exemplified in the case of one woman who had left the relationship earlier, but returned to her partner because of insufficient support. She and her children endured 10 more years of abuse before contacting the GVDVS:

…and the system is so disappointing that it forces women to just go back. I thought I'd just go back, to just put up with whatever he did… Unless I have a service such as this, I would be back with him because I wouldn't have received help from anywhere.

One important type of systemic intervention is the provision of ***court support***.

The first court hearing I went to, Linda took me, she came with me. She picked me up and took me and if it wasn't for her, I wouldn't have gone.

(Getting the AVO) It was scary…I was very grateful, very grateful to have had Linda's support, not just her physical presence, that fact that she came to court with me, but the actual idea that there was agency who took me seriously. There was somebody who said, 'he can't treat you like that, and what he is doing is wrong. Everything that he says and does is wrong and what he's doing is abuse.' To have somebody validate what you're going through was a big thing for me…

And that was my biggest fear as well, what was going to happen? If I go through all this and drag him in and my biggest fear was what if I do all this and they turn me down(for the AVO)?...So I guess having that service there was a big affect too knowing that if this stuff doesn't happen at least I can go and these people take me seriously and there's somewhere I can go to.

Helping the children overcome the impact of violence

One woman spoke of the reasons for asking the service to counsel herself and her children:

Yeah, they need it. We all need it. I can't bring myself to tell him the things that have happened. If I tell them things that have happened in the past I don't want to put stuff into his head. I don't want to tell him things that have happened. I don't know how to talk to him about things.

This woman had been assisted by the CPFS counsellor as part of the team to build a new life with her children, by developing new parenting skills:

And they're so happy. They used to come home scared, scared that they're dad will hit them. They used to leave the house scared. It was really different. It took a while, like a year and a half. But the routine is beautiful. The routine is they get rewards, they don't get blamed and criticized every time they do something. Sometimes I try to tell them that's wrong and this and that but not to insist on it to a degree that I make their day miserable.

Reported outcomes of the intervention

A number of themes about the outcomes of contact with the GVDVS emerged from the women's accounts. These are reported in the words of the women.

Reduced self blame (and reassigning responsibility to the perpetrator)

I just needed something, someone to talk to and like, I always was just "Is it me? Am I the drama queen? Am I this? Am I that? Have I done all this?" And that's all it was, because I felt so bad that I had done all this, like I've created this and sort of thing. And at the end of the day, it wasn't me, it was him, just minimising.

By the end, I'd virtually answered my own questions: it wasn't my fault.

Because he made me believe that I was such a useless, worthless piece of shit… where she [counsellor] sort of made a lot of sense with it.

…that I wasn't the only one and it wasn't my fault. And just the way he was so…how he was playing it, and how I was reacting to it, and how he was still controlling me…

A sense of empowerment

I was just a little mouse. I put up with everything. I'm not putting up with it any more!

They give you a lot of courage to move on, that we can do it on our own.

My life has just begun. My confidence is back.

I want other women to know what I went through. I'm not shy anymore if people say that happened to me, like I've been a victim. I don't feel lower than other people, I feel the opposite. I feel like I should and I'm so blessed. I want to tell other people and hope I can prevent other situations…

They gave me my confidence back - that I am not worthless, not just a "thing" on this earth.

Free from the abuser's control

I feel good because I know that he's not in control of me.

Like his idea of a respectable family was me forgetting about everything he's done and take it from zero again. Like me putting him first in front of people like respecting him, like he's in charge, he's the one, he's the boss. I think he was shocked, he's still shocked now because he expects me to do things now that he thinks he can press my buttons and he presses some of my buttons but I think to his surprise, I'm not doing what he wants. In the old days I would have anything he wanted if he pressed on those painful spots.

Improvement in children's well-being

Her grades have gone up since I left him. She did a basic skills test in year 3 and she only got band 1 and 2, which is the lowest you can get. Then she did it this year, only 2 years after and she got the higher part of 5 and I just thought unreal.

I don't want my daughter to go through that when she grows up. I think if I'm going to put up with her dad, that maybe she would put up with someone like her dad thinking it's normal and that's what's keeping me going. No way, they're going to have a better future than mine!

An alternative to psychotropic medication

Two women talked about the way in which the counselling and support offered by the GVDVS, gave then ways to cope without using medication:

All the doctor does is give you tablets. I thought 'this is not the way to go', and I don't take anything now.

I was put on tablets when I was 11. I've been kept on medication. No one really spoke to me before Linda. (incest survivor abused in a number of subsequent relationships)

Suggestions for change and development:

Given their satisfaction with the GVDVS, the women had few suggestions for changes or additions to the service offered. One woman, who had had a brief contact with the service around applying for an AVO, suggested that there could be more long-term follow-up, to deal with the ongoing effects of violence. She planned to recontact the service because of ongoing distress and felt comfortable to do so. She further suggested that there could be a system to follow up women at the time that their AVO expires:

The other thing is, perhaps, I don't know how you'd do this I'm sure it would be a huge job but maybe a you could have a follow up with the terms of your AVO. So what's going to happen next. You could see if you need to go back again…They can tell you what your options are.

One organisation about which the women reported mixed experiences, was the Police. These experiences ranged from excellent and supportive, to highly distressing. It should be noted that the experiences described were with Police at a number of different stations, not exclusively Green Valley Police. One respondent suggested improved training for general duties police, while praising police who specialise in working with domestic violence:

In terms of the police, with the people at the front desk, when someone comes in to make complaints, I see they have specific domestic violence officers, which I didn't know about and I think that's a good thing. Perhaps a lot more training for them in the

way that they treat people who make a complaint. Although I have to say to that the police who come in and out of the women's room [at court] are great. They're very supportive, they're very helpful. They're lovely. They've been very good.

Other had less favourable experiences and suggested that a more victim-directed approach would be helpful:

They (police) put you on trial. They make you feel as if you've done something wrong. They should be more sensitive and they should talk to a woman…If they come to you, they shouldn't be bossy and tell you what to do, you should be allowed to make the decisions, what you want to happen in court. Yes I want an AVO, yes I want this. But when they take over and tell you what they're going to do that's when women drop the charges and this is the reason why because it's just too intimidating.

Two women reported experiences of police minimising the violence, and their fear of their partners, for example:

…it got the stage it was really awful and I talked to my lawyer at one stage and he told me, 'go report it to the police, he can't treat you like this. Go and report it.' So I went to the police station to make a statement and they just said to me, "well love, until he actually pushes you under a bus or a train or until he actually kills you there's nothing we can do."

Other women, in contrast, praised the safety and support offered by the Police:

The police said that the court would be in about 16 days but the second day they contacted me and told me that court is tomorrow and I was so terrified. I thought how am I going to do it and where am I going to be and what's going to happen? It was terrifying…The police car came in the morning next to my door to make sure I would get out of the house safely. They were afraid someone might try to stop me getting out… They were very helpful. I kept telling them, "I don't want to do this. I'm not sure." I almost went back at the last minute before I got in… They said to just keep him from hurting me.

And [the DVLO] was really good too, because when he (ex partner) came to pick up his stuff, because he had belongings at my house, she actually asked what time he was going to be there. And I said 8.30..9.o'clock, and she rang straight on 8.30 to make sure I was OK and sent police officers around and all the rest of it ….

This points to the need for ongoing training of Police so that women receive a consistent response when they make the decision to take action to protect themselves and their children. In a context in which the Police response may not meet women's needs, the role of the GVDVS in liaising with police on behalf of women, is very important.

In summary, the women's reports indicate that the GVDVS is providing a flexible, responsive and appropriate specialist response to the complex situations which these women and their children face in dealing with violence and abuse. To complete this section of the report, one woman sums up the importance of the service to both women and children:

It fills a very big need. I guess one of the things from my own experience is that perhaps it promotes the fact that these things aren't just physical. I know for myself that that's one of the hardest things because when something's physical you can see the damage but with something like this there's so much fallout and that's the hard part is dealing with the fallout. And it's not just you, it's your kids too.

SECTION 3

Interviews with Human Services Personnel

Introduction

The interviews set out to explore knowledge about, expectations of, and views on the GVDVS, by personnel in human service agencies in the Liverpool area. The perspectives of these "frontline" service providers are an important source of data on the process of the implementation of the GVDVS.

Twenty five semi-structured interviews with service delivery personnel from human services agencies in contact with those affected by domestic violence in the Liverpool area were conducted between November 2004 and March 2005. The data collection period was extended into 2005 in order to obtain interviews with personnel from the Police and Department of Community Services. The crisis-nature of the work of these two organisations presented some difficulties in finding suitable times to interview representatives of these organisations. Interviews were conducted with personnel from the following organisations:

Health

- Two Hospital Social Workers (Emergency & Ante-natal)
- Community Counselling Team (CCT), community health
- Two Child Protection Family Support (CPFS) workers (PANOC service)
- Miller Early Childhood Sustained Home visiting (MECSH) team
- Park House (paediatric mental health)

Police

- Five Green Valley Police (general duties)
- ECLO (Ethnic Community Liaison Officer)

NGOs

- DV Outreach Worker
- Refuge Case worker
- Liverpool Women's Housing
- Child and Family Service
- Family Support
- Neighbourhood Centre (The Hub)
- Two women's domestic violence court assistance program workers

Court/legal

- Chamber Magistrate

DoCS

- Three caseworkers

Table 2 contextualises the organisations of participating respondents, summarising their main role and responsibilities in relation to domestic violence as described in the interviews. It can be seen that the agencies represented range from specialist domestic violence services (e.g. court support; refuge worker), through to agencies who deal with domestic violence regularly but who do not focus solely on domestic violence (e.g. health services, police). There was common agreement across respondents on a definition of domestic violence: rather than solely physical abuse, most respondents included a range of emotional, verbal, social and economic abuse in their definition.

In order to locate the interview data within the context of the respondents' work regarding domestic violence, they were asked about the main problems or issues faced by their agencies in dealing with domestic violence. The most commonly raised issue was the ***lack of resources***. For example:

> *Lack of services is a problem. Lack of housing, not enough emergency, accommodation for these women. It is just the lack of resources for them. You feel quite powerless and helpless when there is a woman and she is in this situation and you have nowhere to direct her. (NGO respondent)*

> *If we do come across a family, for a referral there is lack of resources. Huge, huge lack of other services in the area. There is a lack of places to refer to. (Health respondent)*

> *…lack of specialised services and inability to access existing ones due to long waiting lists…there is such a huge demand on workers. There is not enough trained workers. (NGO respondent)*

Regarding the *problems faced by the Green Valley Police* when dealing with domestic violence issues, the main one that arose was victims wanting immediate help but no further action. This problem was highlighted by a majority of police respondents. For example, as put by one respondent, there's a problem with:

> *Repeat victims and offenders. A lot of people just want to call us down there and sort something out for the time being. They don't want us to do anything with it, like make orders. They just want us there for that and then they want us to leave. They call you down and then they don't want to know you when you get there.*

> *The biggest problem I find is that the victim doesn't seem to want to go through with it. I think the last three I have had have really been badly assaulted and we apply for the TIOs and they don't want to turn up to court. They don't want help for it.*

One police respondent also raised the issue of the lack of an after hours response by other agencies, leaving police as the sole resource for much of the time.

Three respondents raised the issue of language barriers for women dealing with domestic violence, in this part of Sydney. For example:

In our area language is the biggest problem for the woman, especially because they are under control of the husband and they don't allow women to go out and participate in other activities so they are very isolated women and they don't understand the language. (NGO respondent)

Problems for NESB women accessing services with language and cultural difficulties to get through to access. Most of our service `is Anglo-speaking. We are trying to access more and we have a high population of NESB women. So that is another thing for NESB women to access services. (Health respondent)

Respondents' level of knowledge and awareness of the GVDVS

As can be seen from Table 3 there was a high level of awareness about the GVDVS among respondents from human service organisations covering the Liverpool (including Green Valley) area. Given the emphasis on the fax-back referral system as a core element of the GVDVS, it is notable that all general duties police officers interviewed were aware of the GVDVS, of the process for offering referrals when called to domestic violence situations, and of the process of making referrals to the GVDVS via the DVLOs.

We had a training day and it is compulsory that we ask everybody if they wish to have their details passed on. So we had a training day and we actually had one of the counsellors from the team come and speak to us at the training day.

What we do is take the details and give it to the DVLO at the station and then they just go from there. They are contacted by the service.

There was also a high level of knowledge by respondents about the reasons behind the establishment of the GVDVS, and its aims. In fact, only two respondents stated that they did not know why the service was established. Many respondents reported that it was their understanding that the program had been put into place because the Green Valley area (postcode 2168), has a ***high risk*** population:

That area was identified as a hot spot where the police in the area were inundated with lots and lots of DV situations…[I am] under the impression that it was put there as a pilot to see if that was going to continue and assist to bring those numbers down. It was a needed service as far as the government was concerned. It was advocated for and it was started as a pilot project in that hot spot. (NGO respondent)

Other respondents recognised the ***intention to improve interagency coordination***, in order to provide a better service to clients:

Obviously the Green Valley area has a high need. They have a high level of instances of DV so my understanding was the funding was to focus on the needs of the people in that area and have other services in that area so clients could access it more easily, more like a "one stop shop" for them. And to try and get the whole community working together a bit better. So having the counsellors and the child protection all together, I mean that would probably get a better result than trying to do it separately. (Health respondent)

…at the time it was acknowledged that there were DV services in the area that catered for DV but not at a level that was required. There were some classes being run and some early intervention but it wasn't coordinated and it wasn't multi,

interagency support and all that sort of stuff so women were falling through the gap. (Health respondent)

Another highlighted the aim to *"to try and address DV in a slightly different way out here"*. Also, it was observed by one police respondent that the GVDVS provides a specialist domestic violence resource for the 2168 area: *"GVDVS is the only service dealing with DV [in the Miller area]. The others are more refuges and things like that"*.

The ***broad focus*** of the GVDVS was mentioned by many respondents. For example:

I understand it was set up as a preventative program not just aimed at counselling but aimed at working with the family and the defendant as well as the person in need of attention to develop change. Also to inform women who are in need of protection their options, their legal rights, referrals, counselling. (NGO respondent)

Enhancing the resources available for dealing with domestic violence in the Miller area was identified by one of the Green Valley Police respondents:

From what I understand they have access to a lot of services that we might not be able to get for someone. They can offer short-term counselling, they can arrange for the long term things like emergency housing and financial things. They can arrange to have that sort of stuff done; things that people might need who are experiencing domestic violence .

A further police respondent believes "it is supposed to help women in particular and what they should do when they face the situation and that and they can get help in terms of counselling, whether they want to refer the matter to court or if they just want to talk it over with a counsellor."

Respondents' expectations about what the GVDVS will achieve

Respondents' expectations of the GVDVS were explored, because it is against such expectations that evaluations of its success will be made.

• GVDVS as a useful resource

A number of respondents expect that the GVDVS will be a useful resource in the area. As stated by one, *"[the GVDVS] would be great and an excellent resource for the community [and] it will be useful. I was really excited….we knew that it would be helpful"*. Another respondent commented, *"I suppose there are a lot of expectations, that they would be available for referral and that sort of thing. Just to be available as a resource and a service to refer to".*

One respondent feels *"it would be nice to be able to direct the clients there [to the GVDVS] or refer them there for counselling or group work, anything they are doing over there. Our forte is their housing and we need to be able to refer them over their for their expertise"*. (NGO respondent)

Finally, one respondent expressed their support for the GVDVS in an affirmative manner by stating an expectation *"that they would work with women in the area on DV issues - we will support it to the death"*. (NGO respondent)

• Success of the GVDVS

A general expectation that the GVDVS would be a success was held by some respondents, one of whom stated, *"they spent a lot of time planning. So they had done their research to see what would work well for them. So I was expecting that once they had gotten established and known that people would respond well to them. So I thought that it was probably going to be a successful project and I am hoping that it will continue"*. (Health respondent)

The above respondent also commented on the role of partnership and how important this is in terms of ensuring the success of the GVDVS. This respondent stated, *"I think the hindrance in not succeeding is not having great partnerships with everybody. They need the police to do their part as well as DoCS and other organisations involved"* .

A further respondent expressed an expectation of success upon stating, *"my expectations regardless of the pilot program, my expectations were that they could achieve a case plan and that would be that according to the assessment they would help the family through the situation and reduce the impact of DV on the children. You can apply that to the GVDVT but that is no different to any agency"*. (DoCS respondent)

• Educational Aspects

Amongst other things, the expectation that the GVDVS would educate people about domestic violence, was mentioned by several respondents, one of whom stated:

> *My expectations were, that more women and children would hear what DV was and be educated. More services and departments would understand what this is and have more information about that. I thought there would be more education, community capacity building stuff, more crisis and casework, more of a service to help refuges. I thought there would be more identification as a child protection service as we begin focusing on children and families as DV becomes part of the act. Living in Liverpool I thought it was good.* (Health respondent)

Another respondent commented that they held the expectation that the GVDVS would help in *"making the mums more aware that there is somewhere to contact …So it is just getting it out that there are other people out there who just deal with….I didn't really have an expectation that they would change anything dramatically or that DV incidents would go down or anything. They are still living the same life, but maybe women wouldn't feel so isolated"*. (NGO respondent)

A further respondent stated, *"I didn't really know much about them so I didn't have a lot of expectations. I was just hoping that they would be able to provide support to the mother and educate her. I think a lot of these females who are in a DV situation are quite powerless and do not know how to get out of the situation and having a service like the GVDVT it can assist females and educate them"*. (DoCS respondent)

Achievements/Strengths of the GVDVS

The majority respondents believe that the impact of the GVDVS has been very positive overall. In the following comment, the respondent draws attention to the visibility of the GVDVS across the diverse areas of direct client work, interagency collaboration and awareness raising activities:

> *I think extremely positive. For those families that do want to work together the service is available to them. For community awareness they have been very active in all of the local DV teams and committees, local projects they have done together so they*

have been very active. So you know they are there and available and they are a good resource to know what is going on. (NGO respondent)

Specific areas where the GVDVS was seen to have an impact were:

Improved interagency collaboration

Given the focus of the GVDVS on improving interagency collaboration, it is notable that the role of the GVDVS in promoting improved interagency relationships, was the most commonly mentioned positive aspect in these interviews. Within these responses, a number of different aspects were highlighted. A common theme of the responses was the ***visibility*** and ***active participation*** of the GVDVS team in interagency activities and forums:

They have meaningfully contributed to the interagencies in the area. They have been active participants in the interagencies. They are always represented no matter what interagency you go to in the area. There is always someone from the GVDV team there. They meaningfully contribute. There are usually a few people at the interagencies that are always very vocal and active and wanting to do something in the area and there are a whole bunch of people who sit there and do not open their mouth. The GVDV team are not one of those. They are the ones who are vocal, out there, active and well represented. (NGO respondent)

They are very active in as far as I know in the interagency….they have organised seminars and have joined the DV liaison committee and are quite active in that way. I think they are probably constrained by time and resources but I know they are active in getting out in the community and rasing awareness.

They are involved and active which is hard because everybody is overworked…..it appears that it is a focal point of what they do because you will always see someone from the team on individual projects and committees and they are there and active.

They go to a zillion committees and child protection groups. I think they have been very well set out in the way the service has been set up to integrate them into the community and all the services being aware of them. So services can refer to them as well as them referring out.

Some respondents highlighted the way in which the GVDVS staff's active participation in interagency work ***added value to the interagency process***, because of their specialist role and expertise. The significance of this can be understood by recognising that, for many participants in domestic violence interagency forums, domestic violence is not the sole focus of their job role. In addition, for the small group of specialist domestic violence workers in the area, the additional resources, are highly valued:

I think they have [had an impact on interagency coordination] because whenever there is falling out or not active, I see Lisa or Linda take over. They activate participation. Both of them frequently share the role. They listen, shake it up and make people more eye catching and emphasize the importance of the committee and workers coming together and make this forum more active and successful.

[The GVDVS] have been great. A new bit of life and put a spark in there. When it is limited services you all attend the same networks and people attend the same meetings and they were getting tired. They came in and got straight into it and had a big impact.

For some, this value-adding was related to the ***specialist expertise*** of the GVDVS:

> *You learn from their attitude and skills whenever they attend the meeting….whatever happens they are equipped to handle things. It is a good thing for you to learn too. The way you react to matters. You listen to them because they always have a strategy. It makes you learn and respond to things differently.* (NGO respondent)

For some respondents, the efforts of the GVDVS to ***link with the key agencies*** responding to domestic violence, was important:

> *I think it is good that they [GVDVS] have that very strong connection with DCS. I think that has been worthwhile. I think with the police they have worked very hard with them. I think they are fairly well known in the community and I think there has been a lot of support particularly with the NGOs of the service and they are really motivated to keep them going. So I think out there it is seen as a valuable addition to our services in the area.*

> *…it seems…like a good design because it is important to have the child protection element…it is good that they are developing strong links with the police and the police are encouraged to refer to them and also that they built up the links with the male perpetrator program as well.*

Another Health respondent commented that *"they are very closely linked in with a lot of the NGOs which we aren't, which is a useful source to tap into when you need to know what is going on. They have cast a broad net over the women's refuges and health centres which is great and hopefully it will have some impact and good collaboration"*.

One response highlighted the role that the GVDVS plays in identifying systemic issues that need to be addressed:

> *…in terms of difficulties we have with certain organisations, the team is very good at highlighting the issues and trying to negotiate with those powers and try to work with them the best that they can. When women fall through the gaps they provide the information as we would when we find women who are in that situation.* (Non-government respondent)

It is highly evident from the above research findings that the majority of respondents believe that the GVDVS has a very positive impact on interagency collaboration. However, it is important to note that two respondents were critical of the interagency collaboration process. Notably, neither held the GVDVS team accountable for the problems identified. One respondent stated, that the GVDVS have *"probably 'attempted' to look at working effectively with the Green Valley police. The failure of this I would not see as their fault. They attempted as much as they could do with partnerships, education and strategy. The partnership process is a "wank" (That is with DCS, Health and Police). It is lip service. They can't lay that on the doorstep of the team.* (NGO respondent)

Another respondent referred to the greater partnership in which the GVDVS is involved. This respondent is evidently unhappy with the result, stating:

> *I don't think it was as coordinated as it stated it was. My own analysis was that it was quite dysfunctional as a coordinated network of government bodies working together. It was very difficult for each agency to come to agreement of what role they should or shouldn't be playing. I think the end result was that each government body was working to their own perspective and own philosophy and at times they clashed.* (Government service provider)

A valuable resource

Some of the respondents identified the GVDVS as a valuable addition to the domestic violence resources available. For example, a police respondent stated that *"it [GVDVS] helps a bit, like if they don't want to go with the matter, they can sit down and talk and get counselling and that through the police contacting them and arranging the time when they can be seen. I know the victims can be seen by someone coming to their house to talk to them"*.

Another police officer believes *"it is a good option and it is good to give them (women) somewhere else to go. I think it is a good card. I would hate to go there and not be able to give them anything. Being able to refer them to other services is good"*.

A Health respondent made the point that: *"We have been able to refer clients in the area to that service and it has taken some of the pressure off us so that is good."* This respondent further to emphasise the importance of the GVDVS as a ***specialist resource***:

> *…it has been a very positive impact because it has been great to have an identified service like that and I think they are an approachable service and they are good to have someone to pass clients on to if it falls into their jurisdiction. I know they will be in good hands. It would be good if the whole area could be referred there not just 2168. It is certainly valuable to have that team there.*

The specialist skills that the GVDVS added through their contribution to the court support scheme was particularly appreciated by one respondent:

> *We are lucky that we have her [Lisa] there because sometimes they [women] are so emotional, they have nervous attack or something and we have her to help with these hard cases. That is her skill so we are lucky that we have someone with such high skill in the team. We are not trained as counsellors but in the court environment we really need someone like that.*

Some respondents gave examples of ***mutual sharing of resources***, in the interests of clients:

> *Whatever they [GVDVS] need from us we will help and the same way with them…for example if they are too busy they can't be in court with their client, they may also be our client too and…. usually we don't have immigration lawyers so we deal a lot with that one, so we work together on that one".* (Non-government respondent)

A further respondent commented that they *"share knowledge and skills [with GVDVS], share referrals, for example if it didn't fit in the 2168 postcode they can refer to me and vice-versa"*. (Non-government respondent)

Another non-government organisation is *"involved in projects with the GVDVS…and having run one [project] very successfully with them in the past I certainly would like to do another and maybe even make it a regular thing…or having it continue and expand to be an ongoing group. So when one finishes the next one starts"*.

> *At the moment we are running groups with the GVDVS and we have had the team refer to us and vice versa. They also have a huge contribution to our work in regards to education around child protection. We work together with them on cases and families. I would say they are our other half. They are not in terms of numbers but in terms of DV and child protection going hand in hand.* (Health respondent)

A respondent in the NGO domestic violence sector described an experience of co-running

a women's group with one of the GVDVS team. Prior to this teaming up, her service had encountered difficulties in recruiting and maintaining participants in groups such as these. She acknowledged the importance of the GVDVS worker's group work skills in this success:

> *Lisa and I ran a DV group for women…who had in some way passed the crisis stage so they were ready to look at what DV was all about and the long term effects on them and how they could get beyond that so it was about moving forward and getting beyond DV and basically getting their life back together. It…was very successful… previously it had been such a failure to get women together. But it was a success. We got it together and the women attended and kept attending…It was certainly a big help to have the GVDVS there. With the experience that the staff had in regards to running a group ...*

Two respondents gave examples of how the GVDVS staff provided the resource of ***specialist consultation and support to colleagues***. This support in managing the stress of working with women experiencing violence and abuse, was valued:

> *It was frustrating me that women are not disclosing and she [member of GVDVS team] was counselling me in a way saying, there is nothing you can do until the woman says something.* (Health respondent)

> *They support me and whenever I need them they are there. I feel so lucky that they treat me as a friend and help me when I need it.* (NGO service provider)

In providing an example of calling on the specialist expertise of the GVDV team, one generalist health worker noted that: *"…because it [DV] is not my area of expertise I certainly kept them in mind for such a case. I had one mum who turned up and she had two black eyes and a broken nose and I just didn't know, she didn't want to file a police report, she didn't want to go to the hospital, all these things she didn't want to do and I was just stuck I didn't know what to do and with that I rang Linda from the DV team to get some support for myself, to find out what to do because this mum wouldn't let the team come in but I went through Linda".*

High quality work with clients

Many respondents gave examples of high quality work by the team, based on the ***positive outcomes*** that they had observed for women:

> *Just with the clients it has been amazing. I think the team has done a very good job in my observation because when I talk to them, the clients, I can see that. It is amazing when the client told me that she called them 100 times and every time she called they answered her call and they listened to her and without them she didn't think she could go that far.* (NGO service provider)

> *I think given that it is such a time limited service, in the time I have seen them achieve good, positive outcomes for individual women and I think that is what it is there for.*

One respondent highlighted the importance of the GVDVS offering ***longer-term support and assistance***:

> *….one of our clients who were housed in the Miller area through DOH, she accessed them and found it to be great assistance. So that is another thing, we do our bit and then we put the women back in the community and they still need that ongoing stuff. So she accessed them through me and so she contacted them and they assisted her with a case plan…* (NGO respondent)

In this respect, another pointed out that recovery from the effects of domestic violence can take many years, highlighting further the role of the GVDVS in ***longer-term work***:

> *They not only provide court support but helping with Centrelink, children, counselling and it is ongoing for years, it is not short term…If you only provide a little support the client may go back to the similar situation. With mental abuse it takes a long time to recover and you need to have professional ongoing counselling to help get through the crisis stage and also bit by bit move on. In some services we can't do that. It is resources...I know the service provide tremendous support for the client and it needs to be recognised.* (NGO respondent)

It was also noted by the court support service, that the addition of the GVDVS as a resource available over to women over time, can assist women to use the legal resources available to protect themselves and their children:

> *…we have seen women in court consistently withdrawing [AVO applications] but when the [GVDVS] team have seen them it may still happen but to eventually have a positive outcome. The fact that they do case work they can persist and I don't mean that they force themselves on women but they can assist women at a later date or whenever they are ready.*

For one DoCS respondent, the ***interagency collaboration*** was crucial to the high quality of work with clients:

> *They are always in contact with the department [DoCS] especially with the case worker. I can only talk about my experiences. They have referred clients to appropriate services, they have provided clients with appropriate information about DV and how it impacts on kids.*

Sometimes the client service was innovative, one respondent describing an occasion when the GVDVS worked with one of their clients to arrange *"a forensic examination of a lady that I had so that was fantastic. It was fantastic for her, it was so empowering. She really felt like she was believed"*. (Health respondent)

One respondent could identify that the GVDVS can have an impact, although this may be small, and progress may take time: *"I would say yes it has had an impact for families even though families may not have continuing engagement with them if it has been a negative experience for them and although the family or victims of DV don't always put into place the skills and information they have been given, in talking to me they have been able to take on board some of that knowledge even though it may not be showing in their behaviour. But I would say yes it has had an impact"*. (NGO service provider)

A further respondent added, recognizing that the nature of the work is complex and challenging: *"I give them a lot of credit for what they do because it must be frustrating for them knowing the females do return."* (DoCS respondent)

A client centred, holistic approach, that tackles the entire system

Several respondents identified as significant, the way in which the GVDVS worked to facilitate women overcoming the many barriers to achieving safety for themselves and their children, through ***systemic advocacy***:

> *The counsellors are very client focused and they are able to guide the client through the maze of services and provide them with counselling and support that is required.*

They can access things quickly where a woman doesn't have to wait. They also represent their service very well in interagencies. (Health respondent)

…that holistic stuff, I can't rave enough about it. It really works, not just dealing with one part of what is going on. They look at the whole picture. The positive outcomes we have seen for mutual clients. (NGO respondent)

It has a lot of positives as the woman can go there and get the whole service like counselling, other information etc. they case manage from what I understand so you don't have 6 people involved, you have one that can oversee the things that are happening for them. (NGO respondent)

Education/awareness raising (for both clients and other services)

One respondent highlighted the importance and value of the educational aspect of the GVDVS, stating, *"education is a big one and just making the mums aware that there is someone out there that can help them if they want to do something that they are not by themselves and also education for us [services] too"*. (Health respondent)

A further respondent noticed an increase in the amount of people using their service, implying that the GVDVS has had an impact in terms of raising awareness:

Yes [the GVDVS has had an impact] because we are getting more people coming in. The word of mouth is getting around and we advertise in our little community newsletter now. So people are feeling safe coming here and they know they are going to get the support from here. It is approachable. (NGO service provider)

It was commented by another respondent that *"the one thing [which] is working really well is our awareness. We know that they are there and they have made themselves really visible to at least the social work department here"*. (Health respondent)

Aspects of the GVDVS that are seen to be working less well

Postcode restriction

A consistent theme that emerged throughout the service provider interviews, was frustration that the service was limited to the 2168 post code area. This reflects similar comments in the Key Informant interviews and is understandable, given that most respondents in this sample provide services across the entire Liverpool area (and some, to Fairfield/Liverpool), rather than solely to Green Valley. The more highly regarded the GVDVS, the more keenly was felt the inability of the service to respond to clients from the broader Liverpool area. The following comments exemplify this common theme:

It is frustrating having a service there and not being able to access it, and not only that, it is a bloody good service. They have the structures there and you know if you send someone it is a holistic counselling. It is not just limited to the woman or the kids' protection or limited to the restraints of an AVO or the legal process. They are there together. They do a holistic assessment. How many women of ours would just benefit from that! (NGO service provider)

If someone is in 2168, I always feel slightly relieved, always, and it is the same with all the social workers on the team. If anyone has a client in 2168 you always feel relieved because you know that there is a really good resource out there. So if you are in that area it is fantastic, really fantastic. (Health respondent)

I think the constraints of the postcode really impact…There has been a number of people it would have been good to have referred but couldn't because of the postcode constraints.

…that is the main thing. I mean it is really not workable the way that it is. It is OK to have these people working and participating in other ways in the Liverpool area, but you can't refer clients or have any clients from this area go there. Really we are so close, the postcode thing is just so ridiculous. (NGO service provider)

One police respondent highlighted the problem for agencies that covers wider area than 2168, and the consequence for clients in possibly being referred for a service that cannot respond to their needs[1]:

…we cover a bigger space that is more than 2168, but on the same token most of the DV occurs in 2168. If in doubt I offer it to everyone.

Location

One non-government respondent mentioned the move of the GVDVS from Miller to Hoxton Park and believes that the current location is presenting problems of access. This respondent stated, *"being up there is harder for clients to get to"*. This respondent goes on to state that *"the good part there is when they were available up here. They were still accessible and they are trained to do that. They are trained to do the job that they do. It could work a lot better if they had more staff and moved back here"*. On this issue, some of the police respondents were not aware that the team had re-located: *'…we went to see them one day and they were not there. We thought we would stop in and see what they do but they weren't there.'*

Another non-government respondent saw the location of the GVDVS within Health, as problematic and hence: *"...the workers have band aids on their mouths and can't say anything."* While NGOs can provide advocacy and lobbying, and the kind of exposure that domestic violence needs, this respondent believes that *"the workers from Health in this regard are set up to fail, they are not allowed to say certain things. So in a sense they can't address all the issues"*. This respondent ultimately believes that *"they as a team cannot address the concerns. For example the funding issues and postcode issues. They try to look at it but a decision has already been made. How can they address the concerns when they are band aided. They are restricted in their ability to advocate."*

Mixed opinions about strengths/areas for improvement

An area in which mixed opinions were expressed concerned whether or not the establishment of the GVDVS was contributing to an improved Police response to domestic violence. The following quotes express the different positions expressed by a small number of respondents:

The frustrating thing…has always been the police. It is hard to get through the culture of the police and appropriate referrals. I guess it wouldn't just be police it would include all government departments including Health and DCS. From what I hear it is more about the culture of the police and lack of understanding. I also see the difficulty working with so many different government systems with so many different priorities to get the women to what they want. Having to negotiate through that is a difficulty. I say police first though. (Health respondent)

1 NB The boundaries for GVDVS referrals from now Police have subsequently been realigned.

One of the biggest areas of difficulties we have had is Green Valley police. I guess the lack of resources they have for whatever reason, the inability they have to follow up on matters, not have them served, not do what needs to be done so when we get to court we can't go ahead. (NGO respondent)

...I know GV police are working with the GVDVS very closely and I think the impact of that will be very positive.

I gather anecdotally that it has had some impact on the police service. I don't know how true that is but I gather there has been some education whether formal or informal work that has been done at different levels. (Health respondent)

It [GVDVS] is progressing well with women and children. I have heard that they have worked very hard to have that relationship with the police, with the fax-back aspect.

Suggestions for improvement/development

Expansion of the service – removing the postcode restriction

Given the strong feelings expressed about the limitations of the GVDVS to the 2168 area, it is not surprising that many respondents argued for the expansion of the service to cover the Liverpool area. It was recognised that adequate resourcing would be required to achieve this:

[The GVDVS] has been set up as a resource with a limited geographical area. We need a well resourced DV team to cover the whole of Liverpool LGA.

I guess the postcode thing could be removed and they could be more accessible to the women out there. Otherwise I think they are doing a great job.

I think yes that would be really good to cover Liverpool. It is obvious that we have DV in Liverpool too, but many workers cover both areas and that becomes really exhausting. Most of the job should be done jointly for Green Valley or Liverpool because we cover both, because if you are in different areas doing different things it becomes a real issue for us. Mostly workers are covering both. So it would be good to go forward rather than backwards. This area really deserves something. I have worked in different areas…and you can see services in those areas…but in Green Valley and Liverpool they don't.

I think it would be really good if they could expand to a wider area and we could use them as a whole resource. So it would be great if they could be super-funded to provide a service to a broader target group…The ideal would be if there was enough money to make this work. (NGO respondent)

It was really exciting and they were talking about expanding it across the area and I would probably have more involvement if it was broader but it is just 2168.

Uncertainty was expressed by one respondent as to the expectations of the life of the project, also as to its expansion, which was seen as crucial. This respondent stated, *"I am still not too sure on whether it is meant to expand or go away now. I am not too sure. It has to expand, we are all rooting for it to expand because they do such a good job but what they can achieve with that postcode stuff is really limited"* (NGO respondent)

One respondent argued for the model that had been successful in Green Valley to be ***replicated in other areas***:

It is a very good model and it should be maintained and developed for other areas as well as the Miller area and the work they achieve should be well known to other people because if you don't work in Liverpool for example you don't know them. It is a waste of resource and everything if you set up a resource and it disappears. That is my expectation, that it continues and expand it. (NGO respondent)

One respondent believed that an expanded service should be based in the non-government sector:

[The GVDVS should be] re-set up in the Liverpool CBD as a Liverpool-wide service that is set up with the NGOs to become a one stop shop for DV. Should have all the workers and services in one central area. Get the police there, Centrelink, Housing etc., do outreach from different people in one central location. Needs to be auspiced by the NGOs and fully resourced.

In contrast a Health respondent urged more commitment from the Health department to addressing domestic violence, on a state-wide basis:

I think if Health is serous about providing a service like this, they really need to get behind it and provide a whole appropriate service rather than just lip service…The service should be set up for DV as it is for sexual assault throughout NSW. I don't think that it is addressed and recognised and it is a very serious problem. I think to take the problem seriously that would be my bit.

More Resources

A strong theme in the interviews was the importance of increasing the resources available to the GVDVS. Because of the changes of team personnel, part-time workers being limited in time for interagency work and team vacancies, most respondents saw the GVDVS as comprising the two domestic violence counsellors who have worked in the GVDVS from its inception.

As far as I know they are doing a really good job…. and I think we are lucky to have them there to set up the service……so it is a matter of making sure they are well resourced so they can make sure they do what they set out to do.

I think there should be ten of them employed not four!

Two workers and covering Green Valley with DV I think they must be over loaded.

If it expands we will work more closely and [be more] involved with the project. Two people in that position running that organisation. I assume it is not possible to meet all the needs. I know they are active and they want to do many things, but without more resources I don't think they can. If it expands we need to get involved. There is a need to do many things.

My suggestion is to give more funding, to continue funding rather than drop. We would like to go forwards not backwards and Liverpool needs more government support and funding in different areas because children are involved with crime, families are disadvantaged so there is a need for the area.

Ongoing, permanent funding

Clearly, funding a pilot project leads to uncertainty and anxiety about losing a valued resource:

Well I guess they have provided a specific service to a specific area and now I feel the service has been up and running for a while now and I think they have settled in and are now able to make a meaningful contribution. I think where do their clients go and where do they refer them to if this thing suddenly stops, if they weren't there anymore. They have started this service from the ground up and they have started to be quite successful and the service is being used. There is a high need for it and to have that taken away, it would put a lot of women in danger of not having anywhere to….If we have another service close down it would be drastic. (NGO service provider)

It would be really good to get the funding sorted out so that people will know if the funding will continue.

If you set something up for a two year period without a commitment to ongoing funding that is about service provision is difficult

It would be great if they could be funded. I think it is a really good service and the idea is great. It makes a difference. The workers are valuable women who have great skills and we don't want to lose them. (NGO service provider)

Summary

It is clear from these interviews that the GVDVS is judged by most of the interagency players in contact with women experiencing domestic violence and child protection issues, to have made a positive contribution to the interagency collaboration in the Liverpool area. Their very success, has resulted in frustration among agencies serving the wider Liverpool area, that the service is limited in the area it serves.

SECTION 4

GVDVS Documentation of Activities

PART 1: File Audit of Referrals

Introduction

A file audit was undertaken of the referrals to the service in the first eighteen months of direct service provision to clients (from February 2003 to August 2004). The aim of the file audit was to gain a comprehensive picture of the type and source of referrals to the GVDVS and the nature and scope of the interventions offered, in addition to a profile of the women referred. This "big picture" of the client work of a new service complements the in-depth data about service delivery provided by the interviews with women clients.

Service context and staffing

It is important to note that direct client work is only one component of the work of the GVDVS in the period under review. In comparison to many other new services, and to other services funded under the Community Solutions and Crime Prevention Strategy, the GVDVS 'opened its doors' to clients within a very short time of receiving funding. Hence client work and service development – raising awareness about the role of the service, developing partnerships and formalising these through service agreements – were being undertaken simultaneously. The service's concurrent activities in education, community development and the development of service agreements with partner agencies, are discussed later in this section of the report. In the period under review, most of the client work covered in the file audit was conducted by the two domestic violence counsellors in the team (1.8 FTE) and the part-time drug and alcohol counsellor, although this position was not filled for the entire period of the audit.

Process

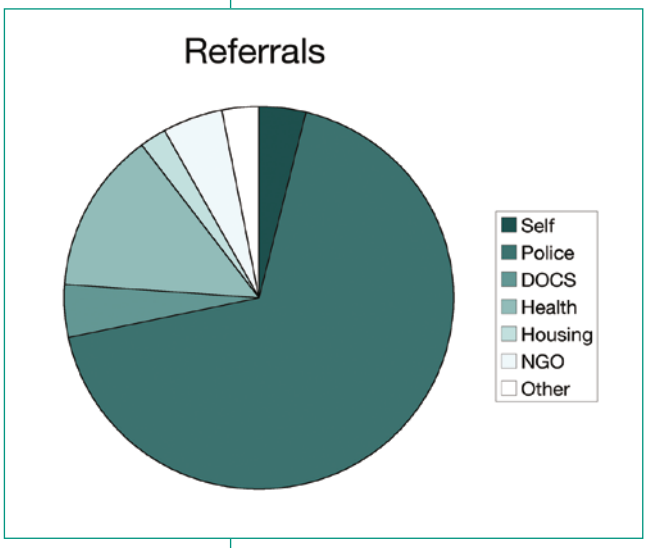
Referrals to the GVDVS are recorded in a referral book. When contact is made, more detailed information is obtained and if the referral involves follow-up action, a file is opened. The audit involved an analysis of all information recorded in these documents over this period. The information obtained included:

- numbers and sources of referral
- reasons for referrals
- household living arrangements
- family composition
- accommodation and income support
- immediate safety concerns
- forms and patterns of abuse
- prior involvement with health human and community services, occasions of service
- occasions of service from GVDVS
- interventions and support provided by Green Valley Domestic Violence Service
- collaboration with other agencies working with clients

Numbers and sources of referrals

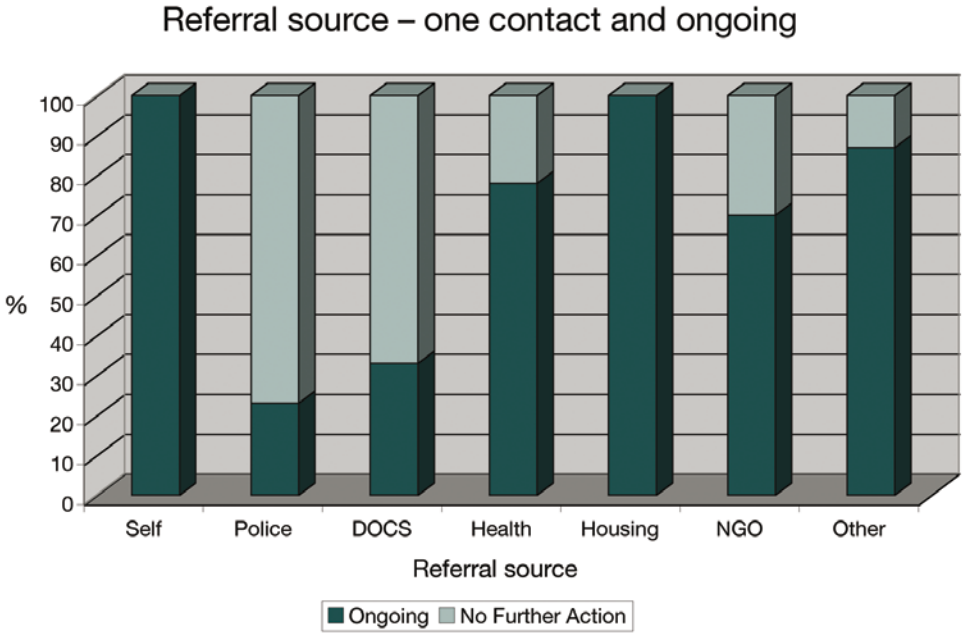
In the eighteen month period there were a total of ***202 referrals***. Of these, ***84*** (41.5%) involved some ongoing contact and ***118*** involved one contact after referral with no ongoing action. Only limited information was available of referrals where there was a single contact.

The majority of the referrals were from the police who made 137 referrals. The majority of these (122 or 89%) were through fax-backs to the Green Valley Domestic Violence Service. Of these referrals, there was just one contact in 106 referrals (over 77%).



The next most frequent source of referrals was health services (27). Of these, 22% (6) involved one contact. The other main sources of referral included the Department of Community Services (9 referrals with 6 involving one contact), non-government organisations such as refuges, Anglicare (10 with 3 involving one contact) and the Department of Housing (5). Six women self referred and all used the services offered.

As would be expected, as the service has developed there has been a trend of ***increasing referrals***. In the period since the file audit (August 2004 – March 2005) there has been an increase in referrals – ***316*** referrals in this seven month period. Of these, 291 have involved one contact and twenty five involved ongoing case management and/or counselling.



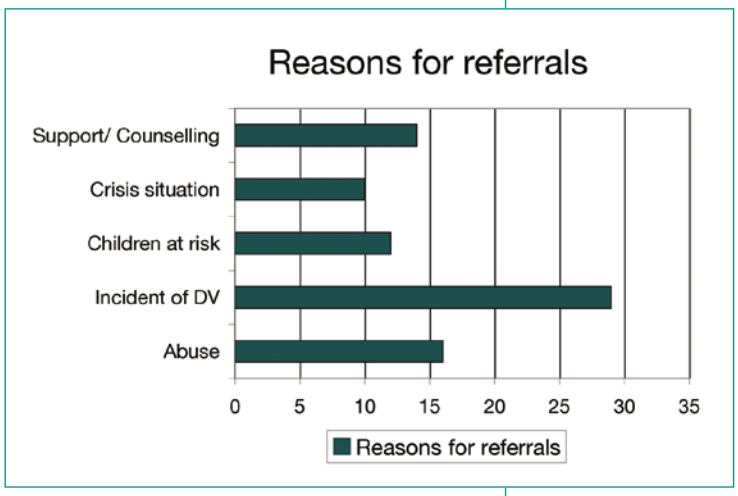
Referrals involving one contact

Of the 202 referrals during the audit period, 118 (58%) involved a single contact (or contact attempt). The highest percentage of these referrals came from police (77% or 106). Referrals from agencies other than the police were more likely to involve ongoing intervention (74% or 57). Many of the referrals involving one contact did not wish to have any further follow up. The single contact often involved telephone contact or counselling, referral to another agency, the provision of an information kit and/or referral to another agency.

Referrals involved in ongoing contact

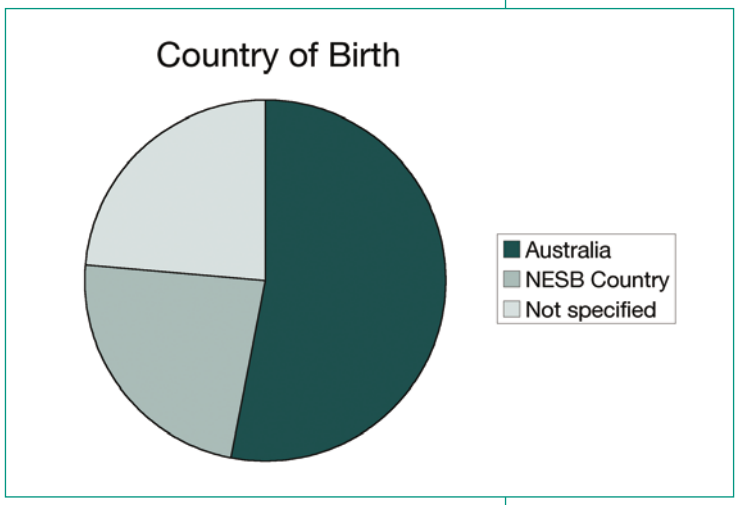
Reasons for referrals

The most frequent reason for referral in ongoing cases was a domestic violence incident (29). These referrals were almost all made by the police after being called out to a domestic violence situation. The next most frequent related to ongoing abuse (16). Many of these women were referred by health, human services or community agencies. These agencies also referred women who were in a crisis situation (10) and those who were seeking ongoing support and counselling (13). There were 12 referrals on the basis of the risk of harm to children.



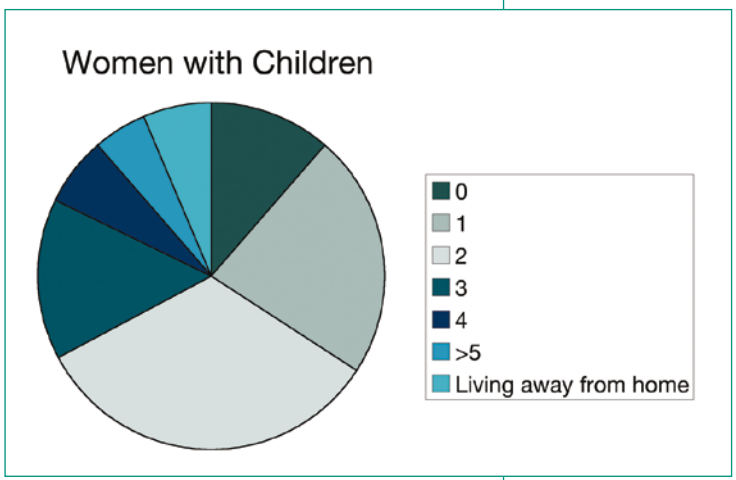
Case Closure

At the time of the file audit, 65 cases were closed and 17 remained ongoing. Of those closed, 15 discontinued contact without specifying the reasons, 16 did not need further assistance, 15 were successfully completed and 12 had left the area or were referred to another agency.



Country of Birth

The majority of women were born in Australia (45). Four of these specified they were Aboriginal or Torres Strait Islanders. Twenty women were born outside Australia in counties where English was not the main language. Of these, eleven came from Asian Pacific countries (eg Cambodia, Vietnam, Indonesia, Fiji, Samoa) and nine came from countries in other regions (Turkey, West Africa, Egypt, Iraq). The country of birth was not known for 20 referrals.



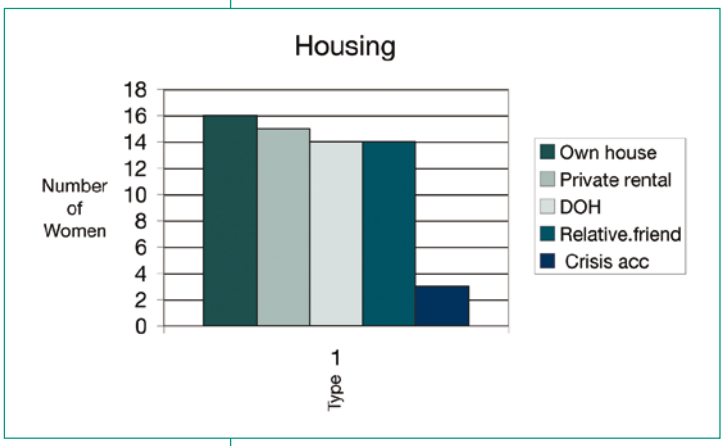
Family composition

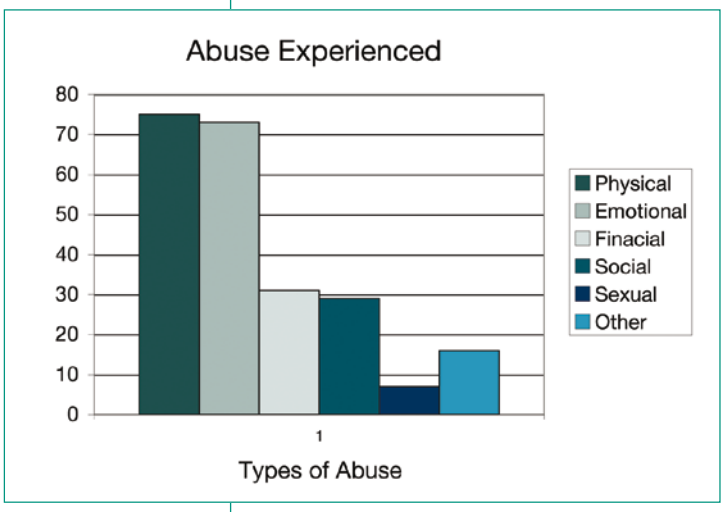
The majority of the women who had ongoing contact with GVDVS had children (89%). The majority had two children (26), with 18 women having one child and 16 women having three children. Four women had more than four children. Four women had older children who were no longer living with them. Nine women had no children.

Forty three women – just over half of the ongoing cases – had children who were aged less than five years.

In the majority of ongoing cases, the women were living away from their abusive partners: some had been separated for some time while others were in the process of leaving their partners. For many of these, the abuse continued post separation. Thirteen of the referrals who were ongoing remained living with their partners.

Accommodation and income support





Information about accommodation and income was not available for all of the clients where there was ongoing involvement. Housing posed a problem for women when they were fleeing a domestic violence situation. Information about the housing was available in 62 cases. Some were able to stay in accommodation they either owned or rented, while others had to leave their home and move in with relatives and friends or go to crisis accommodation. Sixteen women stayed in their own house or unit. Fifteen were in private rental, fourteen were in Department of Housing accommodation, fourteen were staying with relatives and friends and three were in crisis accommodation. Nineteen women stated that their accommodation arrangements had changed as a consequence of their domestic violence situation.

Information about income was available for 53 women. Thirty five of these women relied on some form of income support from Centrelink. Four of these applied to Centrelink for income support after leaving their partner. Seven women worked fulltime, two women were financially dependent on their partner and nine women worked part-time.

Experiences of abuse

The women experienced physical, emotional, financial, social, sexual, stalking, harassment, intimidation and threats of violence. The most frequent type of abuse was physical (75) closely followed by emotional/psychological abuse (73). For many women, this was not their first experience of abuse. Fifty six women indicated they had experience abuse earlier in their life.

Prior involvement with health, human and community services

Some women had histories of contact with health, human and community service agencies prior to their referral to the GVDVS. Twenty two women had contact with DOCS prior to the referral. Many of the women also had contact with an array of non-government organisations such as family support and accommodation services.

Occasions of service provided by Green Valley Domestic Violence Service

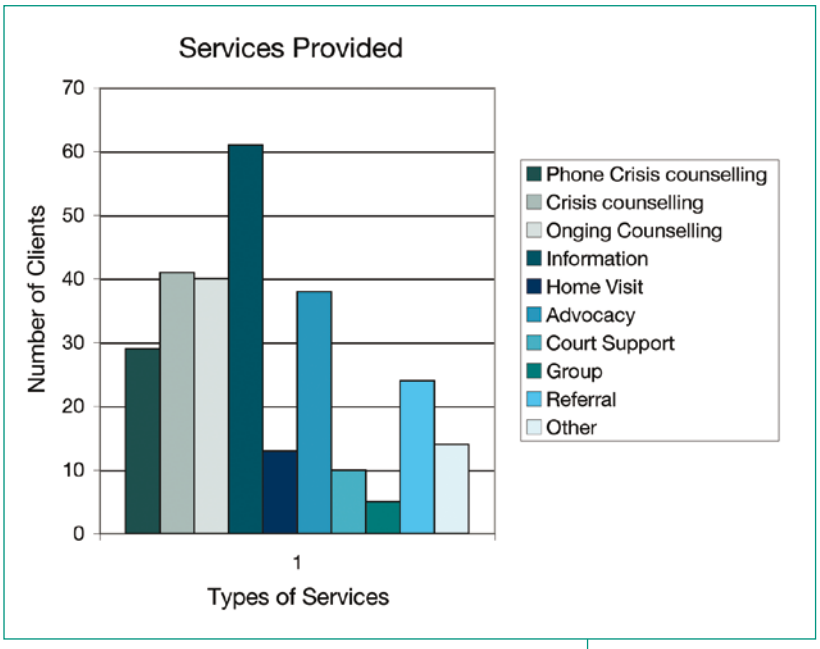
Of the 84 women who had ongoing contact with the GVDVS, 54 (over 64%) had in excess of 6 contacts with the service, with 22 (26%) having more than 20 contacts. Thirty women had between 2 to 5 contacts with the service.

The types of services offered most frequently by GVDVS were the provision of information (61), crisis (41) and ongoing counselling (40) and advocacy (38).

Within the context of these types of services a broad range of interventions were provided, as outlined in the table below. These included finding accommodation (15), assisting with obtaining an AVO (29), advocacy with police on behalf of women (20), addressing

safety issues, including developing safety plans (29), writing reports (24), protective behaviours (28) and making referrals (23).

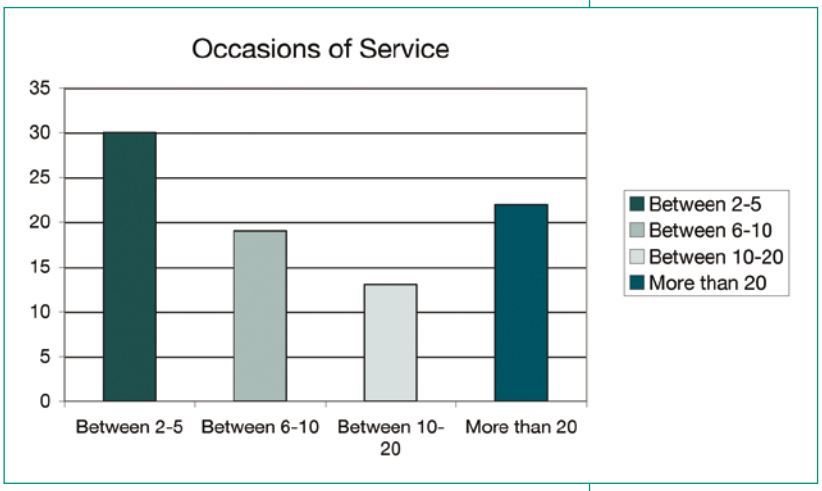
Numerous issues arose in the women's contact with GVDVS. The most frequent of these related to housing (33), child protection (22), family law (20) and financial concerns (20).



Other Agency Involvement

Many of the women referred were linked up with other agencies for appropriate intervention and ongoing support. These included DOCS, health, police, accommodation services, legal services and a range of non–government organisations including family support.

In a number of situations there was a high level of interagency collaboration. For twenty six women (31% of ongoing cases) between one to three agencies worked in collaboration with GVDVS. For twenty four women (28% of ongoing cases), the interagency collaboration involved four or more agencies.

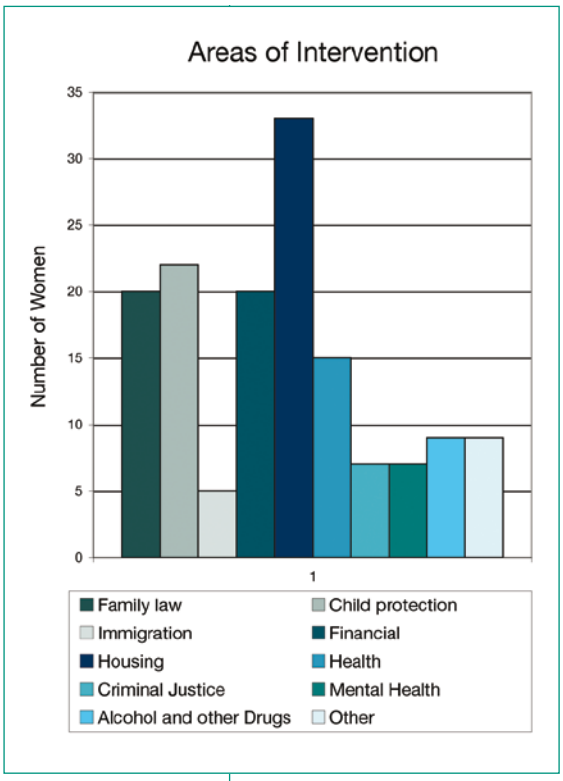


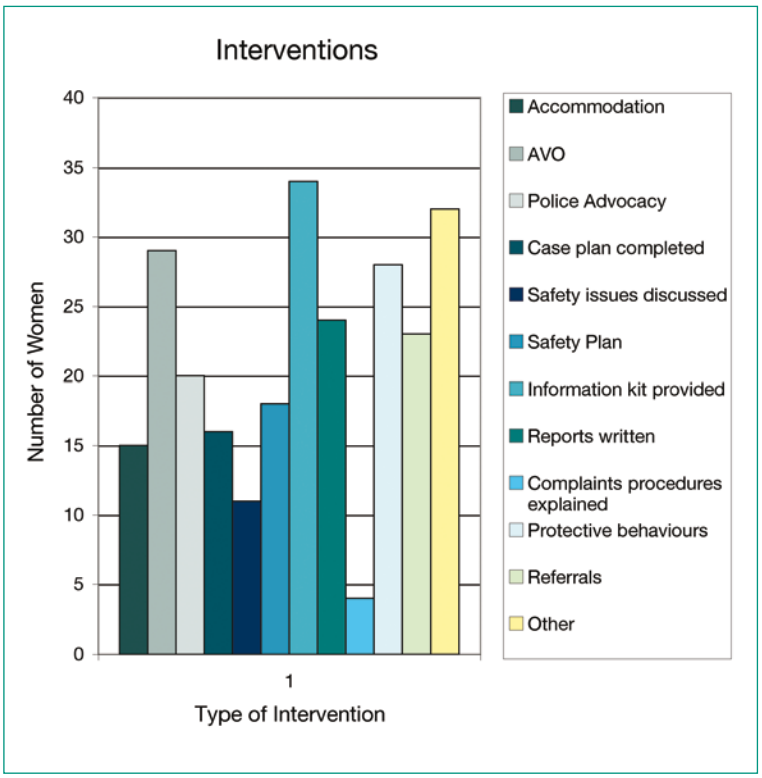
Discussion

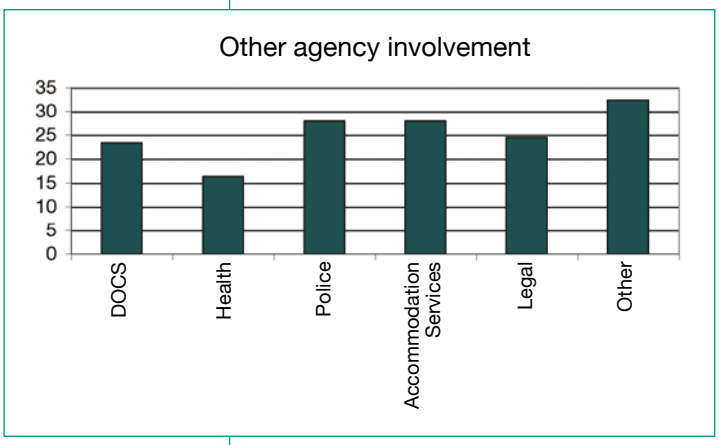
A number of issues that are relevant to evaluating the progress of the implementation of the GVDVS arise from the file audit. These are identified and discussed briefly here, and discussed in greater detail in the final section of the report – *Section 6: Progress in Development of the GVDVS*.

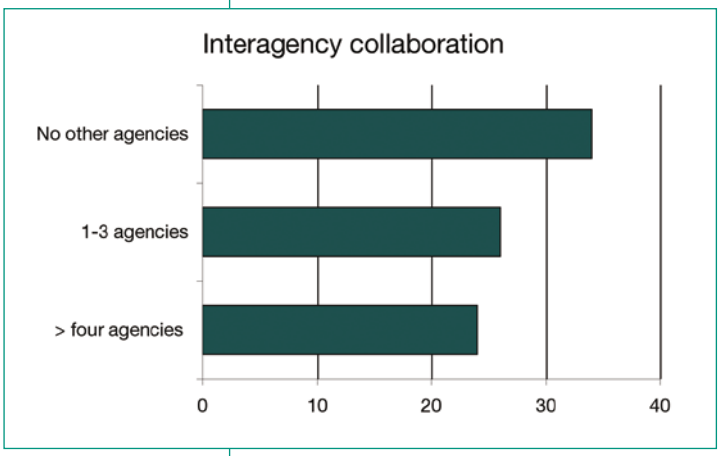
Referrals from the police are least likely to lead to ongoing contact

One aim of the fax back, was to offer assistance to women in crisis, who may not have had previous contact with domestic violence support services. It is widely recognised that women call the police for a complex range of reasons, but primarily to ensure the immediate safety of themselves and their children: they do not necessarily want to be involved in a long criminal justice process (Holder, 2001), nor may they be at the stage of readiness to leave, or to consider leaving the relationship (Patton, 2003). Hence, the low take-up of counselling at the point of referral is not unusual. Research with women who have eventually left violent relationships has found that a timely, supportive and non-directive response that provides information about domestic violence and about services available, without judging the woman or prescribing how she should act, is an important intervention that can have long-term benefits in the woman's subsequent actions aimed at improving the safety of herself and her children (Patton, 2003). Hence these single contacts are potentially important interventions but little information about their impact is currently available.









Intensity of the intervention

Almost two thirds (64%) of women having ongoing contact with the service had more than six contacts with the service. This indicates a strong capacity of the GVDVS to engage with women.

Protecting children

Forty three women – just over half of the ongoing cases – had children who were aged less than five years. This indicates that the GVDVS is making an important contribution to child protection concerns that arise in the context of domestic violence through the ability to engage mothers of this most vulnerable group of children.

After housing issues, child protection issues were the second most frequent issue addressed as part of the GVDVS intervention. If the Family Law issues are included with child protection issues, these child protection-related activities comprise a significant proportion of the work done with women.

Interagency collaboration

The file audit shows that work with women involved many interventions beyond counselling, and that these activities were, in the majority of cases, conducted in collaboration with other agencies. As discussed further in section 6, systemic advocacy that assists women to access a range of resources has been demonstrated to be effective practice that increases the well being and safety of women and their children.

PART 2: Documented group work, training, community education and interagency activities of the GVDVS

Group Work

In addition to work with individual women, the GVDVS provides group work interventions, often in collaboration with other agencies. Some of these have a ***therapeutic*** orientation:

- Ten week writing workshop for women recovering from domestic violence and sexual assault, *Stories from the soul*. Seven participants. (Partnership with Fairfield/Liverpool Sexual Assault Service)
- Eight week workshop *Women Moving On*. Eight participants. (Partnership with Joan Harrison Support Service for Women)
- *Connections Program* - Rebuilding the relationship between mothers and children in the aftermath of domestic violence. (Collaboration with Park House, child and adolescent mental health service.)
- The GVDVS also refers women to the *Opportunity and Choices* group run by CPFS for GVDVS clients

Other groups offer ***support*** and information:

- *Breakfast Support Group* for women. Six to eight women attend fortnightly for six weeks.

Other group work has a ***preventive focus***:

- *Young Women's Photography* Project to educate on healthy relationships and awareness of domestic violence as well has gaining and enhancing photography skills (partnership with Liverpool Women's Health Centre and Fairfield/Liverpool Youth Health Team)

Some groups for clients provide ***specialist information*** about issues of common concern to clients:

- Family Law Seminar for clients of service

Training

An important role of a specialist service is the provision of training to other agencies in contact with women and children experiencing domestic violence, in order to enhance the capacity of those agencies to identify and respond appropriately to domestic violence, and to raise the profile of the GVDVS as a referral source.

Over the 18 month period in 2003/4 corresponding to the period of the file audit, training on responding to domestic violence was provided to **304 service providers in 11 agencies**. (See Table 4)

In the same period, **616 service providers in 17 community based agencies** in contact with children and families, were provided with training about domestic violence and child protection. (See Table 5)

The GVDVS also presented a workshop for service providers around "Working with groups from specific cultures around domestic violence" in collaboration with Mimosa House, the Refuge for Indo Chinese Women.

Contribution To Interagency Work

As part of their role in enhancing the interagency response to domestic violence, the GVDVS plays a key role in many interagency fora and agencies. These span domestic violence and child protection agencies, reflecting the GVDVS focus on bringing together issues of safety for women and children:

- The GVDVS domestic violence counsellors co-convene the Liverpool Domestic Violence Liaison Committee. This is the key domestic violence interagency forum in the Liverpool area. As part of convening this committee, the GVDVS has played a key role in organising a series of public forums on Family Law and Exclusion Orders and a well-attended 'hypothetical' addressing issues of gender and violence
- The counsellors are seconded fortnightly to the Liverpool Court Support Assistance Program. As was seen in the section of this report on responses from human service providers, the contribution of their specialist expertise in working with women was particularly valued by the court support service.
- Child Protection Interest Group
- Mimosa House Management Committee (Indo Chinese Refuge for Women)
- Liverpool Women's Health Centre Management Committee
- Joan Harrison Support Services for Women Management Committee
- Rosebank Child Sexual Abuse Service Management Committee
- Liverpool Court Advisory Group

In addition, the team actively participates in many **community awareness-raising** activities:

- International Women's Day Activities (2003-2005)
- Stop DV Day (2003-2005)
- Production of the Chrysalis Newsletter which is distributed in the community and which provides information about domestic violence to women (5 editions to date)
- Contribute articles to the Community 2168 newsletter produced by The Hub (2003-2005)
- Heckenberg Parents Expo
- Byani Aboriginal Women's Healing Festival
- Three Miller Festival days
- Austral Festival

Service Agreements

Documenting interagency policies and procedures for working together is an important component of developing interagency responses to domestic violence. The following service agreements have been developed and are judged by the team to be working well.

- Miller Department Housing (2003, ongoing)
- Police (2003, ongoing)
- Huz and Buz childcare centre (2004, ongoing)
- Sloanes Removalists (2003, ongoing)

- Wesley Furniture (2003/2004 - Until agency ceased operation)
- An agreement with Lifecare has been in place since 2003, but to date has not been used due to lack of uptake of perpetrators of violence.

The service agreements cover the following:

- Roles and responsibilities of both agencies
- Referral process
- Confidentiality and Information Exchange
- Refusal of Referrals
- Feedback Mechanisms
- Review Date

Building resources within the GVDVS

As part of efforts to provide a "seamless" service to clients, the team has invited relevant agencies to provide in-service staff training:

- Department of Housing - applications for women experiencing domestic violence
- Centrelink - applications for women experiencing domestic violence
- Department of Immigration - applications for women experiencing domestic violence
- Integrated Perinatal Infant Care
- LIFECARE - working with perpetrators of violence

Summary

The documented activities of the GVDVS in providing group work, training and community education about domestic violence and child protection, are directly related to the service goals, to:

- improve the service system's capacity to respond to domestic violence in Green Valley, and to
- promote community awareness about domestic violence

The development of service agreements with key interagency partners puts into place, one of the cornerstones of an effective coordinated response, i.e. *Policies and procedures to guide the coordination*. Formal documentation of these interagency procedures then provides one of the building blocks for another core aspect of an effective coordinated response: *a formal structure for monitoring the coordination*. Progress in the development of the coordinated response is discussed in further in section 6.

PART 3: *Power and Responsibility* evaluation tool outcome

As discussed in the description of the methodology, the use of psychological measures of change in women was not seen as appropriate, and other tools more appropriate to measuring outcomes of multifaceted interventions were seen as too intrusive on the counselling process. Hence the evaluation methodology sought data about change for women from interviews with clients, and to a lesser extent, from interviews with referring service providers.

The GVDVS has developed an evaluation tool that is consistent with the domestic violence practice theory underpinning its intervention (Burke, 1999). The rationale, tool and results are presented here as part of the documentation kept by the GVDVS. It represents an innovative approach to developing an evaluation tool based on contemporary Australian domestic violence practice literature, and reflects the service's commitment to assessing the impact of its work with women.

"The **purpose** of the scale was to identify change in women who had support of our service over a period of time. We wanted to measure the sense of power that they had in their lives, how responsible they felt for the violence and abuse. Chris Burke's article outlined, "women's and children's beliefs and behaviours are greatly influenced by the domestic violence context, especially their understanding of power and responsibility and gender roles". (Burke, 1999, p. 258) The construct of confidence was chosen because it was our belief that when women left the domestic violent relationship, confidence would be gained through their increasing independence."

This **tool** is a self rating scale (0-10) for clients.

Frequency distribution was used to determine the mean.

The three constructs are power, responsibility and confidence.

N = 10

The pre score was taken at the first session with client and post score was taken 3 to 6 months down the track with clients who were still with the service.

The tool comprises three questions:

Q1. How much power do you feel you have in your life?

[0= None 10= A lot]

Pre: 2.8 Post: 7.6

Q2. How responsible do you feel about the abuse that has happened to yourself and your children (if you have any)?

[0 = Not at All 10= Extremely]

Pre: 4 Post: 3.1

Q3. How confident do you feel about making decisions in your life?

[0 = Not at All 10 = Extremely]

Pre: 5.1 Post: 7.9

Summary

These changes indicate that women are reporting change in the desired direction on areas targeted in the intervention. Although the absence of a comparison group means that the changes cannot be definitively attributed to the intervention of the GVDVS, this tool has a number strengths that recommend its wider use:

- High face validity
- Short and easily administered in a counselling situation, where many clients are in crisis

SECTION 5

Interviews with Key Informants

This section of the evaluation reports on the data collected from interviews with Key Informants primarily between June and July, 2004 and previously included in the Interim Report in September 2004. Data from two interviews conducted after the submission of the Interim Report, has been incorporated. The data analysis is based on 18 interviews involving 21 respondents.

Key informants are senior representatives of participating interagency partners, and/or participants on the GVDVS steering committee. Since the GVDVS is an interagency initiative, interviews with members of the interagency network provide a rich source of data on the opportunities, barriers and progress towards the development of a more responsive domestic violence service delivery system.

Developing and maintaining effective interagency relationships is a complex and challenging endeavour, as noted by one of the respondents:

> *I think looking back we recognised we really needed to have everyone on board and that was where the steering committee came in so all the key players needed to be on board and I think where that was one model and management and key leaders was around about making sure we had the team very closely aligned and working together from the different agencies. That was obviously going to create problems but perhaps none of us really saw how many problems it would create.*

Purpose of the GVDVS

Each interview began with a question about the respondent's understanding of the purpose of the establishment of the GVDVS. Why was it established and what were the expectations about the outcomes? Clearly respondents' views on this would shape their perception of the progress to date.

There was considerable consensus about the reasons for the establishment of the GVDVS. Where differences were evident, these were in the relative emphasis placed by respondents on particular components of the GVDVS.

By far the most common response to this question was that the GVDVS was established to address a significant gap in service delivery: a specialist domestic violence service.

> *As far as I am concerned, the aims are to actually have some support network for the actual victims of DV so that they can get early intervention, they can get access to information, they can get referral to other services. Things that prior to their existence were not available to people in this area. That is the most important part that I can see.*

> *Well I guess it was just the lack of a specific DV service. We have been around here for a long time and there has never been a specific DV service. There has always been other people doing little bits.*

> *I think they were there to fill a gap that wasn't really being filled because it is actually quite hard to get people in for DV counselling. That was the issue I think, that is how it came up and they looked at that quite intensely and they wanted to set up a different service and they wanted to target an area where there was a high need for DV counselling.*

However, whether this "gap" existed specifically in Green Valley, or in the wider Liverpool area, was an issue of enormous contention. While this will be discussed in detail in the later section on implementation issues, it is worth noting that a majority of respondents – although they understood the context in which the funding had been received – felt that the small area covered by the service, which did not match other partner service boundaries, was a barrier to working with the GVDVS.

> *...it is specific to 2168 postcode and for a service like ours that covers all of Liverpool and doesn't have strict boundaries it has been quite difficult.*

The vision for this new, specialist service included the following features:

- provision of early intervention to women, specifically through the development of a partnership with the Police, to operate a 'fax-back' referral system
- located within a multi-disciplinary, multi-agency approach
- longer term, 'therapeutic' intervention, rather than merely crisis intervention
- flexible service delivery that included more than counselling/therapy
- responsive to the complexities of domestic violence - specifically the co-occurrence of drug and alcohol, mental health and child protection issues
- able to measure improvements in women and children's well-being over time
- finding new ways of responding to domestic violence ('*Ideally what you wanted was to work a bit differently than workers would normally work in their normal agencies and to test something out.'*)
- improving coordination (*'…it was an attempt to address the lack of coordination at times with the three principle agencies which were police, health and DCS…'*)

Most respondents saw that the GVDVS must also offer more than an intensive counselling/intervention service. It was also seen as important that the GVDVS contribute to:

- systems change
- capacity building within the network of services in contact with those affected by domestic violence, though the provision of training about domestic violence and the development of networks and partnerships
- prevention of domestic violence by community education efforts with the wider community

A smaller number of respondents mentioned expectations that the GVDVS would also lead to:

- broader crime prevention
- community development
- the development of a perpetrator program or some type of response -beyond a criminal justice one - to perpetrators (this being a point of strong disagreement for other respondents)

Where differences of opinion emerged, they were in relation to the emphasis which should be placed on direct service delivery, capacity building and community education. For those who struggled to locate resources for women dealing with violence and abuse, direct service delivery was the priority:

In terms of a good side to that aim was that the girls always said they were going to do grassroots stuff and that this was not going to be another policy writing project or an awareness project because all those projects do for us is to make more work. So they made that part of their aims, they were going to get their hands dirty...yes that was critical to us.

Achievements/Strengths

The interviews with Key Informants identified the achievements of the GVDVS. Apart from two respondents, from one agency, there were universal positive responses about the work of the GVDVS team across all aspects of their role: in the provision of direct service to women and children, in raising community awareness about domestic violence and in promoting enhanced service responses across the broader system. This is in contrast to more mixed views of respondents about the broader system's response, which is addressed in the section on implementation issues. Specifically, the strengths and achievements identified are summarised below, and examples of comments about them provided after this.

Improved direct service provision to victims of domestic violence

- The GVDVS fills an identified gap in services for women experiencing domestic violence in Green Valley
- evidence of positive change for clients
- flexibility in service delivery
- the expertise of the staff/quality of the service
- innovation in service development

Building the capacity of the service system

- providing consultation
- reorienting the Health approach to domestic violence

Promoting partnerships

- building partnerships
- promoting partnerships

Community education

- putting domestic violence on the local agenda

Promoting system change

- challenging different thinking
- incorporating additional elements/partners

Improved direct service provision to victims of domestic violence: filling a gap in direct service provision

The service is clearly meeting the expectations of respondents in the provision of a specialist, direct service to women experiencing violence:

From our point of view the greatest impact is that [our staff] here have somewhere to refer the person to whereas that didn't exist before.

The service that they promised has been provided. Any referrals that we make and any clients that they have become involved with, from our knowledge, we feel they have actually provided what they said they were going to provide. I think it is a very thorough service. I have never had anyone come to me and say, these people won't help me and they didn't do anything. It has all been very positive...Clients have been helped and some have ongoing involvement.

I think one of the biggest impacts for us is somewhere to refer people to... knowing that you can send someone somewhere and they will be dealt with straight away and with all their needs being met. Otherwise women get a big run around.

I thought they might not be able to pick up the amount of families they had. I though they may have had difficulty in doing that but we haven't experienced that with families we have referred to them. So for us it turned out better than what I thought it would.

Improved direct service provision to victims of domestic violence: positive change for women and their children

Respondents reported that the people whom they referred to the service, were positive about the service that they received. In most cases, they did not have ongoing contact and so could not comment on observed changes over time. (More data on this aspect is available in the section on service providers). However, where contact enabled this longer-term view, there was some feedback:

So there's been different clients that they've seen that they've had and you can certainly see a shift in where people are at in their lives. How stable they are, their level of happiness and safety and those sorts of things....If she's safer and feels happier and able to stabilise her kids and they're able to go to school without feeling fear or whatever, that's got to be the best impact....We have seen examples.

Improved direct service provision to victims of domestic violence: flexibility in service delivery

This was strong theme in the views of respondents, who often contrasted the approach of the GVDVS staff with more usual Health approaches to dealing with domestic violence (see also later discussion of reorienting Health's approach to dealing with domestic violence). The fact that the service offered a range of interventions including, but in addition to counselling, was valued and seen as appropriate to the needs of women and their children.

What it has done is, it is a designated community based service proving DV support and we want that to continue. That is what it has done, that is what is needed... we do need more refuges because they are always full, but there is that coordinated step before that is about, and it is really key I think to women making it. Some women will make it anyway because they do, we are pretty resilient really but with that extra hand that is about this is what you can do for your finance situation, this is what you can do with accommodation etc. all of that stuff, if you can offer that in a community based setting it is a really useful thing to do and then maybe that might make the difference between 'it is too hard and I am going to go back because it wasn't that bad' and' it is still hard but I am getting there'. If we can address some of the barriers that keep

women there, then that is a really good thing. So having a community based service that is not focused on any of those specific areas is a really good thing that kind of coordinates the other different things.

They did great advocacy stuff, we did some great joint work with them...They did interagency things, tackled mental heath, drug and alcohol stuff. You know whatever the issue was they got in there, they worked very hard and advocated for their clients.

With [some other services] they actually have to come into the service but with the GVDVS they go to the person's home which makes a difference and they can also do work with the children which is good.

So it's a bit of a one stop shop sort of stuff and I think rather than being 3 phone calls later with 3 different voices you're finally getting to talk to someone about long term abuse for you and your kids and the impact it's had on your family. It's got to be an easier process than this chain of the merry-go-round that people find themselves on I think. And I think it's a good sort of holistic approach as well to DV that because they're very well partnered with other services that are prepared to go out of their way to help them.

Improved direct service provision to victims of domestic violence: the expertise of the staff/quality of the service

A common theme in the interviews was the quality of the service provided, based on the expertise and commitment of the team members:

One good aspect of that service and I mentioned it assisted it to work, having quality staff who were committed to the issues.

They've got an incredibly good reputation in a very short space of time. Lots of people have to work long and hard for a long time to get a good reputation and I think this team has built it up really quickly which is a big plus.

Improved direct service provision to victims of domestic violence: innovation in service development

Some respondents mentioned that the team had promoted innovation in development of additional service components, such as the forensic medical service. This involves accessing resources from within the Health system, in order to develop an additional service for women, and a service component that can support the service response of the legal system, through better evidence collection.

So whether that's about enhanced evidence collection, I mean the forensic medical officer has been just great.

Building the capacity of the service system: providing consultation

Through sharing expertise, a specialist domestic violence team can build capacity within the service system. This was a clear expectation of the GVDVS, for which evidence of meeting this expectation was provided by several respondents. Often this happens in informal ways as people work together:

I think just professionally resourcing people in a fairly informal way, I think they've done very well with that.

In other instances, the team were perceived as open to requests for consultation:

The support they provide has been very positive, even for us to have that buffer, someone to actually pick up the phone and say look we have got a client, I don't know if they want to come and talk to you but this is the scenario can you give us some ideas of what we should do and they are happy to provide advice and support. They are also happy to talk about the team and where to go for help. It has been really good.

If we are stuck on a case we call them because I trust her judgment and she knows what we are going through.

Building the capacity of the service system: reorienting the Health approach to domestic violence

One of the expectations of the GVDVS, is that is would stimulate new ways of responding. Several respondents commented on the way in which the team had reoriented what was seen as a more usual response by Health workers to domestic violence.

One thing is I guess you have got Health providing a DV service that is pretty rare, they provide counselling and there are a lot of different settings where DV comes up as an issue but I don't think they have done DV work very well. Like they do counselling but often that beginning stage around DV is that negotiating with other services, different casework kind of stuff, a lot of focusing. It is more support advocacy kind of stuff as well and I don't think Health has always seen their role there. So I think it is good to get Health thinking about that a bit more.

I think there is a little bit of change in Health that DV is something that we need to be doing and in a community level.

They learnt about a whole new area, they were clinicians and they developed their casework skills. Now you have workers that are sensational. They know what they are doing and they are great caseworkers.

These comments fit with the experience reported by team members, who have taken up the opportunities for both more comprehensive service delivery and earlier intervention. For example:

I'd have to say [in terms of the greatest impact of the GVDVS] just being able to provide a service that's flexible to women. You can do things that are a little bit out of the ordinary in terms of a lot of other services. Very rarely do we say, 'no we can't do that.'

One respondent saw a role for the GVDVS team in providing training to other health workers, based on their developed expertise:

If their expertise is around working with the police and what the police response is I think that that would be helpful for health staff to know because I think that causes some anxiety with staff because it is in the policy that police are called so what do we expect when they come. That sort of thing. Also their experience about how you deal with a woman who discloses…So I would like to see drawing on their expertise to run awareness raising within reason.

Promoting partnerships: building partnerships

The team's success in building partnerships was widely acknowledged, although areas for further development exist and are documented in the following section. The GVDVS were seen by most respondents as proactively reaching out to other organisations and as willing to participate in joint activities, such as participating in the court support scheme, taking a leadership role on the local domestic violence committee and working on joint projects, particularly in activities aimed at raising community awareness about domestic violence and prevention. The partnership with Housing was reported by many respondents as an example of success. While it involved a formal service agreement, the elements of trust and ongoing development of a co-operative relationship, based on honest evaluation of the capacities of each service, was noted:

> *We were very clear up front with what we couldn't provide and we needed to be..... They often come over here and bounce off us and say what do you think about whatever. So there has never been any pressure from them [for a particular resource] or anything like that...it was all very clear and outlined and no demands that we couldn't meet and vice versa. We understand that we can't just walk in there and say do something. And it has worked well...We have a great relationship.*

The result for women is that they do not have to repeat their story to different agencies and can quickly be put in touch with access to necessary resources. Strong partnerships mean a better service for clients:

> *I think the networking is the most important as far as (our agency) is concerned. We need to know that if we are referring a client to the team then our client will get the support and the service that we are expecting them to get, what we are needing them to get for us to be able to help them. So as far as we are concerned networking..... It has been great for when we have clients come in here, we are able to speak to the service on the phone, make an appointment with them rather than telling them to go off and contact them. We have had that really personal relationship with them, which I think has worked well for the clients and made them feel more secure.*

Again, team members commented about the flexibility that working in a specialist domestic violence service provided them as health workers, in developing strong partnerships, in comparison to other roles within Health services. For example:

> *I wouldn't ever have the relationships I do with other services. Yes, I went to interagency meetings and stuff like that but you don't develop a relationship that you do working how we're working. So in fact we are working that integrated stuff where we can talk to other services, we refer them to the refuge and we can get feedback, how they're going. Maybe we can do something while they're doing something else. We're actually supporting one another. They do the DIMIA stuff and we can actually provide other stuff like take them to appointments or whatever. So they're not solely feeling completely responsible for that client. We can all share that. And sometimes we don't agree on things and it's actually challenging each other to look at different ways.*

While many respondents commented positively on the efforts of the team to develop and maintain partnerships, the outstanding example of networking and overcoming substantial barriers was reported by many respondents, with reference to the GVDVS team's work in building a strong partnership with many of the non-government agencies with expertise of working with domestic violence. These agencies had been unhappy with the level of con-

sultation in the establishment of the GVDVS and at one stage, some had withdrawn from the Steering Committee. However, in all but one case, the GVDVS team has established productive working relationships at the service provider level. This represented quite an achievement in overcoming what could have become a major barrier to developing important partnerships and robbed the project of significant expertise and experience in working with domestic violence.

In relation to this, a common theme in discussion of the initial planning process is reflected in comments such as these:

...for the NGOs in this area and particularly women's services in this area who for years had been trying to get money and services and input, suddenly DCS and Health had got this money, have consulted nobody and have set up this service down there. They weren't services that were used to working - of course there were DCS workers but they work in child protection not DV and Health the same. So those things have been a problem and they were on the agenda for such a long time and it was realizing that there were certain people that as much as they consulted with the rest of us had their own agenda all along and that has caused a lot of problems and some difficulties for us all....

But looking at the developmental phases as an NGO I found that there was really a lack of acknowledgment and understanding of the nuts and bolts of things. How things work at grass roots level.

I don't think the [initial planning] process was respectful in some ways and it did create some conflict.

The fact that these difficult beginnings were overcome with the majority of agencies was attributed by respondents to the ways in which team members engaged with, and respected the expertise of, services with experience domestic violence service delivery.

I keep going back to the same thing I suppose, that I was happy literally because of the people who work on that team, they are fantastic women and they have the same sort of commitment that the rest of us did, they just happened to work for government departments. They made it work I think.

We were quite vocal in what we thought should happen but it wasn't listened to at that [beginning] stage. However the team now works extremely well with [my organisation] and things like that. The team now are working extremely well in partnerships.... yes now the relationship between us and the team is fantastic.

I think the service's saving grace was the very people who work there...

For me personally it has reinforced my belief that you have to have transparency you have to have trust, all those elements if a project is going to succeed. In the short term I think that the team have managed to achieve what wasn't achieved in the beginning. I think they have developed relationships with other providers in a respectful manner, they have worked very well which has compensated for what was lacking.

...the team as a whole has managed to develop trust between the stakeholders and has acknowledged the work and the input, the value of the NGOs.

Promoting partnerships

In addition to developing partnerships, the GVDVS was recognised by some respondents as promoting the development of partnerships across the service system:

> *I think it's the raising of the agenda, with all those partners. Not just raising the agenda of DV, but raising the need to work together in relation to it. And that includes the NGOs in that set of partners.*

> *I think there have been significant impacts for most of the partners.*

> *I actually think the biggest benefit in terms of consultation has been Kerrie's role (the DoCS team member).. Because she's based [in Health] and has a relationship with the nurses and doctors, people know she's around, I think there's certainly been an advantage that people know her face and don't have the myths about DoCS and what they'll do. And she's certainly been able to train people up about understanding the child protection system and child protection knowledge.*

Community education: putting domestic violence on the local agenda

> *It has put DV on the agenda a bit more.*

> *I think just having an agency like that around in our area has meant a lot to this community. There never was anything before and it is an area with a lot of need... and it is the sort of thing that as it becomes more readily recognized, women will be more willing to go there so I just think that having it there has been great and it has been something that has been needed in the area for a long time.*

Promoting system change: challenging different thinking

> *The positives I guess is that it's actually had a debate, the discussions are occurring and we're at a point where we can actually look at informing a better service model. So I think that's a good thing.*

> *...I think they've certainly been good at promoting the need to open up DV to it being more of a community issue that we all need to take a bit of a role in addressing.*

Promoting system change: incorporating additional elements/ partners

The team's work with the magistrates at Liverpool court was mentioned by a number of respondents.

An alternate view

As noted, the vast majority of respondents identified a range of achievements of the GVDV team. The minority negative view of two respondents can be summarized by saying that serious concerns were expressed about the ability of the GVDVS to ensure the safety of women, children and the staff of the service.

> *...they are not looking at safety. It is primary for me and they are not looking at it. The safety of the women, children, workers... They think it is a relationship problem that can be solved.*

Implementation Issues

As would be expected in any new interagency endeavour, Key Informants identified a range of issues, which they saw as problematic, or as requiring further development/refinement, in the implementation of the GVDVS to date. These were:

• Less than optimal involvement by some key organisations

A number of respondents expressed disappointment with what they saw as a lack of support and commitment to the development of the service and to an interagency domestic violence response by the Police, and to a lesser extent, by the Department of Community Services. These difficulties were identified as lying predominantly at the organisational, rather than at the interpersonal level and were, in part, attributed to the turnover of staff in senior positions in both organisations.

I think the police response and commitment is a huge problem...

I think DoCS' commitment has also not been 100%. Again the DoCS worker is fantastic...but having said that partly because of the structure, the restructure of DoCS there has been no stable DoCS manager at Liverpool right from the very beginning.

...very senior DoCS management participation on the steering committee dwindled, dwindled, dwindled and now we have no one attending from management at the steering committee. I think that's an indicator of commitment as well.

As far as I could see the police didn't fulfil their side of the bargain and there were problems with that....I suppose that article in the paper is a classic example of the police doing stuff without consulting

In the case of the Police, there was considerable disappointment that the *fax-back scheme*, identified as a key early intervention mechanism, had not yielded referrals in the numbers anticipated.

Looking at collaboration, one of the critical components was with the police with the fax back system and that has failed miserably in my opinion and depending on who you speak to you will get a different account of why.

The problem part is the fax-back which we really saw as a predominant feature of the crisis arm of responding quickly, the identification, the early intervention. That's been the problem arm.

Despite these views of key informants, staff of the service reported that, over time, the working relationship with police was developing and improving, and that time was required to further develop this important partnership.

• The short timeframe in which to establish a complex service of this type

Overall my comment will be if you set something up for a two-year period without a commitment to ongoing funding that is about service provision is difficult. Sometimes you have to do that to get a service and then argue the other fight later, but as a model those kind of pilot things that then get taken away are difficulty I think. With a service like DV intervention, it is really unfair.

I think we feel annoyed that it is a pilot program...in the UK, their idea of a pilot program

is a 10-15 year process and this ridiculous thing about throwing something in there for two years, I feel really angry about because it is unfair on people, on all the players involved, on all the partners who try to bend over backwards in their systems to suit this thing for a limited amount of time without any commitment to something ongoing.

- **The geographical boundary of the service – limited to the 2168 area**

This was raised as problematic by a majority of respondents, although the reasons for the funding of the service in this geographical area, and the links to previous community development work in 2168, were understood. Nevertheless, for agencies whose remit included the entire Liverpool area, the limitations in being able to refer to the only specialist domestic violence service in the area, remained a source of frustration. This was also seen by some as a factor in the difficulties for police in implementing a fax back service: i.e. as a barrier or source of frustration which interfered with the willingness of general duties police to use the new referral mechanism. Nevertheless, it was also recognised that an extension of geographical reach of the service would have implications for the level of staffing and other resources.

... they need to have a bigger postcode because we get families outside that and it is hard for us to get them into somewhere else.

We get back to that postcode issue and I know that they're are as flexible as they possibly can be so it is not a criticism to them (team) but it is the guidelines, the funding. So it is about being restricted to that postcode area. I think that whole idea is quite flawed.

...the reality that the project is so short term, only covers a very small geographical area, that has made things very difficult. I cannot refer clients from here to the GVDV because we are the Liverpool postcode area. We work with clients that they have been working with but it doesn't work in reverse. So that has been a problem, but none the less it was a problem we knew was there from the outset and...it has been a primary issue for everybody.

- **The physical setting of the service and the move to Hoxton Park**

Consistent with best practice domestic violence service delivery, the service attempted to offer a safe service to women, but faced barriers to this in the physical environment of Miller community health centre due to the lack of on-site administration/reception and the shared premises with teams offering different service types. During the period covered by this report, the team moved to the Hoxton Park Community Health Centre, which offered an environment where the principle of safe service delivery could be achieved. In addition, this allowed the team members to be co-located. However, this move away from Miller was seen as raising other issues by two of the respondents.

Oh yes they have an appalling space, but they are actually moving to Hoxton Park... I would have preferred that they stay here... I think it is a real shame that they are moving down there...that is a pity because this is the heart of 2168 and down there it is 2170 or something. I know it is not their fault, the location here isn't adequate but it would have been better if they stayed.

I think the key of its success for me is that it's based in here in the area and it's physically close to lots of the services that they lean on for support and we lean on for a bit of resourcing so it's a co-resourcing partnership I guess. My concern that

if it moves to Hoxton Park, we may lose some of that but up until this point I think it's been one of its keys, because we're talking about domestic violence now in conversation more than we did before and I think that's a good thing... so my concern is that if it moves, we're gonna lose a bit of that.

- **Information and data sharing**

Consistent with all co-ordinated domestic violence responses, this was identified as a major area requiring development.

We have huge issues around information and data sharing...As a steering committee I don't think we have had any influence or the ability to influence that. We need to pull and share information about stuff so that we can do future planning.

But it was clear that was one of the major issues that came out, the way information was being shared and clearly one party saying they weren't getting the information and the other major player not supplying the information. To a certain degree I think it was reliant on personalities…but again it should not have been dependent on personalities with the principal players. It should have been clearly set down guidelines.

- **The difficulties in developing the role of the DoCS worker within the team**

As noted earlier, including child protection services within coordinated responses to domestic violence has often been put in the "too hard' basket, and there are few models of success on which to build. Having tackled such a complex issue, it is inevitable that the GVDVS has struggled to find a way forward.

I don't know how the DoCS position has enhanced or impacted the team...maybe it hasn't been as impacting as it could've been.

... I think there are some people that see that having a DoCS worker has been a bit of a big stick in a team that maybe didn't need a big stick around DoCS reporting and child protection issues and whatever. I think there's some people that probably still see that as a bit over the top.

Many respondents acknowledged that the difficulties encountered lay not with the individuals or organisations involved, but in the complexity of the task of findings effective ways for two very different services - domestic violence and statutory child protection - to work together:

I think trying to locate the DCS stuff has been difficult and we find that evidenced in our own work around DV, that locating DV within a child protection framework, which doesn't mean that you don't work with child protection, but it is difficult. So that has been difficult too. Some of the things haven't been achieved because it has been difficult.

One respondent thought it important to draw a distinction between dealing with the impact of domestic violence on children and young people, and a child protection (statutory) response:

I think the problem is to make sure that we don't just improve child protection outcomes, instead of have a broader brief about how to improve outcomes for children and young people in families.

There was consensus that the way in which the DoCS/Health partnership was developed 'on the ground' required further discussion and negotiation. In hindsight, the expectation that a sole worker from DoCS could develop a reoriented role, was not feasible. The solution adopted – involving the DoCS worker in a training and education role – while valuable and contributing significantly to one of the three aims of the GVDVS – is not seen as viable by informants in the longer term.

- **Lack of appropriate consultation with services with expertise and experience in working with domestic violence**

  So our concern is that there is an idea that the project continue that all the players are consulted about what is a model that might work best and in any of those models, the NGOs have been sidelined which is really sad because I think we are really well placed to respond.

  Partnerships can work but they need to be very carefully negotiated and I think people didn't put in to that....The best partnerships are where that is all negotiated but this wasn't. So in a way the partnership stuff was set up from the very beginning.

- **Difficulties in developing a common philosophy**

  I guess there has been some serious conflicts around philosophy...like taking out 'woman' and putting in 'family'. Philosophically there were some barriers there to achieving the greatest outcomes.

  We have got a very strong women's network in Liverpool, we have got 4 women-specific, feminist based organisations in Liverpool. We are really lucky and we all work together, so we network, plus we have the VAW worker and the court support. So for them to take women out of the aims and objectives was incredible to us.

  I think one of the things that was a concern for us as well apart from looking after women in the 2168 area, the service was narrowed down to the child protection stuff and we used to say what about older women and those without children and those women came down quite low on their level. They were more concerned with families with kids and we sort of had a few problems with that and where do the other women go. Did they fit into the service? DCS really pushed the child protection stuff which is fine but where did we slot the other women.

  They were not interested in the safety of the woman and they were focused on the perpetrator...The perpetrator has committed a criminal offence he should be punished. So I was coming from a different perspective and philosophies.

- **Lack of progress in the development of a response to perpetrators**

One respondent raised the issue of programs for perpetrators, less as an identified need than as an issue that had not yet been addressed in any depth.

I don't know if they are doing the perpetrator programs and I really don't know if they can.

For other respondents, as expressed above, there was, in contrast, a clear belief that the focus should be on women and children, rather than on perpetrators. Several other respondents mentioned the desire to see the GVDVS promote greater accountability for perpetrators through stronger action of the criminal justice system:

...you'd have to see that there were some changes in terms of the rate of justice follow through with perpetrators. And successful outcomes there.

But also too the ideal model would be that you have a credible and effective criminal justice response...Because unless we have criminal justice response, nothing's going to change.

- **The number of clients seen**

There was considerable difference of opinion as to whether or not the service was seeing sufficient clients, with some respondents clearly disappointed on this score: ' Again we might have thought that it would deal with more clients.'

Another respondent had a different view, being *"…overwhelmed with what they had done….[there was] something like a number in the 70s of women they had had face to face contact and referred etc, not just a phone call. And I thought that was really amazing if they have helped that number of women…they have had an impact and they have also had a huge number of phone-ins"*.

For some respondents, who placed their assessment of numbers seen in the context of the other types of intervention that the team is involved in – community education, training – there was no such concern. Indeed, there was recognition by some that the lower level of referrals than anticipated, made it possible for the service to offer the specialist and multifaceted response required if a domestic violence service is to offer more than a crisis/referral response.

- **Some respondents identified a need to develop a response to other forms of family violence (e.g. young people's violence towards parents)**

- **Mixed views about the effectiveness of the Steering Committee**

Not unexpectedly, there were mixed views about the effectiveness of the Steering Committee in the management of the GVDVS and the development of a co-ordinated, interagency response to domestic violence. It was pointed out that the committee's beginning, overseeing the development of both the GVDVS and an extended home visiting program, had resulted in some confusion about the committee's role and purpose. Issues raised about the steering committee included:

- problems with the level of representation from some agencies - i.e. loss of senior agency representatives
- lack of representation of key agencies at times
- lack of continuity of representation (*'It has had a huge impact on the committee. I think it has a significant impact when you have a huge change in players across meetings for people to understand the history and develop a relationship and keep the consistency and vision.'*)
- uncertainty about what was expected of members (*'Basically if they had a set guideline about what each participant was to report on each month, if they had a set guideline for each participant I think it would make life a lot better because you would go to the meeting knowing what they were looking for and what they wanted to hear from you'*)
- it focussed on monitoring the work of the GVDVS team, rather than on developing the interagency response
- there is no CALD or Indigenous representation

There was a range of responses on the issue the effectiveness of the committee in addressing the "difficult" issues, which inevitably arise in implementing a complex, interagency project. Some saw the committee as having addressed such issues quite well. For example:

> *...when you look back, it's been a pretty strong steering committee. We've had a few problems simply getting a terms of reference but it's been meeting regularly, it's been discussing some of the issues that need to be discussed...[It's] challenge[d] people's ideas and ways of working. And I think it's hard to sustain that over a long period of time. We've been meeting for probably close on 2 years, I'd say.*

Others saw the convening of meetings of government agencies, outside the steering committee, as evidence of the failure of the steering committee to address issues of key importance to the GVDVS.

> *.... you would have to question how effective the steering committee has been given that the issues that have recently been identified have obviously been there the whole way along.*

One participant was of the opinion that the difficult interagency issues had not been addressed:

> *…in the [time] that I was there I didn't see any improvement in terms of the relationship with the principal players and that is the short fall that I think needs to be addressed…It wasn't through a lack of commitment for the parties but the organisations were not willing to compromise I think would be the best way to say it. They needed to come to some sort of agreement where no one would come in and change the process. They may have seen that there was a limited amount of time and that it would come in at the review process but the difficulty is that then it is never addressed and it becomes entrenched and more difficult to resolve…*

Some informants expressed the view that the committee had been moving to a different stage of development towards the end of 2003, becoming more strategic in its approach, developing a work plan and a system of subcommittees. However, this process was seen to have become de-railed by the need to focus on the issue of funding for the GVDVS as the time for the completion of the pilot funding period approached.

Developments since the Key Informant interviews

In February, 2005 the Steering Committee convened a Planning Day, with the following aim:

> *To provide an opportunity for all those involved in responding to domestic violence in Green Valley to identify and review the progress and achievements to date, to identify areas for further development over the coming 12 months, and to develop a plan for working on identified goals.*

In part, this was a response to a question raised in the Interim Evaluation Report, i.e.: How can the Steering Committee reorient and broaden its role, from monitoring the development of the GVDVS to developing a coordinated interagency response to domestic violence?

The day was attended by 11 members of the Steering Committee and four staff of the GVDVS. All participating agencies, with the exception of DoCS, were represented. The day provided the opportunity to jointly document the many achievements of the GVDVS over

the previous two years, many of which are included in this report. Participants described the GVDVS as a '**hub to coordinate other agencies for sustainable outcomes**.'

Participants rated the progress of the development of the interagency response to domestic violence in Green Valley against the key components of coordinated community responses, as identified in the literature (see discussion in section 6), and identified future priorities for development of the interagency response. This has been operationalized through the development of a structure for future Steering Committee meetings that focuses explicitly on strengthening the internationally recognized components of an effective interagency response. While some of this work has been occurring to date, there is now an explicit framework for addressing change at policy level, for the next phase of the development of the coordinated response.

The GVDVS continues to play a pivotal role in both the provision of services to women and children and in highlighting the systemic issues that require attention. However, the responsibility for the ongoing development of the coordinated interagency response is more evenly shared among all the organisations involved and the focus is more directly focussed on the interagency response, rather than solely on the specialist GVDVS.

SECTION 6

Progress in Development of the Green Valley Domestic Violence Service

Introduction

This section of the report discusses the findings of this evaluation in the context of the current research on:

- coordinated responses to domestic violence and their evaluation
- improving collaboration between statutory child protection and specialist domestic violence services.
- good practice in service provision to women affected by domestic violence

Since the GVDVS is located within the Health system, a brief discussion of the health impacts of domestic violence and of the role of the health system in responding to domestic violence, is also included as a context for discussing the findings and for the recommendations that are made.

A context for the findings of the evaluation

What is a coordinated/integrated response to domestic violence?

Calls for 'working together', whether termed interagency or multi-agency 'co-operation', 'co-ordination', or 'collaboration'1, are commonly made in fields such as domestic violence. The call for interagency coordination in domestic violence is based on the rationale that the services required to address domestic violence are provided, not by one single agency, but by many different agencies. However, this is an extremely complex undertaking:

> *We are continually urged to "work together" as if this is merely a matter of goodwill. Yet interagency collaboration is highly complex and involves interpersonal, inter-professional and inter-organisational dimensions.* (Scott,1996, p. 1)

In discussing coordinated responses, it is important to note that the terms 'coordinated' and 'integrated', when applied to domestic violence responses, are often used to mean both a process and an outcome. The founders of the internationally renowned domestic violence coordinated response, the Duluth Abuse Intervention Project (DAIP) in the United States, caution against making co-ordination itself the goal (outcome) of domestic violence responses.

> *Although coordination is a method to reach the overall goal of victim safety, it is not in itself the primary goal of the Duluth model. When reform efforts focus on coordinating the system rather than on building safety considerations into the infrastructure, the system could actually become more harmful to victims than the previously unexamined system.* (Pence & McDonnell 1999, p. 41)

1 These terms are commonly used interchangeably, and this common usage is adopted here.

The definition of coordinated/integrated domestic violence service provision developed by the Australian Domestic and Family Violence Clearinghouse also emphasises that coordinated responses are a means to achieving the *primary goal* of enhancing victim safety and the secondary goal of increasing perpetrator accountability, rather than the key goal in itself.

> *Integrated service provision means: coordinated, appropriate, consistent responses aimed at enhancing victim safety, reducing secondary victimisation and holding abusers accountable for their violence.* (Mulroney, 2003)

Hence, evaluation of coordinated responses explores the processes of coordination, but always in the context of a an overarching focus on the impact of these processes on *outcomes for women and children* exposed to domestic violence. Also highlighted in this definition is the concept of *secondary victimisation* – the recognition that women and children may experience harm, in addition to the direct effects of domestic violence, if their attempts to seek help are met with inappropriate responses. Examples of responses that may cause secondary victimisation include blaming women for their victimisation, blaming women for the harm caused to children by men's violence and abuse, providing inaccurate information about resources, and not addressing safety issues.

Efforts to prevent such inappropriate responses go to the very heart of the elements that are addressed in efforts to improve the coordination of responses across agencies. Based on the Australian and international literature, a number of elements or components of successful interagency responses to domestic violence, have been identified:

- A shared philosophy and understanding of domestic violence
- Policies and procedures to guide the coordination
- A formal structure for monitoring the coordination
- A mandate for change
- A respectful and participative culture between participants.
- Membership - involvement of the key agencies and of representatives with the seniority within their organisation to commit the agency to decisions.
- Involvement of victim advocates.
- A focus on process in creating institutional change
- An evaluation component – especially for unanticipated consequences of reforms
- Incorporation of input from victims (Laing, Mulroney & Gietzelt, 2003)

These are clearly related to the aim of reducing secondary victimisation. For example, the development of a shared philosophy and understanding of domestic violence, requires participating agencies to grapple with the issue of responsibility for domestic violence and thus reduces the possibility that women will encounter attitudes that blame them and

assume that 'just leaving' a relationship in which they are being abused is simple and will necessarily increase their safety and that of their children.

What is clear from the experience of those who have undertaken efforts to develop a better coordinated response to domestic violence, is that it is an ongoing, complex task, that may result in "unanticipated outcomes" for women and children. Hence, ongoing evaluation of change and new procedures is required, particularly from the standpoint of the victims of violence – women and children (Shepard & Pence, 1999).

The challenge of evaluating 'success' in coordinated domestic violence service delivery

Despite the emphasis on developing co-ordinated responses to domestic violence, a recent literature review found a dearth of system-wide evaluations of coordinated responses, either in the Australian or the international literature (Research Unit on Gendered Violence, 2003). Most commonly, evaluation efforts have focussed on individual components of the coordinated response, such as *arrest policies and perpetrator programs*. Less research effort has been directed to the *prosecution* component, and still less to evaluating the *victim services* component. This dearth of system-wide evaluations of coordinated responses is not surprising, given the many barriers to the design and implementation of such studies. Most obviously, the complexity of the system to be evaluated is the greatest challenge:

> *…since CCIs [comprehensive, community based initiatives] operate, and are linked at, a number of levels (individual, community, agency, system), the task of evaluating them can be formidable.* (Adler, 2002, p. 204)

Since the GVDVS is a new project, tackling the complex task of building a better coordinated response from scratch, the focus of this evaluation is on the processes by which the elements of a coordinated response are being developed. This focus on processes has shaped a methodology that explores the perspectives of those involved in its implementation – frontline service providers, managers of participating agencies and staff, and women clients.

Given the recognition that improved coordination is a means to improved outcomes for women and children, the emerging findings are always located in the context of asking:

- How does this increase the safety and well being of women and children?
- How does this "fit" with findings of research that explore women's experiences of help-seeking? i.e. is it accountable to women's views on what helps them and their children?

Sustainability of coordinated responses

Ensuring that the many agencies that respond to domestic violence prioritise the safety of women and children, hold the perpetrator of abuse accountable and do not further compound the trauma suffered by women and children, is a complex, ongoing task. The Duluth Abuse Intervention Project (DAIP), a small, non-profit agency in Duluth, Minnesota, is the best known Community Intervention Project. It has operated since 1980 and continues to identify areas where systemic reform is required, and to implement and evaluate reforms to the coordinated interagency response, such as a multi-agency approach to risk assessment (Shepard, Falk & Elliott, 2002). Similarly, the most effective Australian coordinated responses – such as the ACT Family Violence Intervention Project, initiated in 1998 and the Gold Coast Domestic Violence Integrated Response, initiated in 1996, have been developed over long time-frames, typically rolled out in stages of reform followed by evaluation, refinement and further reform.

Collaboration between domestic violence services and statutory child protection services

The recognition that child abuse and domestic violence frequently co-exist, together with the evidence of the harmful effects of exposure to domestic violence on children, have led to calls for improved collaboration between statutory child protection services and domestic violence services. However, such collaboration faces considerable challenges, given the very different histories, philosophies and structures of these two services. On one hand, domestic violence services:

- are community-based, offering services on a voluntary basis to women and children escaping domestic violence
- stress the empowerment of women through respecting their choices and providing information and support – i.e. are "woman-centred"

In contrast, child protection services:

- have a statutory base and deal largely with involuntary clients
- deal with women who may be at a very different stage in recognising and dealing with the violence, than the women who contact domestic violence services

These differences result in a number of barriers to collaboration, including:

- Tensions between the "child-centred" and "woman-centred" philosophies of child protection and domestic violence services. (Beeman et al., 1999)
- Tensions about how best to hold violent men accountable. Domestic violence service providers often argue that child protection services hold mothers accountable for the behaviour of abusive men. Yet child protection services often have little leverage with abusive men. For example, threats to remove children may not be a concern to the perpetrator of violence and indeed, a woman's fear of losing her children can be utilised by the abusive man as part of his tactics of coercive control. (Beeman et al., 1999; Laing, 2003)

Strategies for improving collaboration

A number of strategies for building collaboration have been reported recently in the literature.[2] Key to building successful collaborations are:

- Establishing "common ground" – i.e. agreement on a common goal of intervention. For example, one US project described the common goal of intervention, identified by both domestic violence and child protection services as:

  …to respond to families where women and children are abused in ways that protect the child, empower the mother, and do not unnecessarily separate children from a non-abusive parent, the person who intimately understands the trauma they face. (Mills et al. 2000, pp. 328-329)

- Understanding the roles of each service system, including the constraints and pressures under which they operate (Clarke et al., 1996)
- Cross-training to bring together two bodies of expertise
- Ongoing consultation between child protection and domestic violence workers on a case by case basis to combine the knowledge and experience of each system, and in this way, develop practice knowledge with complex cases (Fleck-Henderson, 2000)

2 For a full review see Laing (2003)

Good practice in service delivery to women

The dynamics of domestic violence, the crisis nature of much intervention and the pressing safety issues for women and children involved, create formidable difficulties for establishing evidence of effective practice (Abel, 2000). Probably the strongest empirical evidence available on effective work with women exposed to domestic violence is the body of research on "community based advocacy" by Cris Sullivan and colleagues (e.g. Sullivan & Bybee,1999; Allen, Bybee & Sullivan, 2004; Goodkind, Sullivan & Bybee, 2004). In the North American literature, the term 'advocacy' is commonly used to describe woman-centred domestic violence intervention. The essence of advocacy is:

> *…to help survivors of domestic violence navigate the systems involved in the community response as they attempt to acquire needed resources. (Allen et al., 2004, p. 1017)*

In summary, research by Sullivan and colleagues has shown that:

- women who received intensive advocacy services were more effective in acquiring needed community resources than were women in a control group
- positive outcomes persisted even two years after the intervention
- women who worked with community advocates had a higher quality of life, had greater social support, and were experiencing less violence than women who did not work with advocates (Allen et al., p. 1018)
- Although no one (safety) strategy is effective for all women, the two strategies most likely to make the situation better are contacting a domestic violence victim service program (72%) and actually staying at a domestic violence shelter (79%). (Goodkind, Sullivan & Bybee, 2004).

These findings provide evidence of the important role that *specialist domestic services* play in increasing the safety of women and children. It also highlights the importance of *systemic advocacy* in intervention with women, rather than reliance on more narrow responses, such as counselling alone. This research was undertaken with women post refuge, that is with women who have decided to leave the relationship, at least on a temporary basis.

Complementing this research, because it deals with women at other stages of dealing with violence, are the findings of a recent Australian study of how women leave abusive relationships. Based on this study, Patton (2003) has identified a framework for good practice in domestic violence intervention. In this framework, appropriate intervention is identified at each of 5 stages that women may go through in coping with domestic violence: *Pre-contemplation*: managing and/or resisting the violence but not generally thinking about leaving; *Contemplation*: women are beginning to think about leaving and are usually acutely aware of the barriers; *Deciding to leave*: seeking information and making plans; *Actually leaving*: leaving their home either temporarily or permanently, often feeling 'in crisis' and seeking action-focused practical and emotional support; *Establishing a new, violence-free life*: a particularly challenging phase, where women seek non-directive practical and emotional support, and when access to resources is crucial.

Good practice involves a different type of intervention at each of these stages. For example, a women in stage 1, who is attempting to 'deal with' or 'manage' the violence without removing the man or leaving the relationship, requires a non-directive response, that provides information but does not tell her what she must do, or that she must leave. The latter are inappropriate and are:

> *…likely to result in her being less willing to seek further help as she may feel she has failed to do the right thing if she does not leave. She may be resistant to suggestions*

> *or agree with what is suggested rather than offend, but take none of the agreed action and/or feel unable to return for support in the future.* (Patton, 2003, p. 137)

In contrast, women in stage 4, 'actually leaving', seek more active practical and emotional support. Again, woman-focused and woman-directed practice, is identified as central to good practice.

These findings suggest a need to refocus from the commonly held notion of '*early*' intervention to one of '*appropriate*' intervention, based on attempts to understand the women's stage of dealing with violence. In discussing the work of the GVDVS, reference will be made to this framework for good practice and the evidence about the efficacy of community based advocacy.

The role of Health services in domestic violence service delivery

There is increasing recognition that domestic violence is an important health issue, because of its adverse impacts on women's physical and mental health. For example, in comparison with non-abused women, abused women have a 50-70 per cent increase in gynaecological, central nervous system and stress-related problems (Campbell et al. 2002). Domestic violence is also associated with a range of adverse mental health impacts such as anxiety, depression, post traumatic stress disorder, substance abuse and suicidality (Roberts et al. 1998; Golding, 1999).

Flowing from the publication by the World Health Organisation of the *World Report on Violence and Health* (Krug et al., 2002), the first study to estimate the health impacts of domestic violence on women using the 'burden of disease' methodology, found that domestic violence is:

> *...responsible for more ill-health and premature death in Victorian women under the age of 45 than any other of the well-known risk factors, including high blood pressure, obesity and smoking. (VicHealth, 2004, p.8).*

Based on their findings, the authors argue that:

> *When it comes to setting priorities for action and program development, intimate partner violence warrants attention at least equal to that of many other well-established diseases and risk factors, such as high blood pressure, cholesterol and obesity.* (Vichealth, 2004, p. 30)

Further, the deleterious effects of living with domestic violence on children's health, development and wellbeing are well documented (e.g. Edleson, 1999). Women's risk of experiencing domestic violence is elevated during pregnancy and in the perinatal period (Taft, 2002). The findings of the VicHealth (2004) study highlight that the years in which women's health are most adversely affected (15-44 years), are the years in which women are bearing and raising children. Domestic violence intervention that increases the safety of women and reduces the physical and mental health impacts of domestic violence, can play a pivotal role in improving the social and environmental context of children's lives.

These research findings and the leadership of the WHO clearly establish domestic violence as a priority issue for health services. This is recognised by the NSW Health Domestic Violence Policy (2003) which introduced routine screening for domestic violence into health sectors known to have high rates of domestic violence. The GVDVS is one of only two specialist domestic violence intervention teams in the NSW health sector, the other being the St George Domestic Violence Service in southern Sydney.

Findings from the evaluation of the GVDVS in the context of the good practice literature

The GVDVS model

Efforts at developing coordinated, interagency responses to domestic violence have followed a number of paths. In North America, efforts at coordination have primarily centred around enhancing the criminal justice response to domestic violence, underpinned by 'mandatory arrest' and 'mandatory prosecution' policies. One criticism of these approaches is their failure to incorporate child protection and health services into the co-ordinated response (Clark et al. 1996).

In Australia, approaches to coordination have developed from one of four "starting points" (Research Unit on Gendered Violence, 2003). These include:

- Coordinated responses initiated by specialist women's domestic violence services (e.g. Gold Coast Domestic Violence Integrated Response) - i.e. change is initiated primarily from the service delivery level
- Criminal justice system reform projects based around a specialist domestic violence court (e.g. Central Violence Intervention Project, South Australia)
- Broadly based criminal justice system reform projects (e.g. ACT Family Violence Intervention Project, which is closest to the North American models). The stimulus for change was a Community Law Reform Committee review of the operation of the criminal justice system's response to domestic violence within the ACT, which led to the establishment of a statutory Domestic Violence Prevention Council chaired by a Victims of Crime Coordinator (an independent statutory appointment), to provide advice on domestic violence policy and program development. This Council developed the policy framework for the implementation of the FVIP. - i.e. change is initiated from the policy level
- Responses centred around policing initiatives (e.g. No To Violence, South Australia)

Most of these models are based within the criminal justice system, apart from the model in which the coordinated response has developed under the *strong leadership of specialist women's domestic violence services* within the non-government sector. It is important to note that, in this model, although the momentum for the coordinated response is located within specialist women's domestic violence services, responding to domestic violence as a crime remains central to the response.

The interagency approach developed to date in Green Valley is similar to the latter model, in that leadership and focus are provided from a specialist domestic violence service.- i.e. at the *service provision*, rather than the *policy level* of the system. However, in Green Valley, this service is located within the Health, rather than the non-government sector.

Most Australian specialist women's domestic violence services have workers and programs specifically working with children exposed to domestic violence. The inclusion of a member of the CPFS team in the GVDVS is consistent with this approach. However, the inclusion of a statutory child protection worker is a novel feature of the GVDVS approach.

The coordinated response to domestic violence

It is clear from the interviews with both Key Informants and frontline service providers, that the presence of a specialist domestic violence service that has played an active and highly visible role in systemic advocacy and in interagency fora, has been the catalyst for improved interagency responses to domestic violence. The role of the GVDVS was described

by Key Informants at the recent planning day as the ***hub to coordinate other agencies for sustainable outcomes***. Progress has been made, to varying degrees, on each element of a coordinated response to domestic violence outlined earlier in this section of the report. The collaboration has been most strongly developed at the *service delivery level* - in the day-to-day work of service delivery to women and children. This is backed up by documentation of agreed interagency policy and procedures in service agreements.

The following case study, provided by the GVDVS, demonstrates the ways in which a number of agencies worked together to achieve safety for a woman and four children, and the highlights the coordinating role of the GVDVS:

Case Study 1

This client is a CALD woman with four children and no extended family in Australia. She had been in a violent and abusive relationship for approximately 20 years and referred herself to the GVDVS. She wanted to talk about her experience, not knowing what options she had available. Her husband controlled the family finances. Against her husband's wishes, she had undertaken a training course to gain a qualification and obtained part-time work. The husband controlled every aspect of the family's life and the whole family were paralysed in fear. She decided to leave her husband and take the children with her after coming to the conclusion that her husband would never change.

GVDVS Action:

GVDVS coordinated a meeting with a worker from the Department of Housing and the client to discuss options available to her. She subsequently applied for housing and applied for Rent Start after finding an appropriate rental property with the help of the GVDVS. Due to the service agreement that had been developed between Miller Department of Housing (DOH) and GVDVS, DOH approved the client's Rent Start application based on the GVDVS counsellor's assessment of the client's situation. Once the client application was submitted, the Senior Client Services Officer (SCSO), who works closely with GVDVS, arranged the bond and 2 weeks' rent within a day of the application being submitted.

Benefits:

- The client only met with a DOH worker once to discuss options available.
- The client did not have to undergo another interview about her traumatic circumstances.
- Application and approval time were cut significantly so the client could act quickly, thus contributing to her safety and that of her children.
- The client could use her energies in other areas such as supporting her family. She could also continue to work and thus be better placed for the ongoing financial support of herself and her children.

Further action by GVDVS:

About the same time, GVDVS contacted Centrelink to arrange an appointment for assessment for pension, family assistance and child support exemption. Once the appointment was made, GVDVS counsellor contacted the social worker at Centrelink to provide information to put on the system that would support the woman's applications. The GVDVS counsellor also wrote a letter of support detailing the client's safety

concerns regarding the child support exemption. (It is important to note that GVDVS does not have a service agreement with Centrelink; however GVDVS had various visits with the Social Work Department and the Manager of Family Assistance section). The Centrelink manager also concluded that less trauma for the client was a priority and that she would allocate the most appropriate Customer Service Officer to the client. Although the woman had not left the family home at this stage, she was granted the 'separated under one roof ' provision for one month so she had financial support to assist with the move.

Benefits:

- The barrier of moving was extinguished
- One less expense for the client at the time of crisis in establishing a new home and safe life.

Other interagency support

This client has been involved with GVDVS on an ongoing basis. Recently a steering committee NGO service member collaborated with GVDVS to pay for a solicitor's fee. The reason for this was that it takes Health approximately 6 weeks to generate a cheque for service. This local service was able to provide a cheque immediately to cover the cost of the solicitor's fees.

In this case study, the GVDVS worked with the Department of Housing, Centrelink and a NGO to assist a woman who was at high risk in leaving a violent, controlling and dangerous partner. The role of the GVDVS in locating and accessing appropriate resources, and in so doing, overcoming barriers to her escape from violence, was critical to achieving safety for this woman and her children. This demonstrates the vital role that a specialist domestic violence service can play in activating a coordinated response to domestic violence.

In addition to the coordinating role played by the GVDVS, reorientation of the Steering Committee's role will provide a forum for planning and monitoring the ongoing development of the coordinated response to domestic violence at the inter-organisational level. The cross-agency work of the GVDVS will highlight systemic issues that require attention and the Steering Committee will be responsible for taking up these issues at the inter-organisational level.

Service delivery to women and children

Systemic advocacy

Interviews with staff and some of the Key Informants revealed that the type of service offered to women experiencing domestic violence has developed in a different direction to that envisioned in the early planning. Perhaps influenced by the positioning of Health as the lead agency, it was initially anticipated that this new, specialist service would be distinguished by a *therapeutic* orientation. However, in implementing the program in a community setting, the staff recognised that the women referred to the service had multiple, complex, pressing needs across a range of legal, accommodation, social welfare and health agencies.

This required a reorientation of the approach to working with women. Staff who had previously worked in a generalist community health setting with a focus on counselling, were

able to respond flexibly to women's diverse needs within the new service. This is illustrated in the following excerpt, in which one of the staff describes how work with women by the GVDVS departs from a traditional counselling approach within Health:

> *…a lot of people focus on this counselling stuff when in fact, I think it's a word that's misunderstood. Or maybe we've got it wrong, we've got the wrong word happening, but just that practical stuff for women has been the most important thing. That they can call us anytime, ask a question. We can act on their behalf, we can drive them to the Family Law Court, support them through that. Traditionally that's never happened. It's just too bloody hard. So they don't go through with it. Then all sorts of things happen for them. (Staff interview)*

As noted previously in this report, this approach was visible to, and valued by, participants in the service provider interviews:

> *…that holistic stuff, I can't rave enough about it. It really works, not just dealing with one part of what is going on. They look at the whole picture. The positive outcomes we have seen for mutual clients. (NGO respondent)*

In a similar vein, women clients talked of how important to their achieving safety, was the active systemic advocacy provided by the GVDVS:

> *…and the system is so disappointing that it forces women to just go back. I thought I'd just go back, to just put up with whatever he did… Unless I have a service such as this, I would be back with him because I wouldn't have received help from anywhere. (client interview)*

The model of service described in the interviews with staff, clients and service providers, contains the key elements of "community based advocacy" identified in the international research as evidence-based practice with women. i.e. practice that is:

- woman-directed
- flexible
- focussed on system-wide advocacy

This flexible, timely response to women's self-identified priorities may explain the service's ability to engage many women in ongoing intervention: as identified in the file audit, almost two thirds (64%) of women having ongoing contact with the service had more than six contacts. In this respect, it is interesting to compare the difficulties that were reported by a respondent in the community health sector in reaching out to, and engaging, women dealing with domestic violence:

> *Well we have had a lot of trouble getting people to come to counselling…They may come to sessions but then drop out for various reasons. There might be safety fears or they can't physically get here. So there are a huge number of instances of DV but we were not getting a huge number of referrals. (Health respondent, service provider interviews)*

Crisis intervention

The model of service was designed to enable the team to reach women in crisis, primarily through referrals from the Police. This is in contrast to the traditional service offered through community health:

> *…as a generalist counsellor on the community counselling team, we don't have women who present in crisis. Because they know that we can't offer, we don't do that type of work on the community health team. (staff interview)*

As noted in the file audit, many women referred via the Police fax-back system, have only one contact with the GVDVS. This finding can have a number of possible explanations, which may be related to the type of service offered by the GVDVS (e.g. appropriateness, timeliness) and/or the situation and needs of the women referred. Unfortunately, data about women referred in this way is extremely limited due to their brief contact with the GVDVS.

Referring to Patton's (2003) research findings, these brief contacts are potentially powerful interventions with women who may be in the initial stages of dealing with violence: a non-directive supportive response, which provides information but does not prescribe action (include counselling), and which leaves it open for her to make contact when she is ready. Unfortunately, the available data do not make it possible to assess the outcomes of these crisis interventions. Based on the file audit, over 100 women referred to the GVDVS have received an intervention that may be highly influential in their future help seeking, and hence their safety and the safety of their children.

Appropriate intervention for the woman's stage of dealing with violence

In planning the GVDVS, there was considerable emphasis on the notion of early intervention. With reference to Patton's (2003) model for good practice, the alternative concept of appropriate intervention has been raised. The data from the client interviews provide some evidence that women are receiving appropriate intervention.

For example, two of the women interviewed could be categorised as being in the initial stages of dealing with violence, and the others, in the fifth stage. However, a number of the latter group described earlier contact with the GVDVS, when they were at different stages of the process. The women gave examples of good practice at each stage of intervention.

Working with women in the initial stages of dealing with violence calls for a high degree of skill and specialist knowledge about domestic violence. As discussed above, inappropriate intervention at this time – i.e. intervention that tells a woman what she must do and in particular instructs her to leave the relationship - can inhibit future help-seeking. The two women interviewed, who were in the early stages of dealing with violence, gave examples of good practice in their descriptions of their contact with the service. One woman had had only one contact, but felt that she could make contact again in the future. The other woman described the emotional abuse she was experiencing from her partner, but was not yet naming this as "domestic violence". She had been engaged in ongoing counselling, where she described how the counsellor was working at her pace, respecting her choices, and providing non-directive information and support:

> *She [counsellor] is very good, she is very good listener and says to take it slow and make it comfortable… I'm just very lucky to have found her because I have nobody to talk to…She's helped me all the way through whenever I need her I can just call her.*

Other women described how the staff were appropriately active with them when they were at the crisis stage of ending the relationship: they assisted with information, finding accommodation, finances, the practicalities of relocating and court support. Women engaged in the later stage of building a life free of violence, valued the GVDVS for providing the consistent, non-directive ongoing support that they felt able to access as needed to make the long-term changes necessary to establishing a violence-free life for themselves and their children. For example, one young woman explained that she no longer

needed regular appointments with the service, but that their ongoing support was still important to her:

> *The last month or so I've been doing really well. So I've actually asked - Lisa was coming out on a fortnightly basis to see me - But I've actually said I've been doing really well. I've been doing a lot of things. I'm not isolating myself as much as I was so, I actually asked her to still give me a ring every fortnight so that if I do sort of lapse into an isolation sort of thing that I've still got that outlet to sort of help me…and I didn't want my file closed or anything, just cause you know how there are times where [ex-partner] will ring and I want to discuss it with someone. And Lisa is the best I know, I've found even out of all my friends and stuff. (client interview)*

Work with children

A key aim of the GVDVS was the development of a model that was responsive to the needs of both women and children. This was initially approached structurally by locating a DoCS specialist caseworker as part of the GVDVS team. While this approach had some identified benefits, problems were also identified, and the position has not been filled for approximately 12 months. (This is discussed in detail later in this section on partnerships)

This change in the model raises the question as to whether the GVDVS is addressing child protection concerns and the impact of domestic violence on children and young people. The findings from this evaluation would suggest that these issues are being addressed. For example, data from the file audit indicate that:

- over 50% of women engaged in ongoing contact with the GVDVS have children aged less than 5 years. Thus the service is successfully engaging women whose children are developmentally vulnerable to severe impacts of exposure to domestic violence. This vulnerability is highlighted in recent research findings that children under five are disproportionately represented among children who witness domestic violence and that children in this age group are more likely than older children to be exposed to multiple incidents of domestic violence (Fantuzzo et al. 1997; Fantuzzo & Mohr, 1999).
- Twenty nine per cent of women with children engaged in ongoing contact have intervention focussing on child protection issues.
- Twenty six per cent of women with children engaged in ongoing contact with the service had intervention regarding Family Law issues. Abuse by ex-partners of women and children during child contact is emerging as a key safety issue for women and children (Kaye, Stubbs & Tolmie, 2003). It is an important area of child protection intervention and advocacy by domestic violence services.

Direct work to assist children and young people to overcome the effects of domestic violence is offered on some occasions by the domestic violence counsellors. The original premises in which the team was located initially limited this type of work, because of a lack of space and child therapy resources, but that is no longer the case. As noted in section 4, the team has also collaborated with other children's services within the health sector, to run a group aimed at facilitating recovery from the effects of living with violence.

The dedication of a position in the CPFS team to taking GVDVS referrals is also an important resource for assisting children and young people to overcome the effects of living with domestic violence and for assisting women with parenting after violence. Unfortunately, little of this work is captured by this evaluation because of changes in personnel and a vacancy in the position for much of the evaluation period. This position has now been filled and is strengthening the longer-term therapeutic resources that the GVDVS can offer. For some women, seeking help with parenting after violence can be an acceptable entry point

for longer-term work on overcoming the effects of violence and abuse for both women and children.

The tensions inherent in bringing together staff whose roles are defined primarily in terms of working with women or with children, identified in the literature discussed above, were encountered by some team members, and discussed in the staff interviews. Such tensions need not be problematic and can contribute to the development of new practice knowledge.

A number of factors associated with establishing a new service from scratch in a short period of time, meant that developing new practice in this complex area was undertaken in tandem with many other service development activities. These factors included the location of team members in separate physical locations; the different stages at which various team members joined the team; different possible contributions from part- and full-time staff; vacancies in positions; and lack of clarity in roles of the DoCS specialist and the CPFS positions.

The GVDVS employed an external consultant with expertise in both child protection and domestic violence to ensure that GVDVS practice is addressing the needs of both women and children. By focusing on safety, the needs of women and children are seen as inevitably interrelated, rather than in conflict (staff interview).

Relationships with interagency partners

Police

> *"They might not be in uniform but we are all working for the same thing"*
>
> *"I don't think that other stations have got this service and I know it is good for our station….Green Valley is lucky to have it"*

The strengthening of the partnership between the GVDVS and the Police has been the most notable development of the coordinated response in the period between the interim and final evaluation reports. This was raised by the GVDVS staff and by Key Informants who attended the Steering Committee Planning Day in February, 2005. As noted in the Interim Report, disappointment had been expressed by a number of Key Informants about the relatively slow progress in the development of this partnership, especially in view of the emphasis placed on the 'faxback' as a core feature of the GVDVS.

As noted in the section on service provider interviews, all five general duties police, interviewed at random as part of the service provider interviews, were aware of the GVDVS and of the process of referral, where consent had been obtained, via the DVLOs. They had either attended the training offered by the GVDVS, or been briefed by DVLOs or senior officers. Interestingly, the quotations above from two of the general duties police respondents, reflect notions of 'partnership' and 'ownership' of the GVDVS.

The improved partnership appears to be related to a number of factors:

- training offered to police by the GVDVS team
- a streamlining of the internal police processes between the general duties police and DVLOs and of communication pathways between the police and the GVDVS. All domestic violence matters go to the DVLOs, who manage the referrals to the GVDVS. The process is monitored via six weekly meetings between the Crime Manager and the GVDVS and fortnightly meetings between the DVLOs and the GVDVS.
- Clarification of different definitions of domestic violence within Health and Police (staff interview)

- Revising of the GVDVS geographic boundary to include the entire area covered by the Green Valley Police (staff interview)

These developments reflect the strengthening of some of the key elements of a coordinated response, specifically:

- A shared philosophy and understanding of domestic violence (enhanced by training)
- Policies and procedures to guide the coordination (both within and between agencies)
- A formal structure for monitoring the coordination (the regular meetings to identify and plan to address problems or unexpected issues that arise)

The data from the police interviews provided some possible avenues to further develop the collaboration between the police and the GVDVS through the type of training offered:

- Training that increases understanding of the roles and constraints of each organisation

  While the training offered to date was valued, particularly for the opportunity it provided to meet the members of the GVDVS team, one respondent suggested that it would be helpful if the information flow was two-way, so that the GVDVS team gained appreciation of the constraints on Police in responding to domestic violence:

  I think a lot of people got frustrated because I don't think they felt that what we deal with was appreciated properly, they didn't understand what we deal with…People that we see don't necessarily want us to help them sort their lives out they just want us to help them with their immediate problems there and then...I do know that one of the officers offered to take one of the ladies on the shift on a Friday night to see what that is all about and she was all go for that but it never kind of eventuated…if each can appreciate what the other person does more…So I think if you can appreciate where each person is coming from, we are all supposed to be on the same side not fighting each other.

  This suggestion is similar to the use of the Police 'ride-along' in Duluth, so that other organisations can gain some understanding of what Police face in dealing with domestic violence.

- Training that provides police with information on outcomes for those referred

  The Police interviewed had mixed responses to the possibility of finding out about what happens to the people that take up the option of referral to the GVDVS. Some welcomed this:

  I would be curious to see what happens to the people after we deal with them. Just so that when I do go, you know I go to those things and I talk to the victim and I say there is this service and that service but I don't actually know really. So I tell them there are support services for them but I wouldn't have a clue on what support services there are and what they do. So I am trying to help these people but I don't know where I am sending them.

  Other officers were overwhelmed with the constant workload, and did not seek further information once they had referred to the DVLOs and the GVDVS.

  One officer reported getting a phone call from the GVDVS team, telling him the outcome of a referral he had made (although this was not a usual occurrence).

  There are good things that happen from us liaising with them, like the other week Lisa rang me up and said do you remember that lady who you put through to us. She told

me what had happened to her and she just wanted to let me know… With the help of the ladies at the DV team, they have gone to immigration and finally now they can stay in Australia. They have made it that she can stay, they have organised finance for her and now she is studying at TAFE, English classes. She wants to learn and hopefully get employed herself. She doesn't want to rely on the government. She has some teenagers and hopefully they can start work soon. It has all been a result of this service.

It was noted in the service provider interviews that the biggest problem identified by Police in responding to domestic violence was the failure of women to follow through with legal action after a police call-out. Training that provides feedback, possibly through composite case studies, about the complex process of change for women dealing with domestic violence, and the outcomes over the longer-term, may assist Police to see their role within this "bigger picture."

Department of Housing

This partnership was identified in the Interim Report as the most successful at that point, and it continues to operate extremely successfully. The service agreement and well-developed working relationship between these two agencies have established a "seamless" service to clients in that staff of the GVDVS can complete the paperwork required by the Department of Housing: the result for women is that they do not have to tell their story to yet another organisation in order to access assistance with accommodation. The GVDVS provided the following case study to demonstrate the ways in which this partnership is making an important contribution to the safety and well being of women and their children. (Some details have been changed to make the situation less identifiable).

Case Study 2

This woman has five children from pre-school age to adolescence. She was referred to service by the Police DVLO. Her partner was in jail for violent offences, and she was petrified of him. She related a life of severe, life-threatening and terrifying abuse with him and harassment that continued via others during his imprisonment. She tried to move a number of times but he always found her. She did not dare take out an AVO. She was terrified as his parole was coming up. She needed a Department of Housing transfer and intended to change her identity.

Action:

The GVDVS liaised with the Police to obtain information and check about the partner's imminent parole hearing. Housing was also contacted to ascertain the status of her application. A letter of support was written by the GVDVS after contacting Housing and speaking to CSO. One week later the client was advised that they could transfer her.

Benefits

The client had been in contact with the Department of Housing herself but the case was not treated as a priority and she was told that a transfer could take up to 6 months. The GVDVS involvement meant that additional information could be provided to the DOH and through liaison with the CSO/ Housing, the client's case became individualised hence, the quicker response.

The file audit identified accommodation as one of the most frequent problems facing women. Hence this partnership is a key resource for the GVDVS in responding to women's needs for safe accommodation.

In the case of the strong partnerships developed with Housing, and developing with Police, ***the common factor that can be identified as contributing to improved collaboration is the establishment of identified positions within partner organisations*** (two SCSO in Housing and the DVLOs in Police) who act as a link between their organisation and the GVDVS. It was also identified that by Key Informants at the Planning Day, that the incumbents in these positions also provide training and consultation about domestic violence (either formally or informally) to generalist staff within their organisations. This contributes to increased knowledge and skills in responding to domestic violence being spread within these organisations.

Department of Community Services

This partnership has not developed to the extent anticipated in the planning of the GVDVS. As noted in the Interim Report, a number of Key Informants expressed disappointment at the level of DoCS' participation in the ongoing management of the GVDVS.

One aspect of the pilot model that was regarded as unsuccessful by many respondents, both within the GVDVS team and by Key Informants, was the location of a DoCS casework specialist within the GVDVS team. It was initially planned that this worker contact 'level 3' notifications involving domestic violence for families in the Green Valley area, in order to offer 'early intervention'. Problems identified with this included:

- The worker was caught 'in between' two agencies with different approaches to domestic violence.
- The ways in which the worker's statutory responsibilities were to be managed within the Health team, were unclear
- Upon assessment, the clients' situations were often revealed as involving a higher degree of risk of harm to children than was evident from the referral information. The worker was then placed in the position of attempting to negotiate the re-referral of these back to the CSC.

The interim resolution of these dilemmas was that the DoCS worker did not undertake client work, focussing instead on delivering specialised training to community agencies about domestic violence and child protection and providing consultation to both Health and DoCS staff. This approach had some positive benefits that were identified by survey respondents such as:

- Enhancing the knowledge about the domestic violence/child protection connection for generalist Health and DoCS staff
- making a large contribution to community capacity building through the delivery of training to community agencies (see section 4)

On balance, despite these contributions, the experiment of placing a DoCS staff member as part of the GCDVS team, did not promote the strong Health/DoCS partnership to the extent hoped for. This position has been unfilled since the incumbent left in mid-2004.

On reflection, this outcome is not surprising. As noted earlier, there are few well developed models, either in Australia or internationally, for bringing together domestic violence and statutory child protection services, and the barriers to collaboration are unlikely to be overcome through the provision of a sole specialist position.

…sending one isolated case work specialist, certainly when issues did come forward, it heavily relied on the personality of the worker themselves because the immediate supervisor was a Health person and they had very different roles and responsibilities. (Key Informant interview)

Similarly, the constraints on DoCS in responding to increasing numbers of reports of child abuse involving domestic violence in a context of finite resources is a system-wide issue that could not be resolved at the service delivery level.

Despite extending the data collection period and many efforts by the research ream to recruit more DoCS workers to the service provider interviews, only three interviews were obtained. Unfortunately this provides limited data through which to explore the perceptions of DoCS caseworkers about the GVDVS and to canvass ideas about bringing together the specialist knowledge of both organisations about child protection and domestic violence.

Conclusions

The findings of this evaluation provide strong evidence that the GVDVS has developed a model of service delivery to women and children that is consistent with good practice in the specialist area of domestic violence intervention. This is provided through crisis intervention, systemic advocacy and longer-term counselling and support to enable women and children to achieve safety and over the longer term rebuild lives free of the effects of domestic violence. This is consistent with its goal to: improve the wellbeing of women, children, young persons and families.

Through a wide range of activities consistent with its other goals of improving the service system's capacity to respond to domestic violence in Green Valley and promoting community awareness about domestic violence – such as its training, community education and interagency leadership activities – the GVDVS has been the catalyst for the development of improved coordinated responses to women and children experiencing domestic violence.

Recommendations

The following recommendations are made to further strengthen the coordinated response to domestic violence in Green Valley. They are based on the data collected in the evaluation and on the literature on good practice in domestic violence service delivery.

1 The Green Valley Domestic Violence Service continue to receive funding after the pilot period, as a model domestic violence intervention program within the Health sector.

2 Within current resources, the GVDVS cannot provide an effective service beyond the 2168 area. It can, however, provide a model for the development of similar programs in other areas, or with additional resources, be expanded to cover the Liverpool area.

3 The GVDVS provide training and consultation to health service providers within the Sydney South West Health Area so that the specialist expertise developed can be a resource for the health system.

4 The GVDVS consider recording referrals that result in one contact only in electronic format so that later take-up of the service can be more easily identified.

5 The Steering Committee, consistent with decisions taken at the Planning Day, take responsibility for monitoring the progress of development of the coordinated response to domestic violence in Green Valley and for addressing issues at the policy level highlighted through the day-to-day work of the GVDVS and other agencies responding to domestic violence. The recent adoption of a structured agenda to reflect this focus, is a useful strategy for supporting this reorientation of the role of the Steering Committee.

6 Non-government women's services serving the Green Valley area have specialist expertise and extensive experience in responding to domestic violence. Hence they contribute a valuable resource that should be fully utilized in the ongoing planning and policy development for the interagency response to domestic violence in Green Valley.

7 Future policy development explore responses to the emerging issue of violence perpetrated by young people against parents.

References

Abel, E. M. 2000, 'Psychosocial treatments for battered women: A review of empirical research', Research on Social Work Practice, 10(1), 55-77.

Adler, M. A. 2002, 'The utility of modeling in evaluation planning: The case of the coordination of domestic violence services in Maryland', Evaluation and Program Planning, 25, 203-213

Allen, N., Bybee, D., Sullivan, C. M. 2004, Battered women's multitude of needs: evidence supporting the need for comprehensive advocacy. Violence against women Vol. 10, No. 9, pp. 1015-1035.

Beeman, S.K., Hagemeister, A.K. & Edleson, J. 1999, 'Child protection and battered women's services: from conflict to collaboration', Child Maltreatment, vol. 4, no. 2, pp. 116-126.

Campbell, J., Jones, A, S., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., Gielen, A, C., Wynne, C., 2002, 'Intimate Partner Violence and Physical Health Consequences', Archives of Internal Medicine, vol. 162, no 10, p1157-1163

Clark, S. J., Burt, M. R., Schulte, M. M., & Maguire, K. 1996, Coordinated Community Responses to Domestic Violence in Six Communities: Beyond the Justice System: A Full Report, Available: http://www.urban.org/urlprint.cfm?ID=6172

Department of Families, 2002, Practice Standards for Working with Women Affected by Domestic and Family Violence, Queensland Department of Families, http://www.families.qld.gov.au/violenceprevention/publications/documents/pdf/practice_standards.pdf

Edleson, J.L. 1999, 'Children's Witnessing of Adult Domestic Violence', Journal of Interpersonal Violence, 14, 8, 839-870

Fantuzzo, J., Boruch, R., Beriama, A., Atkins, M. and Marcus, S. 1997, 'Domestic violence and children: Prevalence and Risk in five major U.S. cities', Journal of the American Academy of Child and Adolescent Psychiatry, 36, 1, 116-122

Fantuzzo, J.W. and Mohr, W.K. 1999, 'Prevalence and Effects of Child Exposure to Domestic Violence', The Future of Children, 9, 3, 21-32

Findlater, J.E. & Kelly, S. 1999, 'Reframing child safety in Michigan: building collaboration among domestic violence, family preservation and child protection services', Child Maltreatment, vol. 4, no. 2, pp. 167-174

Fleck-Henderson, A. 2000, 'Domestic violence in the child protection system: seeing double', Children and Youth Services Review, vol. 22, no.5, pp. 333-354

Fleury, R. E., Sullivan, C. M. & Bybee, D. I. 2000, 'When ending the relationship does not end the violence', Violence Against Women, vol. 6, no.12, pp. 1363-1383.

Golding, J.M. 1999, "Intimate partner violence as a risk factor for mental disorders: a meta analysis" Journal of Family Violence, 14(2): 99-132

Goodkind, J.R., Sullivan, C. M. and Deborah I. Bybee, D.I. 2004. 'A contextual analysis of battered women's safety planning' Violence against women, Vol. 10, No. 5, pp. 514-533.

Holder, R. 2001, 'Domestic and family violence: Criminal justice interventions', Issues paper 3, Australian Domestic and Family Violence Clearinghouse, UNSW.

Kaye, M., Stubbs, J. & Tolmie, J. 2003 Negotiating child residence and contact arrangements against a background of domestic violence, Griffith University Families, Law and Social Policy Research Unit. Online: http://www.griffith.edu.au/centre/slrc/flru/pdf/wp4.pdf

Keys Young 2000, Evaluation of ACT Interagency Family Violence Intervention Program: final report, Department of Justice and Community Safety and Partnerships Against Domestic Violence, ACT [http://ofw.facs.gov.au/PADV/projects/eval_act_interag_fv_interven_final.pdf]

Krug, E.G., Dahlberg, L.L., Mercy, J.A., Zwi, A. & Lozano, R. (eds) 2002, World report on violence and health, Geneva: World Health Organisation

Laing, L. 2003a, 'Research and Evaluation of Interventions with Women Affected by Domestic Violence', Topic Paper, Australian Domestic and Family Violence Clearinghouse, UNSW, Sydney.

http://www.austdvclearinghouse.unsw.edu.au/topics/topics_pdf_files/evaluation_of_interventions_with_women.pdf

Laing, L. 2003b, 'Domestic violence in the context of child abuse and neglect', Topic Paper, Australian Domestic and Family Violence Clearinghouse, UNSW, Sydney. http://www.austdvclearinghouse.unsw.edu.au/topics/topics_pdf_files/child_protection.pdf

Laing, L., Mulroney, J. and Gietzelt, D. 2003. Co-ordinated Responses to Domestic Violence: Australian models, unpublished paper prepared for NSW Department of Community Services in the development of the Mt Druitt Domestic Violence initiative

Mills, L.G., Friend, C., Conroy, K., Fleck-Henderson, A., Krug, S., Magen, R.H., Thomas, R.L. and Trudeau, J.H. 2000, 'Child Protection and Domestic Violence: Training, Practice, and Policy Issues', Children and Youth Services Review, 22, 5, 315-332.

Mulroney, J. 2003, 'Trends in Interagency Work', Topic Paper, Australian Domestic and Family Violence Clearinghouse, UNSW, Sydney. http://www.austdvclearinghouse.unsw.edu.au/topics/topics_pdf_files/trends_interagency_final.pdf

NSW Health (2003). Policy and Procedures for Identifying and Responding to Domestic Violence, Sydney: NSW Department of Health

Patton, S. 2003, Pathways: how women leave violent men, Women Tasmania, Hobart. http://www.women.tas.gov.au/resources/padv/pathways.pdf

Pence, E.L. and McDonnell, C. 1999, 'Developing Policies and Protocols' in M.F. Shepard and E.L. Pence, Coordinating Community Responses to Domestic Violence: Lessons from Duluth and Beyond, Sage Publications, Thousand Oaks, pp. 41-64

Research Unit on Gendered Violence, 2003, A National Review of Integrated Programs for perpetrators of Domestic Violence, University of South Australia and Partnerships Against Domestic Violence, Commonwealth of Australia, Canberra

Roberts, G. L., Lawrence, J., Williams, G., & Raphael, B. 1998, 'The impact of violence on women's mental health', Australian and New Zealand Journal of Public Health, vol. 22, no. 7, pp. 796-801.

Scott, D. 1996, 'Interagency collaboration: why is it so difficult - how can we do it better?' in NSW Child Protection Council (ed.), NSW Child Protection Council State Conference: Preventing Child Abuse and Neglect: The Way Ahead, Sydney

Shepard, M.F. and Pence, E.L. 1999, Coordinating Community Responses to Domestic Violence: Lessons from Duluth and Beyond, Sage Publications, Thousand Oaks

Shepard, M., Falk, D. R., and Elliott, B. A. 2002, 'Enhancing Coordinated Community Responses to Reduce Recidivism in Cases of Domestic Violence', Journal of Interpersonal Violence, 17(5), 551-569.

Sullivan, C. M. and Bybee, D.I. 1999. 'Reducing violence using community-based advocacy for women with abusive partners', Journal of Consulting & Clinical Psychology, Vol. 67, No. 1, pp. 43-53.

Sullivan, C. 2001, Evaluating the Outcomes of Domestic Violence Service Programs: Some Practical Considerations and Strategies, National Electronic Network on Violence Against Women, Available: http://www.vawnet.org/VNL/library/general/AR_evaldv.pdf [2003, 6/6]

Taft, A. 2002, 'Violence in pregnancy and after childbirth', Australian Domestic & Family Violence Clearinghouse issues paper, No.6, Sydney: UNSW

urbis keys young 2001, Evaluation of the ACT Family Violence Intervention Program Phase11: Final Report. ACT Department of Justice and Community Safety, Canberra

urbis keys young 2002, Research into good practice models to facilitate access to the civil and criminal justice system by people experiencing domestic and family violence: final report, prepared for Office of the Status of Women, Department of the Prime Minister and Cabinet, Canberra [http://www.padv.dpmc.gov.au/oswpdf/Access_to_Justice.pdf, 28/02/03]

urbis keys young, 2004, Evaluation of the NSW Pilot Program for Perpetrators of Domestic Violence, prepared for the Violence Against Women Specialist Unit, Crime Prevention Division, Attorney General's department, Sydney

VicHealth 2004, The health costs of violence: measuring the burden of disease caused by intimate partner violence: a summary of findings, Carlton South, Vic: [http://www.vichealth.vic.gov.au/rhadmin/articles/files/Final%20Report.pdf , accessed 1/11/04]

Tables

Table 1: Summary data – client interviews

Client	Referral	Children	Duration DV	CALD	ATSI	AVO	DoCS	Child abuse	Family Court	Child contact
1	Housing Dept.	1	2 years	no	no	no	no	no	no	yes
2	Police DVLO	1	1.5 years	no	no	yes	yes	no	yes	yes
3	Police	2	15 years	yes	no	yes	yes	no	no	No
4	Police	1	?	no	yes	no	no	no	no	No
5	Marriage counsellor	3 adult	20+	no	no	yes	yes	yes	no	No
6	Centrelink	2	25+	yes	no	?	no	no	no	No
7	Community Health	no	Several violent rels.	no	no	yes	N/A	N/A	no	No
8	Migrant resource centre	1	4 years	yes	no	yes	no	no	?	yes
9	Community Health	no	4 years	no	no	yes	N/A	N/A	N/A	NA
10	Self – saw brochure	2	?	yes	no	no	no	no	no	NA
11	Court support	2	10 years	yes	no	yes	no	no	yes	yes
12	Community Health	1	13 years – ongoing post-separation	no	no	yes	no	no	yes	yes
13	Mental health service	3	Previous relationship 6 years	no	yes	yes	no	yes charged	no	no
14	Police	3	10 years	yes	no	yes	yes	yes, charged	yes	no

Table 2: Role and Responsibility of Participating Respondents' Organisations in Relation to Domestic Violence – Service Provider Interviews

Role of Organisation in Relation to DV	Responsibilities of Organisation in Relation to DV
A & E Social Worker - To find if clients disclose DV, what help they need.	Crisis intervention: assist clients, give them access to resources & services, assist if they want to take action/find accommodation, make sure any children are safe.
Ante Natal Social Worker	Determine what help women in DV need, ranging from ensuring a woman's safety when she comes in to give birth to arranging for safety on the ward and alerting staff to helping them to find refuge accommodation.
Community Health Counselling Team (CCT)	See children under 12 and adults for counselling in a variety of areas - child behaviour issues, depression, anxiety, self-esteem, DV, parental separation. Also do group work, including for children exposed to DV.
Court Chamber Magistrate – No direct contact with GVDVS as a service but with workers in their court support role.	Often the first point of contact for the women seeking protection from DV. Attend meetings of the DV Court Support Group representing the court and chamber magistrate as well as the deputy registrar.
Women's DV Court Assistance program	Support women who are attending court for an AVO. Provide information about AVOs, their rights, procedures, options, and if needed, provide access to legal representation. Make referrals to appropriate agencies. If have referral from the police before the client goes into court, can contact the woman before court.
CPFS Worker - Part of the NSW PANOC (physical abuse and neglect of children) services	Receive referrals from DCS or JIRT. Work with women and children where there are child protection issues. Work with DV perpetrators on parenting issues if they have an AVO in place or there is some protective framework. Endeavour to get DCS place the perpetrator into a DV perpetrator program simultaneously.
ECLO - Ethnic Community Liaison Officer	Develop a better relation between ethnic communities and police. Educate the community not only in relation to DV but also what is happening in their lives. Education about Australian policing law and how it applies to them and the accessing of services. Also provide educational programs with communities. Court support every Tuesday to support ethnic clients because often they do not have enough resources.
DV Outreach worker	Deal with women who are living in, leaving or have left the DV situation: crisis intervention, counselling, support, advocacy, information and referral, casework, political lobbying and advocacy, training other workers, community awareness, access community groups (eg Arabic Women's Group)
Refuge Case Worker	A refuge which houses women who are escaping violence and are unaccompanied by children.
Liverpool Women's Housing	Provide medium to long term housing - supported accommodation, no crisis accommodation. In the case of crisis phone calls, they link to external services which can assist the client.
MECSH – Miller Early Childhood Sustained Home Visiting	Program of support for new mothers over two years. Assess situation of those at risk because of DV and refer on to GVDVS if necessary.
Miller Child & Family Service	Primarily a children's service consisting of a pre-school and early intervention service. Philosophy is family centred practice which looks at the needs of the whole family and where that has effected the child's development.
Park House	Not a DV service specifically but paediatric mental health. A lot of the clients (children and families) are referred for a whole gamete of concerns, many of whom have been exposed to domestic violence.
Family Support Anglicare	Family support, involves education on the subject and referral to relevant services and mandatory reporting. Involved with assessing whether cases are for referral (to GVDVS) or not.
Community Worker, The Hub	Crisis intervention work, identify clients problems and contact appropriate services.
DoCS Worker 1	Offer referrals, deal with enquiries in relation to DV, make contact with families to ensure that they are aware that there are services within the community that can assist them.
DoCS Worker 2	Deal with child abuse reports, involved with on-going team work at keeping child in the home.
DoCS Worker 3	Ensure the safety and welfare of the child, protect the child from any harm, refer the clients to services, appropriate services and that is including mothers, offer support.
Green Valley Police 1	Police Officer - N/A
Green Valley Police 2	Police Officer – N/A
Green Valley Police 3	Police Officer – N/A
Green Valley Police 4	Police Officer – N/A
Green Valley Police 5	Police Officer – N/A

N/A Denotes Question Not Asked (due to shorter - interview schedule used)

Table 3: Respondents' Knowledge and Awareness of GVDVS (Service Provider Interviews)

Organisation	Heard of GVDVS Before? How ?	Received Training on GVDVS?
A & E Social Worker	Yes. Knew somebody going to work there	GVDVS did a presentation but respondent missed it.
Ante Natal Social Worker	Yes. Started at same time as MESCH Team – knew about it as it involved social work	Presentations and discussions – helpful in giving understanding of the service
CCT	Yes. Involved in submission - like another arm of the service	Have close link with the service and information about it
Court Chamber Magistrate	Yes. Has contact with workers from GVDVS in a court support role	No
Court Support 1	Yes. As part of induction	No training received. Did receive briefing on how to make referral
Court Support 2	Yes, through Liverpool DV Committee. Also know the counsellors very well from previous position	No. (Receives supervision from Linda)
CPFS Worker	Yes. Have the same manager as GVDVS	No formal training – get information at team meetings and via e-mails
ECLO	Yes. Through committee meeting in Liverpool	Received flyers etc. Green Valley is not respondent's area, so unsure about training
Outreach Worker JHSSW	Yes. NGOs had been lobbying for a service in the area	No formal training but has brochures and links in with them informally
Case Worker JHSSW	Yes. First came into contact with GVDVS when they first attended meetings	No
Liverpool Women's Housing	Yes. Went to the launch of GVDVS	No. Got brochure
CPFS Worker	Yes. Share the same manager	No official training but has a worker on the program and work closely with GVDVS staff
MECSH	Yes. Found out through work orientation	Nothing formal - information about GVDVS from co-workers
Miller Child and Family Service	Yes. Learnt about it when started work	No
Park House	Yes, was made aware through colleagues	No, received a flyer describing the service
Family Support Anglicare	Yes. Supervisor informed staff	No
Community Worker, the Hub	Yes. Has know about it for about 5 years	No
DoCS Worker 1	Yes. Worked closely with child protection casework specialist who was involved with setting the program up.	Had some talks about DV in general but not from the GVDVS, this was needed.
DoCS Worker 2	Yes. Made aware of everything through DoCS GVDVS team member	Not applicable as worker left the position over one and a half years ago. Could not recall
DoCS Worker 3	Yes. Heard about them when first started working. Approached GVDVS having seen brochure	No
Green Valley Police 1	Yes. Heard about GVDVS at a training day	Attended a talk by one of the GVDVS team at a training day
Green Valley Police 2	Yes	GVDVS Training Day
Green Valley Police 3	Yes	No training. Learnt about the service from senior officers through use of the yellow card
Green Valley Police 4	Yes. Through the DVLO at Green Valley	No formal training, has seen memos about it
Green Valley Police 5	Yes. Through Word of Mouth around the station	No

	Other Info or Resources re GVDVS?	Additional information or support needed to better understand GVDVS?
	There were various presentations & launch but respondent couldn't attend (work load)	Would be beneficial to have a chat with the team, has missed some education sessions with them
	No, but information given was enough	Some refresher training would be good
	Helped them make their brochure	No because of the close link with the service we are kept updated
	No	Yes – would like more information about the service
	Yes, the brochure. Finds it very useful	No
	A pamphlet is displayed in the court room	No. Kept up to date through the contact with the counsellors
	Yes through joint manager	No – they do a great job servicing and giving information to other services
	The brochure	Not really as Green Valley is not respondent's area
	Brochure	No, can access all information required by informal means
	They advertise themselves highly to women's services around the area	No, respondent is "equipped enough"
	Received extra information at interagency meetings	None – they are very good at informing people
	Yes through their shared manager	No, kept up to date
	Pamphlets, flyers, magnets (might not all relate specifically to GVDVS but DV generally)	None – knows that they are there to call on.
	Introduction letter and pamphlets about the service	No. They are a generic service and families are aware of the service and are able to contact it
	Flyer	Meeting the Service team face to face and having an "in-service" to get their perspectives would be extremely helpful
	No	N/A
	Brochure	Would benefit from formal training in interest of the client
	Brochure that we hand out to clients	More information would be beneficial. A case study would also be helpful, i.e. if GVDVS could explain what actions they took and so in some cases we may be able to relate that to a particular family that we are working with.
	As stated	As stated
	No	Not personally, but thinks they should be advertised more to university students or other areas.
	No	Need to know what happens to the women after they are referred to the GVDVS
	No	No
	No	Needs more experience of the service
	No	No need – contact with the DV team is next to none as liaison is via DVLO
	No	Yes. Sends people to GVDVS but doesn't know much about it. With more information could explain service better on call outs.

Table 4: Training to Government Departments on Domestic Violence and responding to clients

Agency	Participants
DV Area Specialists	10
DoCS Liverpool	54
Department of Housing	10
South Western Sydney Area Health Service	70
Green Valley Police	49
Liverpool Migrant Resource Centre	12
School Links Committee	10
Liverpool Health Service: Social Work Dept.	25
Miller Early Childhood Sustained Home Visiting Program	4
DoCS Ingleburn	20
DoCS Bidura	40
TOTAL: 11 agencies	**304**

Table 5: Child Protection and Domestic Violence awareness training

Agency	Participants
Benevolent Society (Wollondilly & Camden DV Service)	50
Barnardo's Auburn	160
Ashcroft Primary School	25
Huz & Buz Childcare	9
Green Valley Childcare Centre	12
Rima's Childcare Centre	5
Heckenberg Public School	25
Getting Started Pre-School	12
University of Western Sydney - Bankstown	60
Joan Harrison Support Services for Women	8
Sister's of Charity	8
Miller TAFE-Intro to Community Services and Health	15
Karitane	12
Liverpool Women's Health	40
Hoxton Park CHC-Nurses	10
Liverpool/Fairfield Court Support	150
Teddies Little Treasures Childcare	14
TOTAL: 17 community agencies	**616**

Interview Schedule: Women clients of GVDVS

Preamble

In the context of discussing the participant Information Sheet and consent form, clarify:

- Purpose of the interview
- Confidentiality and use of non-identifying data in the report.
- Independence of the researchers from the GVDVS and other agencies
- OK not to answer any questions and to stop the interview at any time
- Copy of report will be available from the service

Contact with GVDVS

- Can you tell me about how you came to be in contact with the Green Valley Domestic Violence Service? And about what kind of involvement have you had with the service? (Explore: how informed about the service; referral processes; type and length of contact)
- Was there something about your situation, or about the way you found out about the service, that led you to make contact at the time you did?
- What was it like for you, approaching the service for the first time? Did you have any particular hopes or fears about what would happen when you made contact? How did these go?
- What, if anything, was helpful about the contact that you had with the service? (For you? For your child/ren?)
- What, if anything, could have gone better/been more helpful to you, about your contact with the service? (For you? For your child/ren?)
- Did the service refer you to any other agencies/people? How did that work out (for each agency)? (For you? For your child/ren?) Could the GVDVS have assisted things to go more smoothly?
- I don't need to know in a great amount of detail, just as much as you're comfortable in discussing, but can you tell me how your situation of domestic violence is now, compared to when you first contacted the GVDVS? (Has the violence stopped, or is it still happening? Do you feel safer now? Do you think any differently about the violence and about who is responsible now?)
- Before your contact with GVDVS, had you ever sought help about domestic violence before? (from friends/family/services? Police? Other agencies? How did that go? Were there any differences in the type of help that you received on those occasions?
- Now, a few questions about you living situation (if this has not come up previously). Are you still living with your husband/partner/etc? Do you have children living with you? How old are they?

- Finally, are there any other comments you'd like to make about your experiences of the GVDVS?
- What, if any, key messages would you like to give to those departments or services in this area who have contact with women who are experiencing domestic violence? To other women dealing with domestic violence in their lives?
- How has it been for you today, doing this interview?

Thank you very much for giving your time today. A copy of the report will be available for women to read at the GVDVS at the completion of the research. Nothing in the report will identify individual woman who have taken part.

Interview Schedule – Key Informants

GVDVS Aims

- Can I start by asking what you perceive to be the key problems/issues that the GVDVS was established to address regarding victims of domestic violence? Interagency coordination/collaboration?
- Do you think that the GVDVS has set realistic, achievable objectives for the life of the project?
- Are there any aspects or components of the GVDVS what you think are particularly critical or important if its aims are to be achieved? Do you think that sufficient priority, weight or attention has been given to that in the GVDVS plan or in the project's progress to date? Why is that? How might this be addressed in the short-term? In the longer term?

Interagency management processes

- How satisfied are you with the process whereby agencies/departments agreed to what the GVDVS should be set up to achieve? Why was that? Do you think that your agency/department's views or experiences were adequately acknowledged, incorporated or taken into account in the GVDVS planning/agreement? Why was that?
- For how long have you been a member of the Steering Committee? Has there been a reasonable level of continuity in the representatives to that Committee? How has that affected the operation of the Committee? The management of the GVDVS?
- Generally speaking, how satisfied are you with the Steering Committee's meetings? For example, do you think they are held regularly enough, too little or too often? Why is that? Do most agency/departmental representatives attend most meetings? How does this affect the usefulness/effectiveness of the meetings? Is the content of the meetings useful in developing or monitoring the Green Valley Domestic Violence Service?
- What suggestions, if any, do you have about how the Steering Committee could function more effectively or efficiently in developing or monitoring the program?

Interagency Processes

- What do you see as your agency/department's key contribution to the GVDVS? Are there any major constraints or opportunities affecting your agency's ability to fully implement its role in relation to the GVDVS? To what extent does the GVDVS adequately take account of these constraints or opportunities?
- Is there anything else that you think your agency/department could or should be doing at this stage in the project to address some of the key problems targeted by the GVDVS? What about other agencies/departments? Why is that?

Impact of the GVDVS

- In your opinion how well does the GVDVS appear to address the problems/issues that you identified at the start of the interview? Why is that? Are there any major issues of relevance that you feel the GVDVS does not adequately address? How might this be addressed in the short term? In the longer term?

- What expectations did you have about what the GVDVS would achieve in its first year? In the longer term? Have these been met?
- Twelve months or so into its operation, are you able to make any comment about how you think the GVDVS is progressing generally? In relations to your department/ agency? In relation to other agencies/departments?
- Where do you think the greatest impact or change has occurred to date? Why is that?
- Where do you think there has been least impact or change? Why is that? Do you have any suggestions as to how that might be addressed?
- Thinking about the next few months of the program, are there any issues or aspects of the program that you think should be given particular priority by the Steering committee? By others? If yes, what is that and why?
- Finally, are there any other comments you'd like to make at this stage about the program?

Reference: These questions are based on surveys developed for the evaluation of the ACT Family Violence Intervention Project (Keys Young 2000, pp. 90-91). This is available under the 'Partnerships Against Domestic Violence' initiative.

Interview Schedule – Human service workers

Agency context

- From your perspective, what are the main problems or issues you and/or your agency/department face in dealing with domestic violence cases? Why is that?

Knowledge/Awareness of GVDVS

- Turning now to the Green Valley Domestic Violence Service, have you heard of it before? (if no: where/how in your agency do you normally receive information about domestic violence and domestic violence services and initiatives?)
- (If yes) When and where did you hear about it/get information about it? (training/ briefing/written information)
- What's your understanding of why the program was put in place and what it is aiming to do?
- Have you had contact with it (or referred people to it)?
- How did that go? (What went well/could have gone better?)
- What, if any, additional information, advice or support do you feel you need now to help you better understand the Green Valley Domestic Violence Service, your role in relation to it, and that of other departments or agencies that deal with domestic violence matters?

Interagency Processes

- To what extent do you think the Green Valley Domestic Violence Service is designed to address the major problem(s) you outlined earlier [Refer to issues raised]? Why is that?
- Do you feel your agency's interests/concerns have been effectively addressed in the Green Valley Domestic Violence Service? Why is that?
- What do you see as your agency's key contribution to the Green Valley Domestic Violence Service? Is there anything else you think your agency should or could be doing to address some of the problems you raised? Anything else you'd like to see other agencies/department do?
- Are there any major constraints (or opportunities) affecting your agency's ability to fully participate in the Green Valley Domestic Violence Service? To what extent does the service adequately take account of these opportunities/constraints?

Impact of the GVDVS to date

- In your opinion, what impact, if any, has the Green Valley Domestic Violence Service had on the service response to women and children experiencing domestic violence?
- Generally speaking, what impact, if any, do you think the Green Valley Domestic Violence Service has had on interagency collaboration and cooperation (for example, sharing of information, complying with protocols)? What aspects of the program seem to be progressing or working particularly well? What aspects seem to be progressing more slowly or working less well? Why is that? What suggestions do you have as to how this should be addressed in the short-term? In the longer term?
- Finally, are there any other comments/suggestions you would like to make in relation to the Green Valley Domestic Violence Service or its development to date?

Reference: these questions have been developed, based on the evaluation of the ACT Family Violence Intervention Project (Keys Young 2000, pp.86-89). This is available under the 'Partnerships Against Domestic Violence' initiative.

Interview GVDVS staff

GVDVS Aims

- Can I start by asking what you perceive to be the key problems/issues that the GVDVS was established to address regarding victims of domestic violence? Interagency coordination/collaboration?
- Do you think that the GVDVS has set realistic, achievable objectives for the life of the project?
- Are there any aspects or components of the GVDVS what you think are particularly critical or important if its aims are to be achieved? Do you think that sufficient priority, weight or attention has been given to that in the GVDVS plan or in the project's progress to date? Why is that? How might this be addressed in the short-term? In the longer term?

Implementing the GVDVS

- What is your role within the GVDVS? In what ways has it changed/developed over the life of the GVDVS to date? How has that been for you? For the service that is offered?
- What expectations did you have about what the GVDVS would achieve in its first year? Have these been met?
- What barriers have you identified in your ability to carry out your role? What opportunities?
- What do you think is the biggest challenge facing you over the next 6 months? Facing the service as a whole? How can this be addressed?

Impact of the GVDVS

- In your opinion how well does the GVDVS appear to address the problems/issues that you identified at the start of the interview? Why is that? Are there any major issues of relevance that you feel the GVDVS does not adequately address? How might this be addressed in the short term? In the longer term?
- Twelve months or so into its operation, are you able to make any comment about how you think the GVDVS is progressing generally? In relation to other agencies/ departments?
- Where do you think the greatest impact or change has occurred to date? Why is that?
- Where do you think there has been least impact or change? Why is that? Do you have any suggestions as to how that might be addressed?
- Thinking about the next few months of the program, are there any issues or aspects of the program that you think should be given particular priority by the Steering committee? By others? If yes, what is that and why?
- Finally, are there any other comments/suggestions you would like to make in relation to the Green Valley Domestic Violence Service or its development to date?