FAMILY SERVICES of PEEL
Since 1971

Peel Institute On Violence Prevention

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Identifying Gaps in Data Collection Practices of Peel Agencies that Serve Survivors of Interpersonal Violence

Final Report
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Transforming Lives in Peel

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Acronyms

CATALYST	Catalyst Evaluation and Screening
MCSS	Ministry of Community and Social Services
CRMS	Corporate Records Management System
LHIN	Local Health Integration Networks
MOHLTC	Ministry of Health and Long-Term Care (Ontario, Canada)
OCAN	Ontario Common Assessment of Need
OCASE	Ontario Computer Animation and Special Effects
OCMS OCASI	Client Management System
PCAWA	Peel Committee Against Women Abuse
PCSA	Peel Committee on Sexual Assault
PIVP	Peel Institute on Violence Prevention
SOIV	Survivors of Interpersonal Violence
WISH	Women in Safe Housing Database System

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Executive Summary

In 2013 the Peel Institute on Violence Prevention (PIVP) embarked on this Pilot Survey, with a grant from the Ontario Trillium Foundation, to study the state of current data collection practices of agencies in Peel that are serving the Survivors of Interpersonal Violence (SOIV) and to discover the perceived deficiencies, barriers and required improvements in the current data collection practices. This survey is one of the first steps to develop research initiatives that will assist in understanding how services are organized and provided in the Region of Peel and to identify the gaps in existing services.

Objectives:

1. Understand the scope of services available for Survivors of Interpersonal Violence in the Region of Peel
2. Survey data collection practices of a cohort of agencies providing services to Survivors of Interpersonal Violence in the Region of Peel
3. To promote community engagement and service-level transformation through inter-agency dialogue and collaboration
4. To document the concept of person-focused service provision and the importance of social determinants of health in providing services.

Methodology:

This study employed a mixed methods approach using the following tools: (i) Literature Review (ii) Regional Scan (iii) facilitated questionnaires and (iv) key informant Interviews

Peel has a vast network of community services. Approximately 79 community service organizations identified offer some kind of service for survivors of violence, while 25 of them provide direct services to survivors of interpersonal violence. Of these 25 direct service providers, 12 organizations completed the intensive interviews and questionnaires, whereas another 10 of them completed short questionnaires only. The 12 organizations interviewed were selected based on their membership in the Peel network: namely Peel Committee on Sexual Assault (PCSA) and Peel Committee against Women Abuse (PCAWA).

The survey analysis showed that the 12 agencies collect five (5) types of data from the clients that they serve. The Five Data types are:

I. Demographic data
II. Health data
III. Violence/Abuse details and history
IV. Services provided
V. Services accessed

Key Findings

- A total of 44 types of services were inquired, (based on Statistics Canada's Victim Services survey) that are provided by social service agencies to SOIV in the region of Peel. Results show that data is collected for merely 5-7 types of services out of the maximum of 44 services and a minimum of 15 services provided by these 12 organizations. For example, one organization that provides 43 types of services, collects data for only 3 types of services which constitutes just 7% percent of all services provided. The analysis demonstrates that there is no set criteria or guidelines and purpose for data collection among these social service agencies in Peel. As a result, organizations tend to collect data mostly for reporting purposes to their funding partners. This demonstrates the need for a standard data collection practice among Peel social services agencies with the purpose of evaluating and improving client-centered services.

- Demographic data: Out of 26 variables, only 2 variables (DOB/age, Sex/Gender) are collected consistently across all organizations while 19 variables are collected by less than 50(%) percent of the organizations. The results indicate that the data collection practices among Peel service providers have a large gap in collecting some of the vital socioeconomic and demographic information from their clients when providing services to SOIV. This indicates that organizations only collect data that is essential to provide a particular service or program, and not for purposes of evaluating and planning their services and programs.

- Health data collected by the 12 agencies shows that while 50 – 75(%) percent of the variables are collected for Family doctor, medical history, and present health conditions, only 25(%) percent of the variables are collected for mental health and substance abuse information. It appears that mental health and substance abuse information is not considered important and essential to plan services for their clients. Social Service Agencies do not give priority to the overall health of a client. There seems to be no connection to the Family Doctor to refer to other systems. Overall health of a person will show how the survivor is in the crisis situation and how violence impacts a person in the long term. Prevailing data collection practices prove that health data collection is essential for coordination of social services and for service planning, in order for it to be survivor centered.

- Data related to Violence and Abuse: It is remarkable to note that 83 (%) percent of the agencies surveyed collect 100 (%) percent of the variables related to violence/abuse details and history, while more than 67% percent of them collect information related to treatments undertaken and future actions by the clients. Nevertheless, whether or not this data is helping the organization in planning and/or improving services is not known.

- It is surprising to note that the 12 agencies that participated in the survey provide only four types of crisis response services, while a majority, 98(%) percent of the services, are provided by only 9(%) percent of the agencies, within the Region of Peel, that participated in this study. This indicates the need for more collaborated and coordinated services, given the limited resources available for SOIV in a large area like the Region of Peel. As a result, most of the services provided for SOIV are immediate crisis response and short-term oriented. Very limited long-term services are available for SOIV, and they are offered by few service providers.

Conclusion

From the survey and interview results, it is evident that agencies have bigger challenges in terms of human and financial resources and time to provide all the essential services required by SOIV. As a result of funding regulations, agencies tend to address the immediate crisis in short-term approaches. Socio-demographic data is not systematically collected impacting the understanding of the social location of SOIV. Formal systems of referral and contra referral seem to be weak. This situation reiterate the need for the inclusion of socio demographic data and determinants of health and wellbeing in the planning of services, and a referral system among social service, health and justice agencies in serving the SOIV and a standard data collection practice to plan and improve services to clients which goes beyond the immediate crisis. In addition, the data collection practices among these service providers are quite disparate; demonstrating the gaps in the collection of key socio demographic information and other basic data from clients.

Despite the identified need for increased service coordination about service provided to clients, agency collaboration is suffering, due to lack of funding and financial support. There seem to be a great need to overcome professional prejudices and differing philosophies among agencies; unique histories of development across the various sectors can result in agency egocentrism; and above all, a lack of experience, knowledge, and training amongst service-providers needs to be dealt with, if collaborative interagency relationships and service coordination are to improve.

1 Introduction

1.1 About the Peel Institute on Violence Prevention (PIVP)

The Peel Institute on Violence Prevention (PIVP) was established as a multidisciplinary collaborative initiative among agencies in the Region of Peel working in the area of violence. Based out of the Family Services of Peel, the Institute aims to prevent violence, evaluate the impact and effectiveness of agency services, adapt services and programs to be more focused on survivors' needs, and improve the coordination of services for all victims of violence including men, women, youth, seniors, aboriginals and people with disabilities. PIVP strives to achieve these goals by collaborating with service providers and survivors of violence, gathering data, evaluating current data collection processes, and disseminating information and guidelines to facilitate evidence-based best practices. With funding support from the Ontario Trillium Foundation, this study was initiated by PIVP to find out the current data collection practices of Peel agencies serving Survivors of Interpersonal Violence (SOIV).

1.2 Background

Interpersonal violence exacts a huge toll on our community. It has been linked to a host of adverse mental and physical health outcomes. Survivors of Interpersonal Violence (SOIV) are more likely to suffer from a host of negative health outcomes, indulge in high-risk behaviours, and inhabit lower socioeconomic strata. As a result of experiencing violence, they become more vulnerable than before, and as a group, they rely heavily on health services and social services. Hence, failure to provide coordinated and effective care to these individuals via services in the community is very costly, both in terms of human suffering and financial burden to society.

Data communication and information sharing across agencies would permit numerous critical advantages including increased awareness and knowledge of agency services, more effective and streamlined referral processes, improved consistency, a considerably better experience for clients who need and deserve the best possible service, and would provide the information necessary to oversee and continually improve care. (PIVP, 2014). Absence of this integrated approach to data collection and monitoring, would make it impossible to achieve the level of service coordination and quality that SOIV in our community so desperately need. The current system is comprised of a patchwork of service providers operating within their own "silos" (PIVP, 2014). Developing formal partnerships between service agencies may help to address the barriers to service access, reduce redundancy, and improve efficiency of services, increase accountability and ultimately enhance client satisfaction and safety (PIVP, 2014).

Recent research has identified some key factors in the system's poor response to the needs of SOIV. First of all, there needs to be a better understanding of the profile of this population so that services can be tailored to the needs of the diverse ethnic, racial, gender, and language constitution of a population (Kirst, et al, 2013) and to ensure equity. Unfortunately, what we find is that the current system of health and social services often fails to adequately meet the needs of survivors of interpersonal violence (Haeseler, 2013a,b). Indeed, monitoring inequities in healthcare is increasingly becoming recognized as an important component of equitable and effective provision of services (AHRQ, 2009; IOM, 2002; Krieger & Williams, 2011; Weinick et al, 2007). In fact, the Canadian Institute of Health Research and the Chief Public Health Officer have emphasized the need for the development of tools for health equity measurement (CIHR, 2010; PHAC, 2008). Therefore, it is essential that everyone receive the care they need, without barriers, regardless of sex, age, ethnicity, race, socioeconomic status or any other individual characteristic. Ensuring that this happens and identifying where it falls short requires monitoring the data collection practices among Peel agencies.

Secondly, SOIV need access to a wide array of services, including mental and physical health, economics, child custody, and child protection, and these different services are provided across different agencies (Haeseler, 2013b). Provision of this type of complex care requires that agencies work in a more collaborative and coordinated manner to not only provide a higher quality of care to this population but also improve the efficiency and reduce costs of the often overlapping and poorly integrated social and health services that exist today (Bolman & Deal, 2003;

Brilliant & Young, 2004; Lawson, 2003; Skinner & Whyte, 2004). In Peel Region, there are currently many barriers to service access for SOIV, particularly for marginalized populations (e.g. elderly, immigrant, disabled, aboriginal) (Robinson, & Tregidga, 2007; Hyman et al, 2006; Bennett & O'Brien, 2006; Wahab & Olson, 2004 Plummer & Findley, 2012; Otto & Quinn, 2007). SOIV find themselves traversing a complicated labyrinth of services that fail to meet their needs and only serve to produce client confusion and frustration (Robinson, & Tregidga, 2007). Improved collaboration between health and social agencies can greatly enhance the quality of care to SOIV. In fact, increased collaboration has been recognized in the 2010 WHO guidelines (for intimate partner and sexual violence prevention) as one of the first steps to eradicating all forms of violence (WHO, 2010).

A great example of the benefits of systems and service integration is the Family Justice Center approach that was first introduced in San Diego, California as a "one-stop shop" for violence services. This community partnership model between domestic violence and criminal justice services provided a single location where SOIV could access medical, legal, community programs and services. The interdisciplinary collaborative approach helped to overcome service access barriers and permitted more fluid exchange of information, and improved referral processes. Overall, several positive outcome measures resulted from Family Justice Centers including reduced client fear and anxiety, lower homicide rates, increased survivor safety and autonomy as well as increased prosecution of violent offenders. As a result of the initial successes, this model has been recognized by the Federal Government and has been more widely adapted in many other regions in North America (Sadusky et al, 2010).

Even though the need for more client-centered care characterized by collaboration and integration of a multitude of community services is widely recognized, there exist numerous barriers to translating the vision into reality. These include lack of financial and human resources, non-supportive government policies and systems, as well as lack of education and training around the roles of other agencies and sectors (PIVP, 2014). The literature has yielded several recommendations for the improvement of inter-agency collaboration. Among these, we believe that establishing reliable data collection, monitoring and ultimately information sharing practices across agencies are essential (Macy & Goodbourn, 2012; DeCandia et al, 2013). In order to monitor inequities, develop equity-based service models, and provide client-centered care, collecting patient-level socio-demographic data is critical. There is increased understanding of the importance of collecting socio-demographic data in health equity monitoring (Krieger & Williams, 2011; Lofters et al, 2010). Many studies highlight the importance of collecting data on race, ethnicity and primary language in order to measure disparities, initiate programs to improve quality of care, and provide patient-centered care that will ultimately eliminate inequities (Bierman, et al, 2002, Hasnain-Wynia & Baker, 2006; Rodney & Copeland, 2009).

However, detailed socio-demographic data that is necessary for monitoring is currently not routinely collected from patients in the Canadian healthcare settings or at the level of service agencies (Bierman, et al, 2002, Hasnain-Wynia & Baker, 2006; Rodney & Copeland, 2009). Limited information is collected about their catchment population, service users, incoming and outgoing referral, and the efficacy and outcomes of their services. This hinders the quality of care and support that can be extended to SOIV and the agencies' ability to cater services to their target population (Haeseler, 2013a, b). Without the ability to adequately assess the profile of service users and the efficacy of their programs and services, it is difficult to determine which services require improvement and where gaps exist. Therefore, strong data monitoring practices are essential to informing policy and service improvement (PIVP, 2014).

This study aims to use mixed methods to assess the data collection practices in the Region of Peel. In addition to socio-demographic data, information on services provided and services used will be collected. We hope to identify areas where current collection practices are deficient. This will allow us, in conjunction with literature, to identify the most effective data collection practices within the context of the Survivors of Interpersonal Violence population in Peel and the health equity mandate of our parent agency.

Questions we investigate in this study:

1. What is the state of current data collection practices of Peel agencies serving Survivors of Interpersonal Violence (SOIV)?
2. What are the perceived deficiencies, barriers and required improvements in the current data collection practices according to Peel agencies serving SOIV?

1.3 Objectives

The objectives of this study are:

1. Understand the scope of services available for Survivors of Interpersonal Violence in the Region of Peel
2. Survey data collection practices of a cohort of agencies providing services for Survivors of Interpersonal Violence in the Region of Peel
3. To promote community engagement and service-level transformation through inter-agency dialogue and collaboration
4. To document the concept of person-focused service provision and the importance of social determinants of health in providing such services

2 Methodology

2.1 Research Design

This study employed a mixed methods approach using the following:

5. Regional Scan
6. Questionnaires
7. Interviews

2.2 Instruments

2.2.1 Regional Scan

In order to identify the organizations working on violence/abuse prevention, the first step was to develop the database for these organizations in Peel. To do so, the following resources were searched:

- Community Information Partners Peel, Your Online Information Connection
- Peel Committee Against Women Abuse (PCAWA)
- Peel Committee on Sexual Assault (PCSA)
- Directory of Service: United Way of Peel Region
- 211 Ontario
- Region of Peel - Peel Public Health
- Charity Village - Community and Social Services
- Health Services, Region of Peel
- Brampton Safe City: Database of Youth Services for Queen/Kennedy
- Voice - Peel Region Youth Violence Prevention

Seventy-nine organizations were identified as being a key stakeholder (or essential service provider) in the spectrum of community service agencies involved in supporting victims of violence. Twenty-five organizations were identified as providing direct services to SOIV. 12 out of the 25 organizations did the full questionnaire and interview. They were selected because of their membership in one of two networks: Peel Committee against Women Abuse (PCAWA) and Peel Committee on Sexual Assault (PCSA). 10 of these organizations completed a brief questionnaire (Appendix C).

Table 1. Questionnaire, interview and brief questionnaire numbers targeted and completed.

	Target	Completed
Full questionnaire	**12**	**12**
Interview	**12**	**11**
Brief questionnaire	**13**	**10**

2.2.2 Questionnaires

Data Items Collected by Service Providers about Service Users:

This questionnaire was intended to tally whether or not participating organizations collected a wide range of different types of information. Areas were divided into five groups: demographic, health, violence/abuse details and history, services used, and services offered. Instructions specified, "Please indicate to the best of your knowledge whether or not the following information is currently collected or was previously collected as part of your data collection practices".

Demographic Data: Twenty six of the 52 variables of social determinants standardized with Statistics Canada and covered by Census Profile, 2011 and NHS Profile (National Household Survey, 2011), were covered: age, gender, sexual orientation[1], place of birth, ethnic origin, immigrant status, language, religion, marital status, family characteristics/status, number of children, education, employment status, class of worker, full-time or part-time work, occupation, place/location of work, average income of individual, average family income, sources of income, average monthly shelter costs, as well as housing situation.

Health Data: Four variables: client does or does not have GP/family doctor, medical history, present health condition and other health-related data.

Violence/Abuse Details & History: Four variables: type of violence/abuse prompting current visit, past history of violence/abuse, type of previous violence/abuse, as well as any treatment and action(s) taken.

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[1] This variable is not covered by Census Canada, 2011.

Services Used: Eighteen variables: accessing other healthcare providers for current reason or for other reasons, accessing other social services providers for current reason or for other reasons, accessing other legal or justice service providers for current reason or for other reasons, if there are any health services desired but not accessing, if there are any social services desired but not accessing, and if there are any legal or justice services desired but not accessing.

Data Items Collected by Service Providers about Services Offered to Users:

Data about Services offered: Forty-Three variables for types of services offered for SOIV, have been standardized with Statistics Canada which were covered by Victim services survey, types of offered directly by victim service agencies, 2014.

2.2.3 Interviews

Semi-structured interviews were conducted (Appendix B) with managers of 11 agencies in Peel and were subsequently transcribed and analyzed qualitatively using a thematic analysis approach (Leininger, 2015). Semi-structured interviews were chosen to provide access to the considerable experience and ideas held by current frontline service providers in Peel Region regarding the current data collection practices in Peel.

Specifically, we had several objectives in conducting these interviews. First, we anticipated that the insights gained would supplement questionnaire results with a richer, more detailed picture of what information is currently collected, how it is collected, for what purpose it is collected, and how it informs the efficacy of their programs. Second, we aimed to learn how programs in this field are currently evaluated and how this is affecting the provision of services and subsequent outcomes of their clients. Third, we sought to gain opinions and suggestions regarding deficiencies in current practices, barriers to adequate data collection, and barriers to providing complete and coordinated care to clients. Finally, we hoped to learn about how frontline agency managers believe barriers and deficiencies translate to poorer health and socio-economic client outcomes.

2.3 Sample

For this study, we approached 12 health, justice and social service agencies in the Region of Peel, Ontario, that provide direct services to our study population: Survivors of Interpersonal Violence in Peel. We interviewed 11 individuals, who are the managers in the agencies, who were knowledgeable about the current and existing data collection practices. They are responsible for compiling and reporting agency-wide data and statistics to government organizations. This may include data in the area of client demographics, services offered/used as well as other data that is collected for both public and private funders. The agency managers were able to describe the rationale or reason behind their data monitoring practices and whether these practices are for evaluation of their services, internal reports or funding purposes. In addition, the agency managers provided a unique perspective on gaps in data collection and areas for improvement. The inclusion and exclusion criteria are as follows:

2.3.1 Inclusion:

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

2.3.2 Exclusion:

- Social agencies that operate outside of Peel.

2.4 Data Collection

2.4.1 Purposes of Data Collection

Firstly, we asked about their general data collection practices. We inquired about purpose of the data collected, how it is collected, who collects it, and what is collected particularly in regards to socioeconomic data and client-centered programming. Secondly, the interviewees were questioned about collaboration, referrals and data sharing. Here, we wanted to glean information about the degree of collaboration with other agencies serving SOIV, information being collected and shared around referrals, and the barriers to collaboration of services. Lastly, our questioning focused around client satisfaction and outcome of data collection. We wanted to know how data is being collected in these two areas and subsequently being applied to improving services. In addition to these three domains of questioning, the interviewees were asked about their perception of best practices and poor practices with respect to data collection and monitoring and recommendations moving forward.

Table 2. Agency Reported Purposes of Data Collection.

Purpose of data collection	# of organizations (n=12)
Internal purposes	**11**
Funder requirement	**9**
Individual case charts	**5**
Other	**3**

1 Other purposes include: Case management, Assists with identifying outreach needs and assists with informing requests for new funding for programs

2.5 Data Analysis

2.5.1 Questionnaire Data

For each of the items within the questionnaire, a count was taken of how many agencies answered affirmatively.

2.5.2 Interviews

The interviews were recorded and subsequently transcribed for qualitative analysis. The interview transcripts were analyzed using a thematic analysis approach, which assisted in categorizing the data for qualitative analysis. Based on the interview notes and transcriptions, information was reviewed and appropriately categorized. The thematic approach helped the study move our analysis from merely a broad reading of the data towards discovering patterns and developing themes. Although grounded theory principles of qualitative analysis were applied, our data was more structured around certain specific domains (what information is collected, referral processes, evaluations and client satisfaction). Following the classic methodology of this thematic approach, ideas were coded and grouped to create categories and more general themes. Information was collected until data saturation was reached, i.e., until no new ideas emerged from the data.

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

2.5.3 Limitations

Only 11 organizations of the 25 identified as providing direct prevention services for Survivors of Interpersonal Violence in Peel were included as part of the in-depth interviews. This provided a solid understanding of the total landscape in the Region of Peel, but more agencies needed to be engaged in order to confirm and strengthen the conclusions that were drawn from this study. In addition, the agency manager interviews were qualitatively analyzed by only one individual. Continued iterative analyses may be performed by other individuals to diversify the perspectives of looking at the data and increase the quality and quantity of findings.

3 Results

3.1 Questionnaire Results

3.1.1 Demographic Data

The graph below (Figure 1) is clear evidence in showing the significance of data collection among the social service agencies in Peel. All the agencies surveyed seem to collect only the basic data when providing services, while huge gaps are shown of the proportion of agencies and what demographic data they collect and what they do not collect. In addition, the graph shows that some data collected in the past has been discontinued.

Figure 1. Proportion of agencies indicating that they do, do not and had previously (but no longer) collected various types of demographic information as part of their data collection practices.

Notes: The numbers along the x-axis refer to the question numbers pertaining to demographics on the questionnaire (Questions 1 to 26). Question numbers are depicted from left to right in order from the greatest to lowest percentage of agencies not collecting a particular piece of demographic data.

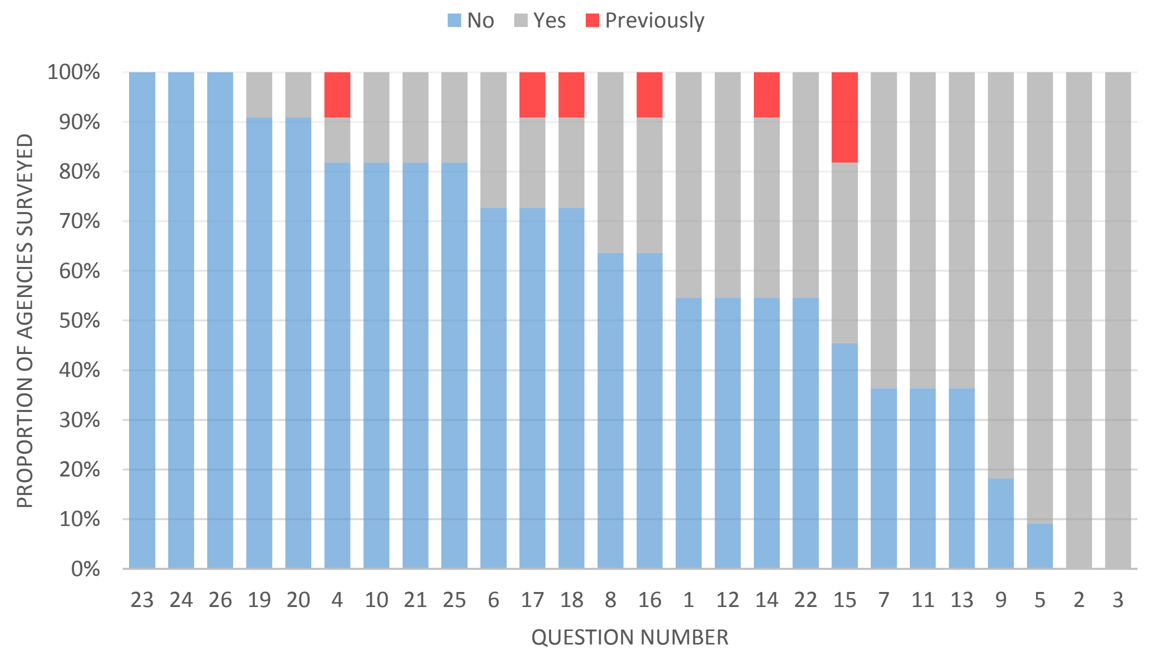


Figure 1 makes it apparent that more important demographic data is not being collected compared to the data being collected, as indicated by greater prominence of the blue bars (not collected) relative to the green bars (collected). The majority of all agencies surveyed do not collect data on most (75%) of the demographic data listed in the survey. In particular, 0 (%) percent collect data on shelter costs for rented or owned dwellings (questions 23, 24); 90(%) percent did not gather data about occupation or place of work (questions 18, 19); while 80(%) percent did not ask about sexual orientation, religion, family income, or housing ownership status (questions 4, 10, 21, 25).

The Table below (Table 3) lists the demographic information in the right-hand column that are collected by the majority (at least 50%) of all agencies surveyed, whereas the left-hand column lists the demographic data that are not collected by the majority of agencies. Clearly, a great deal of important information about clients is not collected by the majority of agencies surveyed. For example, most agencies do not ask about occupation, education level, and family status, despite these being important in the assessment of need, available resources, and appropriate interventions.

Table 3. Demographic data comparison. A comparison of demographic data that are not collected by most agencies versus data that are collected by most agencies.

	> 50% Do NOT Ask		> 50% DO Ask
1	Average monthly costs for owned dwellings	1	Labor force status
2	Average monthly costs for rented dwellings	2	Ethnic origin
3	Dwelling by structural type	3	Marital status
4	Place/location of work	4	Number of children
5	Average income	5	Mother tongue
6	Housing ownership status	6	Community in Peel
7	Place of birth	7	Date of birth
8	Full/part time work	8	Sex
9	Occupation		
10	Immigration status		
11	Class of worker		

12	No. of persons at residence
14	Family status
15	Education
16	Sources of income
17	Average monthly shelter costs for owned dwellings
18	Average monthly shelter costs for rented dwellings
19	Dwelling by structural type
20	Place/location of work

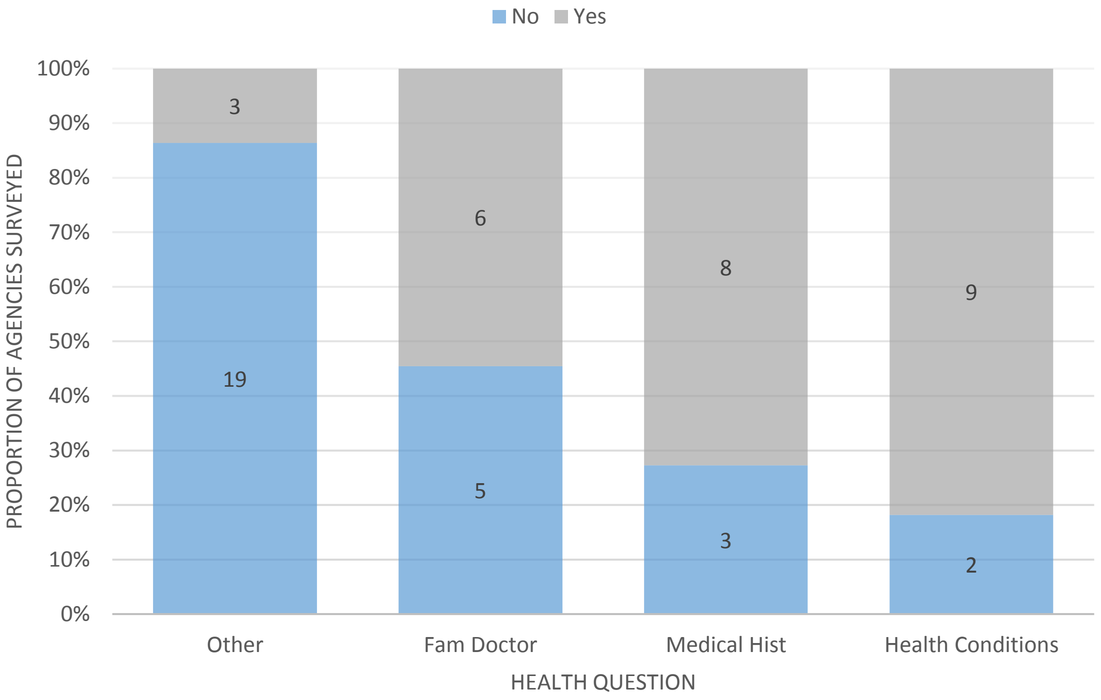
Overall, the survey results indicate that the demographic data collection practice among Peel service providers have a large gap in collecting some of the vital socioeconomic and demographic information from their clients when providing services for the SOIV. Out of 26 variables surveyed, only 2 (DOB/age, Sex/Gender) are collected consistently across all organizations, while 19 variables are not collected by more than 50% percent of the organizations. This shows that services are offered by many agencies without collecting a lot of data from clients.

3.1.2 Health Data:

The graph (Figure 2) on the next page shows the number of agencies that collect health related data and the number of agencies that do not collect information on health related data, namely; clients' medical history, present health condition, and whether they have a family doctor or not. Category "other" in the graph above refers to any other health and/or medical information related to the client's health collected, if any, by the agencies.

Figure 2. Proportion of agencies collecting (yes) and not collecting (no) information on clients' medical history, present health condition, and whether or not they have a family doctor.

Notes: Numbers inside bars indicate number of agencies in the group represented by that portion of the bar. For example, 6 agencies indicate that they do collect information on clients' family doctor compared to 5 that do not; 8 agencies collect information on medical history compared to 3 that do not.



2

More than 80% of agencies surveyed collect information about clients' current health conditions, but about 50% collect information about whether or not clients have a family doctor. About one third of agencies do not collect information on clients' medical history. It appears that mental health and substance abuse information is not considered important to collect data or provide services. In general, without information regarding medical history and availability of a family doctor, it is difficult to ascertain to what extent clients' health needs are being met.

The above data shows that social service agencies do not give priority to the overall health of a client. It does not seem to be connecting the Family Doctor to refer to other systems. Overall health of a person will show how the survivor is in the crisis situation and how violence impacts a person in the long term. Prevailing data

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[2] Other health data; 1 organization collects data about "Mental Health" and 1 other organization collects data about "Mental Health" and "Substance Use".

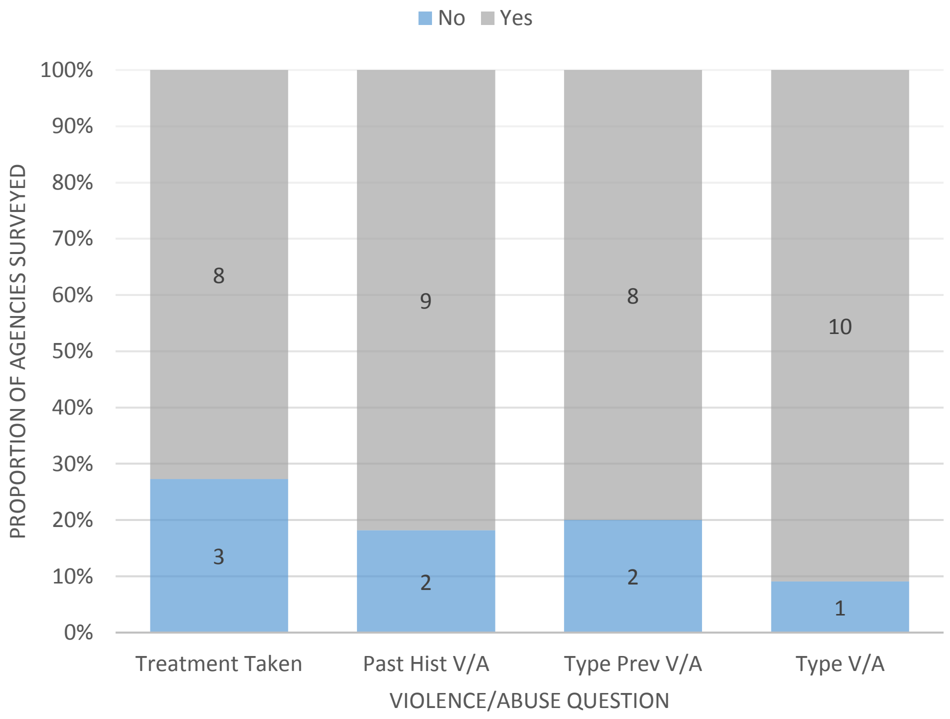
collection practices prove that health data collection is essential for coordination of services, service planning for survivor centered. Then data should be survivor oriented.

3.1.3 Violence/Abuse Data:

The graph below (Figure 3) shows the percentage of agencies that collect information and the percentage that do not collect data about their clients' history of violence, abuse, and treatments as part of their data collection practices.

Figure 3. Proportion of agencies collecting (yes) and not collecting (no) information about clients' history of violence, abuse, and treatments as part of their data collection practices.

Notes: V/A = Violence/Abuse.



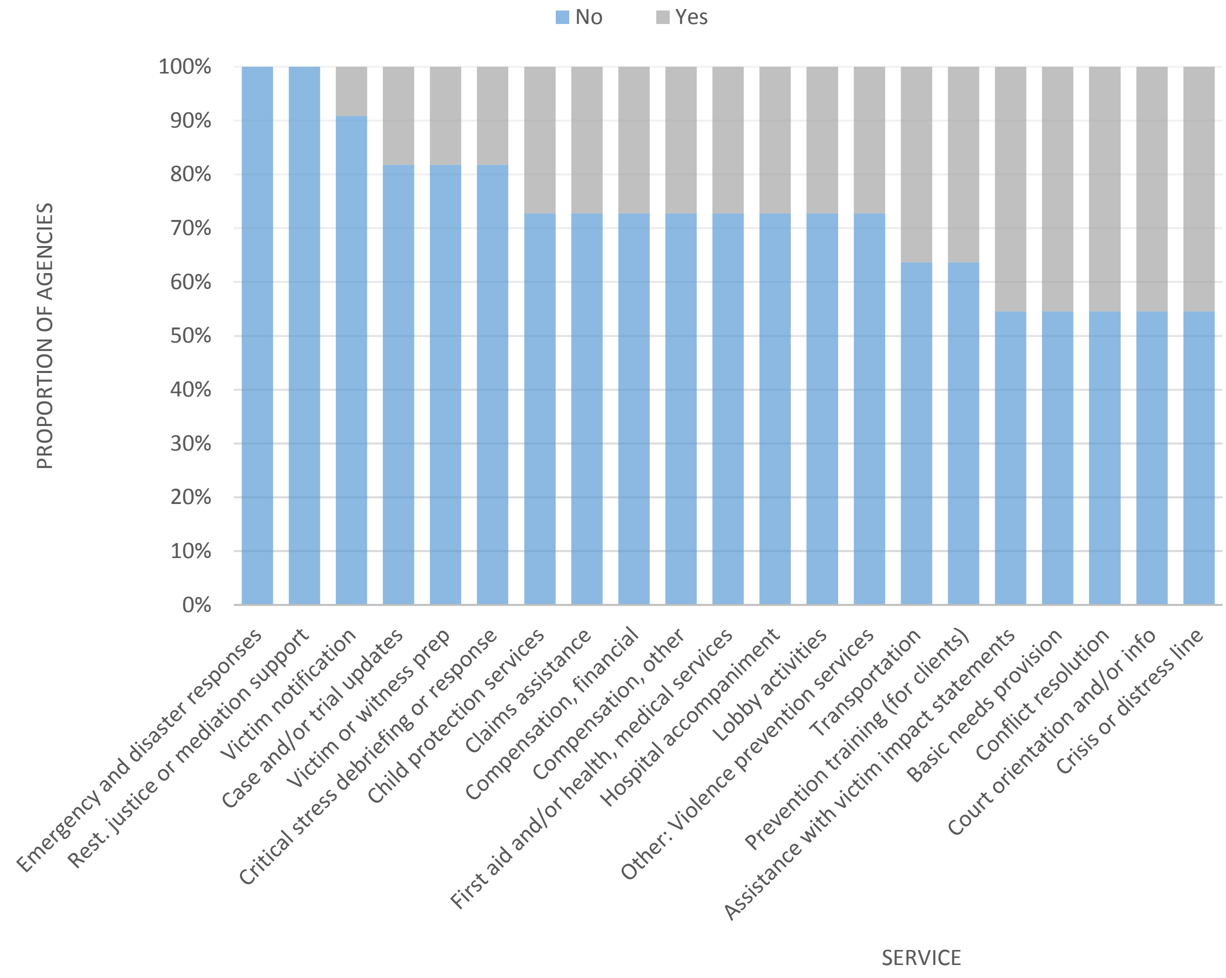
Almost all agencies surveyed collect data on type of violence/abuse to which clients have been exposed and 80(%) percent collect data on history of violence/abuse. Eight (8) out of 11 agencies collect information on treatments undertaken. The results show that the majority of agencies appear to be collecting valuable information regarding past history of violence and/or abuse of the SOIV they serve. This data is important because, if there is a pathway to safety that a person may or may not have used before, collected data will show if a survivor is being abused for the first time or continuously, if the survivor was previously abused, and how that abuse has impacted her life situation. Abuse can be short term or long term, it could be by one partner or by several partners. Data can guide the organization in planning the services.

3.1.4 Services Offered:

The graphs below (Figures 4a and 4b) show the proportion of agencies that are offering each of 43 different services and programs and the percentage that do not offer each of the services to SOIV. The majority of agencies do not offer more than half of the 43 possible services and programs. For example, more than 50% percent of the agencies do not offer any crisis/distress line, psychological assistance, conflict resolution, or family counselling. Just over half provide any kind of shelter, peer support groups, or training of any kind.

Figure. 4a. Proportion of agencies offering (yes) and not offering (no) each of 43* different services/programs to SIOV.

Continues in Figure 4b (below). Notes: Arranged from left to right in order of greatest proportion of agencies answering no regarding whether they offer a service.

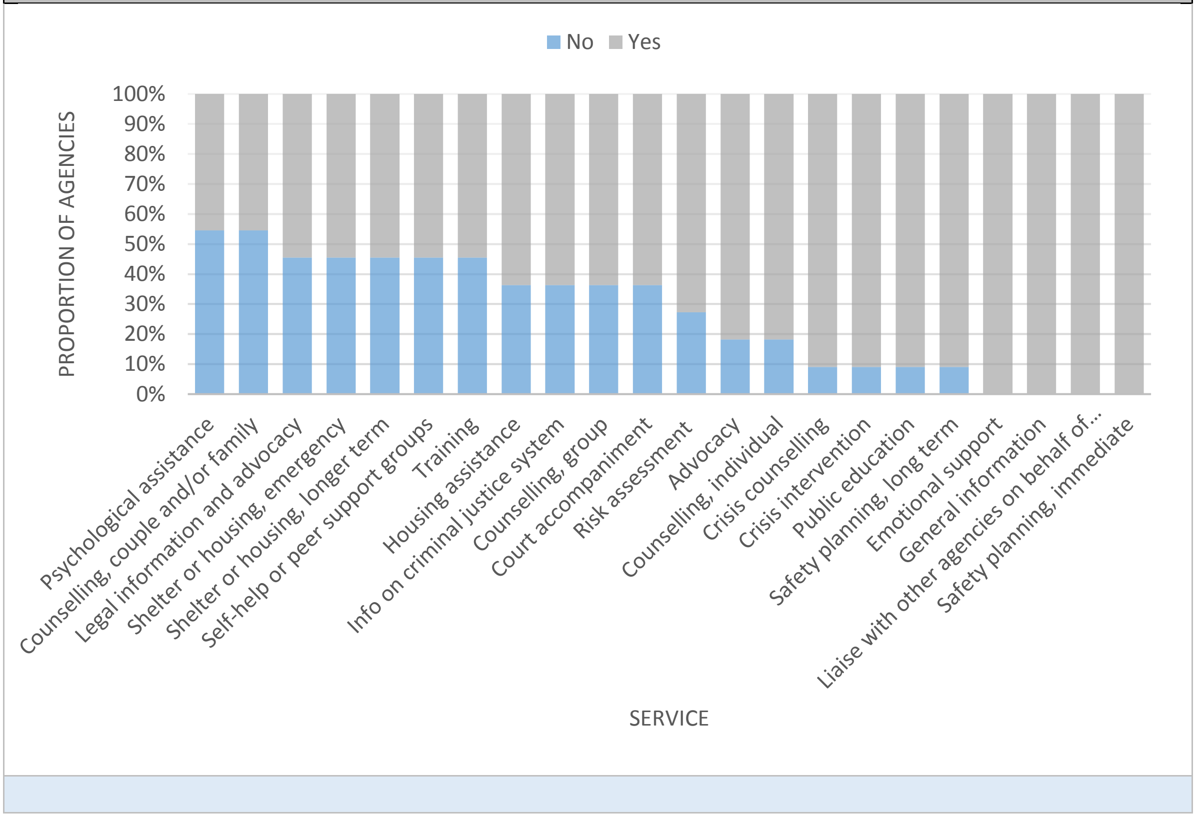


*43 no. of Services derived from Statistics Canada, Victims services survey

Figures 4a and 4b show that some of the vital services such as child protection services, health and medical services, violence prevention services, shelter or housing that are necessary for SOIV to protect, survive and overcome in the long run are offered by less than 30% percent of the agencies. Most of the services are focused on the women survivors, but their children are always part of that situation and the impact is life long, and they perhaps need more support. Moreover, only 9% percent of the agencies are offering a remarkable 98% percent of the services. This indicates the need for more collaborated and coordinated services given the limited resources available for SOIV in a large area like the Region of Peel. Figures 4a, and 4b also indicate that most of the services provided for SOIV are immediate crisis response and short-term oriented. Very limited long-term services are available for SOIV and are offered by a limited number of service providers.

Figure 4b. Proportion of agencies offering (yes) and not offering (no) each of 43 different services/programs to SIOV.

Continues from Figure 4a (above). Notes: Arranged from left to right in order of greatest proportion of agencies answering no regarding whether they offer a service.



It is interesting to note that all agencies that participated in the survey provide only four types of crisis response services. It is evident that agencies are referring clients to other agencies for various services. However, there is no consistent follow-up or feedback on the impact of the services to the clients and vice versa. This situation needs to change if the services are to be client centered. This also proves that services are not client centered but more organization centered. Agencies that have more funds/resources, or those that are able to acquire more funding, have the capacity to provide greater number of services. If so, the big question is who makes the decision on the client-centered services? On the other hand, it is evident that agencies have bigger challenges in terms of human and financial resources and time to offer all the essential services. As a result, agencies tend to address the immediate crisis needs within their limited resources and are not able to go beyond that point.

Table 4 below provides a comparison of services offered that are *not* provided by most agencies versus those that *are* provided by most agencies. It is evident from this table that many important services such as psychological assistance, family counseling, and conflict resolution are not being provided by the majority of agencies. It is evident from the table that most of the services offered address the immediate crisis situation and very little focus is given on long term services for SOIV.

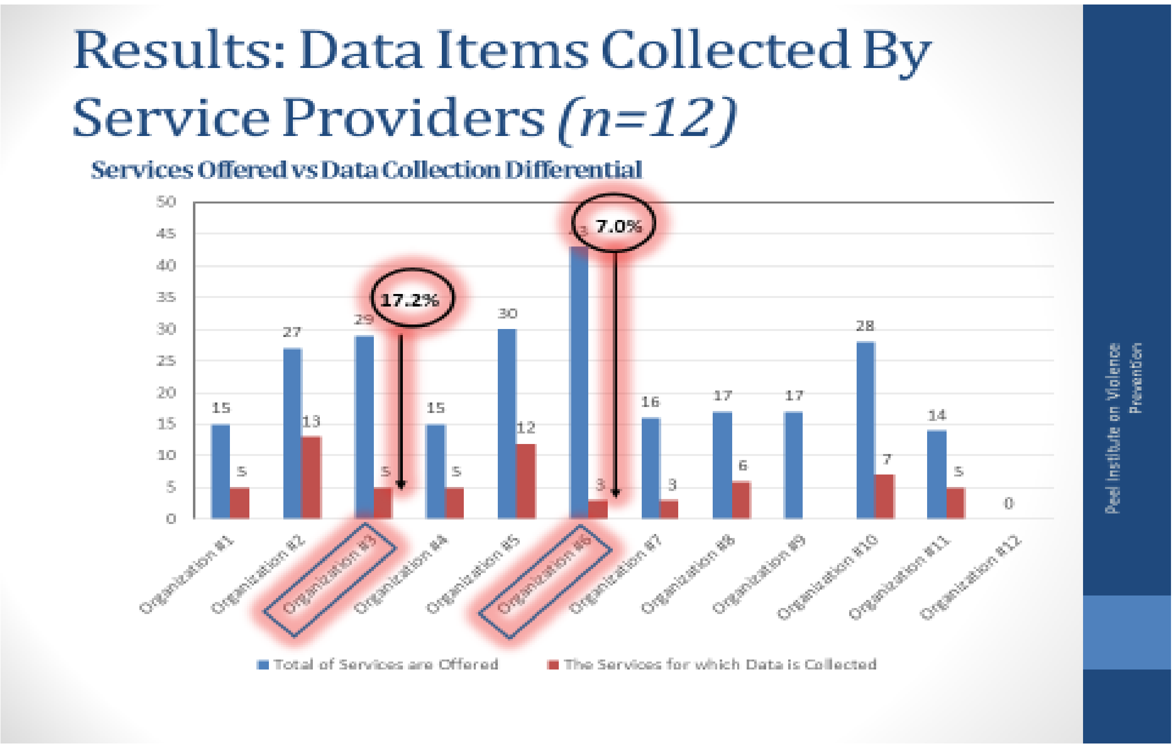
Table 4. Comparison of services offered. A comparison of services offered that are not provided by most agencies versus those that are provided by most agencies.

> 50% Do NOT Offer		**> 50% DO Offer**	
1	Emergency and disaster	1	Legal info and advocacy
2	Restorative justice, mediation	2	Shelter or housing, emergency
3	Victim notification	3	Self-help or peer support programs
4	Case and/or trial updates	4	Training
5	Victim or witness preparation	5	Housing assistance
6	Critical stress debriefing	6	Info on criminal justice system
7	Child protection services	7	Group counselling
8	Claims assistance	8	Court accompaniment
9	Compensation, financial	9	Risk assessment
10	Compensation, other	10	Advocacy
11	First aid	11	Individual counselling
12	Hospital accompaniment	12	Crisis intervention
14	Lobbying	14	Public education
15	Violence prevention services	15	Safety planning, long term

16	Transportation	16	Emotional support
17	Prevention training for clients	17	General info
18	Assistance with victim impact	18	Liaise with other agencies for client
19	Basic needs provision	19	Safety planning, immediate
20	Conflict resolution		
21	Court orientation		
22	Crisis/distress hotline		
23	Psychological assistance		
24	Family counselling		

Figure 5 below shows how the agencies surveyed collect data on the services offered to SOIV. It is clearly shown in the graph that very little data is collected by the service providers of the 43 services offered by them. 5 out of 12 agencies provide more than 25 types of services, while the other 7 offer about 15 services.

Figure 5: Percentage of data collected on the services offered by the 12 service providers



Results: Data Items Collected By Service Providers *(n=12)*

Figure 5 above shows that on average, service data is collected for merely 5-7 types of services out of the maximum of 43 services and a minimum of 15 services offered by these 12 organizations. It is significant to note that one organization that provides all 43 types of services collected data for only 3 types of services, which is just 7% percent of all services provided by that individual agency. This analysis demonstrates that there is no set criteria or guidelines for data collection among the social service agencies in Peel. As a result, organizations tend to collect data mostly for reporting purposes to the funding partners and not to improve client services to the SOIV. This demonstrates the need for a standard data collection practice among the Peel social services agencies if they are to provide better equitable services to the SOIV.

3.2 Interview Results

The agency interviews results were analyzed around the following four major issue-areas that were highlighted in the literature review and supported by experimental evidence.

1. General data collection practices;
2. Referral data and collaboration;
3. Client satisfaction and outcomes;
4. Client-specific training and education

1. General Data Collection Practices

Q: In terms of your data collection practices, have they changed over time, and if so, how?

Finding 1: Data collection practices are largely influenced and limited by funder requirements.

Some of the funders are: Ontario Ministry of Health and Long Term Care (Violence against Women Initiative), Francophone services availability and usage in Mississauga), Ministry Of Community and Social Services (MCSS), Local Health Integration Network (LHIN), Ontario Network, Ministry of Attorney General, Region of Peel, Status of Women, United Way, Canada Immigration Centre, charities, own fundraising • Examples of data bases used: • Women in Safe Housing Database

System (WISH), CATALYST, Excel spreadsheets, OCAN (mental health clients), Catalyst, CRMS, OCMS, OCASE.

A: "Data collection practices in our agency are largely influenced by external funder requirements, namely, the Ministry of Community and Social Services. Funder-driven data collection includes information pertaining to service delivery and service users, such as allocation of funder resources. From the funder's perspective, this ensures accountability. However, the Ministry's focus on accountability measures diverts attention from other, arguably more important, data that is under-collected or neglected altogether. This includes data that is client-centered, which may help improve future programming, service development and client outcomes."

A: "We recognize the need to have the different information because it can certainly dictate how we offer services. I think it's not for lack of motivation, it's always lack of resources. We would really have to overhaul our database in order to be able to capture some of that information in different detail and those are costly endeavors and unless the ministry is willing to fund to make those changes you're kind of going in circles."

A: "It would be great to have a more targeted approach such that agencies are on the same page around what data is useful, regardless of the funder, and collecting the core data that would be useful to plan services and programs."
A: "Lack of funding for data collection is the most significant barrier to improving our current data collection systems, which again falls into the purview of funder-driven data collection practices."

Finding 2: The agencies that were interviewed also identified inconsistencies in the data collection practices within their respective agency. Intake workers and clinicians/counsellors are responsible for client data collection; however, given the diverse staff backgrounds, this leads to varying charting and data input patterns among agency staff and ultimately suboptimal data monitoring procedures.

> A: "We are not collecting enough "right" data needed to plan services/care. Example sexual orientation, where clients come from in the community, information related to the cycle of violence."
>
> A: "In the past our agency used to collect more narrative information about each woman. Now the information required by funders is more quantitative (number oriented), for example number of clients seen in a given month."
>
> A: "Because of funder mandate, our services are more crisis oriented, without a commitment to long-term counselling and care. We collected so limited demographics related to social determinants of health and wellbeing, we do not have a clear picture of who our clients are? Sometimes, I wonder if we are only seeing the most educated middle class women and not the most vulnerable women"

Q: So you mentioned the changes in the way you collected data has become more structured and standardized? What was the motivation or incentive for that?

Finding 3: Data collection practices have evolved to become more standardized and evidence-based to try to better evaluate the services provided to Survivors of Interpersonal Violence (SOIV). Motivation within the agencies was a strong driver for these changes.

> A: "Data is being collected for internal purposes for effective case management: follow-up, for quality tracking, to change some of the services, to find out if some training is needed and if the client is getting the safety plan."
>
> A: "I say we've become more structured in the way we do data collection and analysis. We started out with using logic models and developed in the evaluation forms from the logic models. Up until that point, we had kind of done questionnaires but they were not grounded in the logic model."

> A: Quality of service and also growing funder expectation. Those two things go hand in hand. I say compared to most social services we are way ahead in terms of what we are doing here, because we have an internal interest in the quality of service and kind of evidence based practice.

Data collection practices are strongly motivated by external funder requirements. This means that client information is gathered for the purpose of reporting to funders and demonstrating accountability. Accordingly, data collected does not aim to inform agency improvements and developments. Interviewees identified insufficient allocation of funds as a challenge to improving data collection practices within the respective agencies.

However, agencies are able to overcome the financial barriers to improvements in instances where there was strong internal motivation for the further development of data monitoring tools and practices. For instance, certain agencies have begun to use forms with standardized and objective evaluation measures, such as the State-Hope scale, pre-program and post-program questionnaires, outcome rating scales developed using logic-based and evidence-based models, and have incorporated these into all of their programs. Altogether, these measures provide informative and objective indications of the success of their services and programs. In addition, these validated data tools allow for more meaningful evaluation of their clients' outcomes upon completion of their programs. While challenges remain with respect to the implementation of these standardized tools, these can be minimized with continued staff training and database improvements to facilitate ease-of-use.

Another concerning trend is that more data relating to violence is collected from the perpetrators of violence rather than the victims. As a result, the study found that information relating to a perpetrator's background, motives/motivation, and racial origins is collected more frequently. It is an interesting finding as the majority of agencies interviewed are working with individuals who have experienced trauma while the data collected implies that the perpetrator is of more interest. Investigating the impact on service delivery needs to be done as the lack of data tends to render the victims and their experiences invisible and unimportant.

2. Referral Data and Collaboration

Q: What are your sources of referral in general? Where do your clients usually come from?

Finding 4: There is a lack of inter-agency and inter-disciplinary collaboration within the social services sector and across the health sector.

A: "There isn't a system of data and information sharing among social service agencies both incoming and outgoing."

A: "In terms of health information, I'm at the mercy of what she's willing to tell me or disclose. That's a barrier to getting a holistic picture of what's happening with the client."

A: When we refer to a different service provider we provide only information that is relevant and only if the client consents."

A: "There is no formal communication process for the other agency. Once a client goes away, we do not collection information on the client, and information does not come back to us."

A: "Not usually. Unless again there's a specific reason for that information to come back or if the client is still accessing services with us, it may be relevant to remain in that contact loop but for the most part, no."

Finding 5: Lack of inter-agency collaboration undermines the quality of service provision to Survivors of Interpersonal Violence (SOIV). Privacy is seen as an impediment to sharing information and is not well understood. This suggests that the concept of 'circle of care' is poorly understood by service workers. The result is agency centered, not client centered.

A: "we make a referral, a woman goes to you, and then you have to go through all this data again… this poor woman has to disclose this entire thing to you and then she goes through the entire thing again. I think that becomes a nightmare because if you are referring her to a lawyer, she has to repeat her story. Then she goes to the welfare office to apply for financial aid, she has to repeat the story yet again. She goes to housing to fill out an application for social housing,

> *she has to repeat her story. Then she goes and sees a psychiatrist or a medical doctor, she repeats her story again"*
>
> *A: It means the client has told their story to all of these people they've made contact with but there's no clarity about what each service provider does and it creates confusion even for clients because sometimes they're accessing multiple services at once.*
>
> *A: "When clients arrive at my agency, minimal health or social information is known about the client. At the same time, outgoing client referrals are being made to other community programs and services often without sharing client information or the successes or failures of their previous therapies."*

Thus, agencies are approaching client care with incomplete client information leading to numerous inefficiencies, redundancies and ultimately poor quality of service provision. Without a systematic or standardized data collection system and network for communication, data are either not being gathered or are being lost as the client navigates through the health and social systems.

Q: What would you feel would be an ideal way of achieving increased inter-agency communication and coordination?

> *A: "I don't know exactly what this would look like but some sort of centralized referral system."*
>
> *A: "We need to be more aware of the importance of maintaining the referral loop. This necessitates improved client information sharing and adequate communication between referring agencies. To initiate these changes there would need to be formal partnerships in place, inter-agency and inter-sectorial staff training as well as a centralized or standardized data collection system to facilitate the flow of client information between agencies and sectors."*
>
> *A: "One major barrier to establishing better collaborative initiatives and data sharing appears to be the lack of available resources and funding."*

Q: Is there a more systematic process in place for referrals?

Finding 6: There are some formal referral systems and numerous partnerships in place.

> *A: For few programs, for example the PAR (Partner Assault Response) program, only takes referrals from the courts because they are mandatory clients.*

The Safe Center of Peel (SCoP) is an example of collaboration within a shared location.

Q: What sort of information is shared between agencies in the referral process?

Finding 7: Despite a number of collaborations with other agencies/sectors, referral information, both in and out, is often lacking.

> *A: "It's very hard because most agencies are not integrated. Here we are a separate shop, in terms of what is shared, there are different referral process with different programs."*

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

Finding 8: The major barriers to data sharing between agencies and sectors are inadequate resources and rigid mindsets.

> *A: Resources is a big impediment but also that relates back to capacity. There would have to be some kind of external motivation to create that wave. Social service agencies are so strapped for resources that I don't think they would see that as a priority. I think some agencies are more or less inclined to share or they collect data in their own way for their own purposes and making changes is a huge investment, which they often don't have. So if the will is not there to do it and there is no external motivating factor, it's not going to happen."*

Q: What would you say the external motivating factors would be?

> *A: Funders. It's very interesting that you are expected to collaborate as a transfer payment agency but the provincial government does not collaborate between their silos.*

Finding 9: Ultimately clients are suffering the consequences of a lack of integration and coordination of services. Information sharing between agencies could benefit SOIV.

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

Q: What sort of data information would be important or necessary to be shared among these agencies?

> *A: Most certainly demographic information to understand who is being served and who's accessing what types of service. [Also] things that we know that impacts people's physical and mental well-being like adverse childhood events and other adverse events, that kind of information would probably be a good thing to share because then a more holistic treatment plan could happen. The outcome information I think that would be a good thing to share too because then people can look and see ooh look at the outcome on that program and it may be a good program to refer to. But none of that gets shared. Even some funders don't care about outcome information."*

Despite engaging in multiple partnership initiatives with the health, social and legal sectors, there still exists a gap in communication and data sharing between collaborating members. This, in turn, results in a superficial form of collaboration and, although a good first step in the direction of more meaningful collaboration, there is still work to be done. Due to the gaps that still exist in collaboration, information sharing is still inadequate. Hence, clients are still experiencing considerable redundancies and inefficiencies as they move across the various agencies and sectors. Clients may have to re-tell their stories and start anew once they come to another agency. Ultimately, this leads to poorer support and care for SOIV and suboptimal client outcomes.

However, the initial steps taken by agencies to collect information have allowed them to refer clients to appropriate services because agency staff have awareness and knowledge of other resources that may further help their clients. To further benefit clients, agencies must continue to develop their partnerships and overcome the barriers identified (e.g., lacking funder support and rigid mindset of agencies/sectors). Funders have yet to realize the importance of data sharing and thus have not provided resources for agencies to establish connections with other agencies and organizations.

3. Client Satisfaction and Outcomes

Q: Is there any data collected about outcomes and client satisfaction?

Finding 10: Client outcomes are determined by the client's perception. No objective or standardized measures are used. Client feedback is not directly collected by the agency and there are challenges in obtaining and utilizing this data. This hinders quality improvement and thus improvement in client services. The client is not benefited.

> *A: "It is clients' subjective opinion of the quality of the service or their subjective opinion of whether they're feeling safer, whether they feel they're more informed compared to when they first accessed the service."*
>
> *A: "We don't collect that data. That goes straight to the Ministry. The Ministry of Community and Social Services for VAW clients, we give them a little card with our agency identifier and they go online and complete the survey online. That addresses client satisfaction."*

Q: Is there any way that the feedback gets back to the agency?

> *A: "Yeah, eventually it does come back. Sometimes it comes back as we're not getting enough of these from our clients. From my understanding the information does get back to senior management."*

The agencies that were interviewed face various barriers to obtaining a comprehensive analysis of client satisfaction and outcomes. These agencies measure client outcomes and evaluate the successes of their services using subjective client feedback. This includes clients' satisfaction with the programs and services received, as well as their perceived personal improvement. Although this provides some valuable data, objective and evidence-based measures that have been highlighted in the literature are not used. These include objective data pertaining to improved client safety (e.g., reduced number of hospitalizations, police phone calls and emergency department visits) and client functioning (e.g., employment and housing security). As the data monitoring process does not obtain a complete account of the clients' progress, the information gathered is of limited utility in informing future service changes and developments. Furthermore, client feedback is not collected directly by the agency. Instead, the Ministry of Community and Social Services collects and processes this data and then releases the results to the agency at a later date. This causes a lag in the data collection process, and consequently, a delay in the return of important, potentially time-sensitive, data to the agency.

Clients sometimes access services from multiple service providers, not realizing that some of these services overlap. Clear guidelines and information about service provision are necessary in order for clients to access appropriate services. A centralized intake process would make access to services more coordinated. Clients would have information concerning the services provided by a particular agency. In turn, they would receive more appropriate attention, ensuring that agency resources are used effectively. By lowering the amount of redundancy in services, client confusion over service provision would be minimized.

4. Client-specific Training and Education

Q: Do you have regular training sessions for your staff?

Finding 11: Ongoing training and education for agency staff is limited by financial resources.

> *A: "Not specifically. Again, the barrier to that is always funding and time constraints. Professional development unfortunately tends to be one of the first things to go when there's budget constraints."*

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

3.2.5 Social Determinants of Health (SDOH)

Diversity is a prominent characteristic of the Region of Peel. However, the current system of delivering justice, health and social services focuses primarily on the average, white Canadian and does not account for the diversity of experiences of the people of this region. Agencies recognize that inequities are present in the day to day lives of SOIV in the Region of Peel, and that health, justice and social service agencies have not yet been able to eliminate the inequities seen across the diverse populations of this region. The diversity seen across Peel requires a multifaceted approach to delivering health and social services, which should recognize the unique experiences and needs of each individual or group. Ultimately, such efforts are aimed to make the Region of Peel a more just and equitable society.

The agencies recognize that life conditions greatly influence health of an individual and the overall. People's life conditions include where they are born, grow, live, work, and age. These societal factors are shaped by the distribution of money, resources, and power at the local, national, and global levels, and ultimately, are the social determinants of health. The agencies are not fully aware of determinants of health and their impact on services accessibility. The agencies need to encourage continued staff training and education on a variety of topics relevant to their target population. This translates to more informed and prepared staff that can then deliver more comprehensive and holistic care to clients and address all of the factors that may influence a client's health and well-being. Most agencies are aware of gender, culture, poverty, housing and language. However, they are not aware of some of the other vital factors like income and income distribution, education, unemployment and job security, employment and working conditions, early childhood development, food insecurity, social exclusion, social services, aboriginal status, race, disability, personal health practices and coping skills. SDOH Data that interviewed agencies believe should be collected are:

- Qualitative data that captures diversity of Peel residents
- Housing
- Minute details under each program
- Follow-up on outgoing referrals

Instead of data concerning outcomes, or SDOH-related data, which could stimulate a rich sense of discussion, funders require information on a) program output data (usually fairly narrow in terms of numbers served, hours of direct service provision, etc.) and b) input data (resources such as staff time and budgets). Extensive client-centered training is available and staff are educated in relevant fields. There is an emphasis on taking a holistic approach to serving clients.

> *A: "We like to think that we've developed and are continuing to train/orient people towards trauma informed approach. We do a lot of internal training here and we have a practicum training program and there is an organized training schedule as part of that which includes many of these topics on diversity, anti-oppression, trauma."*

Conclusion

In conclusion, there are many significant gaps seen in service organizations that call for more research. The Peel Institute on Violence Prevention through this initiative is aiming to develop a sustainable research culture that links to the in-depth understanding of Violence against Women and its foundations with systematic data collection on service implementation and outcomes. The survey point out an increased need to develop a framework for violence prevention in the Region of Peel.

Overall, it is evident from the survey results that service agencies have bigger challenges in terms of human and financial resources and time to offer all the essential services. As a result, agencies tend to address the immediate crisis needs of SOIV within their limited resources and not able to go beyond.

On the other hand, the survey results indicate that the data collection practice among Peel service providers have a large gap in collecting some of the vital socioeconomic and demographic information from their clients when providing services for the SOIV. It could be for the reason, certain socio economic demographics are not considered not relevant information to provide services to clients and in determining their current situation. This indicates that organisations collect data that is essential to provide a particular service or program only.

It is significant to emphasize that one organization that provides all 43 types of services inquired collected data for only 3 types of services which is just 7% percent of all services provided by that individual agency. This results demonstrate that there is no set criteria or guidelines for data collection among the social service agencies in Peel. As a result, organizations tend to collect data mostly for reporting purpose to the funding partners and not to improve client services to the SOIV. This demonstrates the need for a standard data collection practice among the Peel social services agencies if they are to provide better equitable services to the SOIV.

The results show that social service agencies do not give priority to the overall health of a client. It doesn't seem to be connecting the Family Doctor to refer to other system. Overall health of a person will show how the survivor is in the crisis situation and how violence impact a person in the long term. Prevailing data collection practices prove that Health data collection is essential for coordination of services, service planning for survivor centered. Then data should be survivor oriented.

Moreover, if there is a pathway to safety that a person may or may not have used before, data is important because collected data will show if a survivor is being abused for the first time or continuously, previously abused and how that has impacted her life situation. Abuse can be short term or long term, it could be by one partner or several partners. However, if these data is helping the organizations to plan the services is not known.

The results verify that some of the vital services such as child protection services, health and medical services, violence prevention services, shelter or housing that are necessary for SOIV to protect, survive and overcome in the long run are not offered largely. Most of the services are focused on the women survivors but their children are always part of that abusive situation and impacted life long and perhaps need more support. This is overlooked in data collection.

Surprisingly, only 9% percent of the agencies are offering a remarkable 98% percent of the services. This indicates the need for more collaborated and coordinated services given the limited resources available for SOIV in a large region like Peel. It is clearly evident that most of the services provided for SOIV are immediate crisis response and short-term oriented. Very limited long term services are available for SOIV and offered by very few service providers.

It is interesting to note that all agencies participated in the survey provide just four types of crisis response services only. Therefore, it is evident that agencies are referring clients to other agencies for various services. However, there is no consistent follow-up, feedback on the impact of the services to the clients and vice versa. This situation needs to change if the services are supposed to be client centered. This also proves that services are not client centered but more organization centered. Agencies that have more funds/resources, or that are able to gain more funds have the capacity to provide more number of services, if so the big question is who decides the client centered services?

Interviews with 11 agencies supporting SOIV provided invaluable insight into the current landscape of data collection practices in Peel. Several preliminary conclusions may be drawn from the results of this study:

1. Current data collection practices at Peel agencies are suboptimal and mainly funder driven;
2. Agency partnerships, data sharing and communication are lacking despite being critical for service quality and improvement;
3. Validated, objective measures provide more meaningful evaluation of client outcomes; and,
4. Insufficient and misdirected funding poses a significant barrier to improvement of data monitoring practices.

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

5 Recommendations

This study has generated several recommendations to address some of the gaps and deficiencies in current data collection practices:

1. Improve data collection (both consistency and content) through the use of more standardized forms/practices to better inform client services and evaluate client outcomes.
2. Increase agency collaboration, ongoing communication and information sharing between agencies to improve the comprehensiveness and continuity of care for SOIV.
3. Raise agency and funder awareness on the importance of data monitoring practices to generate more incentives and to overcome funding as a major barrier to change.
4. Engage in conversations with funding bodies to develop thoroughly researched and comprehensive models of data collection and reporting in order to reduce the frequency with which they are changed and minimize the need for frequent trainings.
5. Reduce retraining of staff with every new data base introduced as it takes resources from service without providing any added value to the client
6. Develop a knowledge transfer strategy to ensure information of this report reach elected officials. I hope this information gets to elected officials (MPPs) as well as others.
7. Try to establish with funding agencies a unified format for collecting information which can become a common data base for services. This can lead to better information and cost savings, as well as better services for clients.
8. SOIV services need to develop standardize systems for collecting data and sharing the data particularly on the same key demographics and determinants of health and well-being.
9. Redesign the services to reflect the diversity of experiences in Peel and according to the demographic diversity revealed in the data and have full understanding of the unique experiences of the diverse SOIV populations coming to seek services is essential to developing the most efficient services.

10. The staff should be trained to understand the diverse set of experiences that the SOIV may bring forth at their organization, and how to provide the appropriate and matched set of services for each.
11. Evaluation of the programs and services is essential in order to determine whether the needs of the SOIV diverse populations are being met and to ensure that the Region of Peel is working towards a more equitable society.

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7 Appendices

7.1 Appendix A: Questionnaires

7.1.1 Agency Data Availability and Service Scan - Pilot

We are embarking on a program of research which will produce empirical findings on some of the priority issues pertaining to violence in the Region of Peel. In the long-term, the goal is to establish a central, collaborative institute to promote evidence-informed practice and address issues such as service navigation, connectivity, and effectiveness.

Your agency has been identified as a key stakeholder (or essential service provider) in the spectrum of community service agencies involved in supporting victims of violence.

Attached is a survey to inquire about (1) what data your agency collects from all service users who have experienced violence or abuse; and (2) what services your agency provides to survivors of violence of abuse. We are interested in both your current and your historical practices. For (1), we are also interested in the method of data collection, and how the data is/was used, and/or the purpose (i.e. what data is sent to funders, what data is collected on individual case/client charts, what is collected for internal purposes, etc.). The survey includes an organized chart, for your convenience, in order to relay your responses. The chart provides some suggestions and prompts, but also leaves important space for you to elaborate. Later this year, with your permission[3], we would like to collect a portion of the client data but first we need to know what data is currently available within your agency.

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[3] Count me in! Collecting human rights-based data, page 3
http://www.ohrc.on.ca/en/count-me-collecting-human-rights-based-data
Many people think that collecting and analyzing data that identifies people on the basis of race, disability, sexual orientation and other Ontario *Human Rights Code*[1] (the *Code*) grounds is not allowed. But collecting data on *Code* grounds for a *Code*-consistent purpose *is* permitted, and is in accordance with Canada's human rights legislative framework, including the *Code*, the *Canadian Human Rights Act*[2], the federal *Employment Equity Act*[3], and section 15(2) of the *Charter of Rights and Freedoms*[4]. The Ontario Human Rights Commission (the OHRC) has found that data collection can play a useful and often essential role in creating strong human rights and human resources strategies for organizations in the public, private and non-profit sectors.

We are querying your agency as a pilot and then will revise our approach as we broaden our scope to include more community agencies within the Region of Peel. Your help with this is essential and of great assistance in informing this new program of research. Since we are approaching your agency with our data availability query as a pilot, feel free to modify the prompts as you need and to write freely. We would like to talk to you or a colleague afterward to get your perspective and to elaborate on anything from the survey that needs to be discussed beyond the constraints of paper. Ask colleagues and share the questions as needed to get the most complete responses. Reminder: This is an evaluative survey. We would like to understand what data you collect and/or have collected in the past (i.e. whether you ask gender of service user, or whether you recorded number of users per program), not the content of the data, (i.e.59% of service users were women; 59 people used a program), which we will be obtaining with your permission later this year.

I. OVERVIEW

1. Your name(s):

2. Your position(s):

1	**Purpose of data collection** *(circle all that apply)*	Funder requirement 1 Internal purposes 2 Individual case charts 3 Other: ________________ 4	
2	Do you submit evaluation for the program or services that your organization provides?	Yes No	
	If yes, do you submit it on a regular basis?	For the Services	For the Programs

	(Circle all that apply)	Each Month Every 3 Months Each year Per Client Other __________	Each Month Every 3 Months Each year Per Client Other __________

2	**Which population is your agency serving?***(circle all that apply)*	Women Families Alders/seniors Youth Aboriginal Immigrants Kids Other ______________________	1 2 3 4 5 6 7 8

7.1.2 Data Items Collected

1. SERVICE USERS

Please Indicate to the best of your knowledge whether the following information is currently collected or was previously collected as part of your data collection practices.

#		**Data Collected**			**Notes**
		Yes	**No**	**Prev Asked**	
	A. Demographics				
1	#Persons in Residence				
2	Date of Birth and Age				
3	Sex/Gender				
4	Sexual Orientation				
5	Community/Neighbourhood in Peel *(e.g. Mississauga/Brampton/Caledon)*				
6	Place of Birth				
7	Ethnic Origin				
8	Immigrant Status				
9	Language - Mother tongue *(language spoken most often at home)*				
10	Religion				

11	Marital Status				
12	Family Characteristics/status *(married, common law, lone parent, w/t or w/o children, etc)*				
13	Number of Children				
14	Education *(population aged 15 yrs and over)*				
15	Labour force status (employment status)				
16	Class of Worker *(e.g. Employee/self-employed)*				
17	Full-time or Part-time work				
18	Occupation/Field of work				
19	Place/Location of Work				
20	Average income of Individual				
21	Average Family Income				
22	Sources of Income				
23	Average monthly shelter costs for owned dwellings				
24	Average monthly shelter costs for rented dwellings				
25	Housing: Ownership Status (PDC) *(Owned? Rented? Band housing?, etc)*				
26	Dwellings by Structural Type (PDC) *(apartment, single-detached house, etc)*				
	B. Health				
27	Has GP/Family Doctor?				
28	Medical History				
29	Present Health Conditions				
30	Other ______________________				
31	Other______________________				
	C. Violence/Abuse (V/A)				
32	Type of V/A which is reason for current visit(s)				
33	Past History of V/A				
34	If Yes, Type of Previous V/A				
35	Treatment and Action(s) Taken				
	D. Services used				
36	Accessing Other **Healthcare providers**? *For Current Situation or Other Reasons*				
36a	For Current Situation, Which Services?				
36b	For Current Situation, Why accessing those services?				
36c	For other reasons, which services?				
36d	For other reasons, why accessing those services?				
36e	Are there any health services desired but not accessing?				
37	Accessing other **Social Services?**				

	For Current Situation or Other Reasons				
37a	For Current Situation, Which Services?				
37b	For Current Situation, Why accessing those services?				
37c	For other reasons, which services?				
37d	For other reasons, why accessing those services?				
37e	Are there any social services desired but not accessing?				
38	Accessing other **legal or justice services?** *For Current Situation or Other Reasons*				
38a	For Current Situation, Which Services?				
38b	For Current Situation, Why accessing those services?				
38c	For other reasons, which services?				
38d	For other reasons, why accessing those services?				
38e	Are there any legal or justice services desired but not accessing?				

2. SERVICES OFFERED

Which of the following services/programs does your organization offer to survivors of interpersonal violence? *(Check all that apply*)

Services/Programs		**Fees per service $**	**No Fees**	**Code**
1.	Advocacy			1
2.	Assistance with victim impact statements			2
3.	Basic needs provision			3
4.	Case and/or trial updates			4
5.	Child protection services			5
6.	Claims assistance			6
7.	Compensation, financial			7
8.	Compensation, other			8
9.	Conflict resolution			9
10.	Counselling, couple and/or family			10
11.	Counselling, group			11
12.	Counselling, individual			12
13.	Court accompaniment			13

14.	Court orientation and/or information			14
15.	Crisis counselling			15
16.	Crisis intervention			16
17.	Crisis or distress line			17
18.	Critical stress debriefing or response			18
19.	Emergency and disaster responses			19
20.	Emotional support			20
21.	First aid and/or health and medical services			21
22.	General information			22
23.	Hospital accompaniment			23
24.	Housing assistance			24
25.	Information on criminal justice system			25
26	Legal information and advocacy			26
27	Liaise with other agencies on behalf of client			27
28	Lobby activities			28
29	Prevention training (for clients)			29
30	Psychological assistance			30
31	Public education			31
32	Restorative justice or mediation measures, Orientation and information			32
33	Restorative justice or mediation measures, accompaniment and support			33
34	Risk assessment (conduct or coordinate)			34
35	Safety planning, immediate			35
36	Safety planning, long term			36
37	Self-help or peer support groups			37
38	Shelter or housing, emergency			38
43	Shelter or housing, longer term			39
40	Training			40
41	Transportation			41
42	Victim notification			42
43	Victim or witness preparation			43
44	Other: Violence prevention services (please list)			44

Q.	A. Services provided CURRENTLY (for Survivors of Interpersonal Violence (please list)	Categories	Data Collected?			Notes
			Yes	No	Previously asked	
1		None 0 Number of users ________________ Number who completed ________________ Number who left early ________________ Number on waitlist ________________ Number ineligible __________________ Number referred to another service___________ Other: ___________________ Other: ___________________				
2		None 0 Number of users ________________ Number who completed ________________ Number who left early ________________ Number on waitlist ________________ Number ineligible __________________ Number referred to another service___________ Other: ___________________ Other: ___________________				
3		None 0 Number of users ________________ Number who completed ________________ Number who left early ________________ Number on waitlist ________________ Number ineligible __________________ Number referred to another service___________ Other: ___________________ Other: ___________________				

Please use the space below to elaborate on the services indicated above that are provided to Survivors of Interpersonal Violence.

Q.	**A. Services provided CURRENTLY (for Survivors of Interpersonal Violence (please list)**	**Categories**	**Data Collected?**			**Notes**
			Yes	No	Previously asked	
4		None 0 Number of users _______________ Number who completed _______________ Number who left early _______________ Number on waitlist _______________ Number ineligible _________________ Number referred to another service__________ Other: __________________ Other: __________________				
5		None 0 Number of users _______________ Number who completed _______________ Number who left early _______________ Number on waitlist _______________ Number ineligible _________________ Number referred to another service__________ Other: __________________ Other: __________________				
6		None 0 Number of users _______________ Number who completed _______________ Number who left early _______________ Number on waitlist _______________ Number ineligible _________________ Number referred to another service__________ Other: __________________ Other: __________________				

Q.	A. Services provided PREVIOUSLY/DISCONTINUED (for SOIV) (please list name and years in operation)	Categories	Data Collected?			Notes
			Yes	No	Previously asked	
1		None 0 Number of users ________________ Number who completed ________________ Number who left early ________________ Number on waitlist ________________ Number ineligible __________________ Number referred to another service___________ Other: ___________________ Other: ___________________				
2		None 0 Number of users ________________ Number who completed ________________ Number who left early ________________ Number on waitlist ________________ Number ineligible __________________ Number referred to another service___________ Other: ___________________ Other: ___________________				
3		None 0 Number of users ________________ Number who completed ________________ Number who left early ________________ Number on waitlist ________________ Number ineligible __________________ Number referred to another service___________ Other: ___________________ Other: ___________________				

Please use the space below to elaborate on services previously provided for SOIV

7.2 Appendix B: Interview Guide

Your name(s):

Your position(s):

Current Data Collection Practice:

1. For whom or for what purpose(s) does your agency collect data? (i.e. For the ministry, for funders, for *internal purposes, on individual case charts, other...)*

2. Which funders support your agency? Which require data, and what do they require?

   Who are your main funding sources and what is the total income of the violence services in your agency?

3. Do you collect beyond what is required? For what purpose? *(i.e. Discuss data you collect for internal purposes, etc.)*

4. How often does your agency collect, organize or submit this data? *(Specify for each kind)*

5. How have your data collection practices changed over time?

6. Who is responsible for collecting data?

Referral Loop:

1. Do you collect data about the sources of referral? If so, what data is collected and how is it used?

2. Does your agency collaborate with other social or health organizations? Is information shared among all parties involved in the circle of care? If so, what information is collected/shared and how is this done?

3. Is data collected after a client has completed your services or left the agency to ensure follow-up? What information is collected and how is it used?

4. What data do you believe should be collected in order to improve continuity of care for clients? Why?

Client Satisfaction and Objective Outcomes

1. Is there any data collected regarding client satisfaction during or after their time at the agency? If so, what information is obtained?

2. What objective measures are collected to assess or evaluate the outcome/efficacy of your services?

3. What measures do you feel are good indicators of client satisfaction, and outcomes?

Your Perspective

1. What data is weaker/less reliable? Which is stronger/more robust? Why?

2. What Data do you feel should be collected which is currently not? Why?

3. What data do you feel is superfluously collected? Why?

Other

1. **Is there client-specific training for staff at your organization? If so, what kind of training/education?**
2. **Do your client services take into consideration the social determinants of health (SDOH) of your target population**? **Do you provide services for victims of trauma?**

7.3 Appendix C: Services Offered

SERVICES OFFERED

Which of the following services/programs does your organization offer to Survivors of Interpersonal Violence? *(Check all that apply)*

	Services/Programs	Fees per	No Fees	Code
1	Advocacy			1
2	Assistance with victim impact statements			2
3	Basic needs provision			3
4	Case and/or trial updates			4
5	Child protection services			5
6	Claims assistance			6
7	Compensation, financial			7
8	Compensation, other			8
9	Conflict resolution			9
10	Counselling, couple and/or family			10
11	Counselling, group			11
12	Counselling, individual			12
13	Court accompaniment			13
14	Court orientation and/or information			14
15	Crisis counselling			15
16	Crisis intervention			16
17	Crisis or distress line			17
18	Critical stress debriefing or response			18
19	Emergency and disaster responses			19
20	Emotional support			20
21	First aid and/or health and medical services			21
22	General information			22
23	Hospital accompaniment			23
24	Housing assistance			24
25	Information on criminal justice system			25
26	Legal information and advocacy			26

27	Liaise with other agencies on behalf of client			27
28	Lobby activities			28
29	Prevention training (for clients)			29
30	Psychological assistance			30
31	Public education			31
32	Restorative justice or mediation measures,			32
33	Restorative justice or mediation measures,			33
34	Risk assessment (conduct or coordinate)			34
35	Safety planning, immediate			35
36	Safety planning, long term			36
37	Self-help or peer support groups			37
38	Shelter or housing, emergency			38
39	Shelter or housing, longer term			39
40	Training			40
41	Transportation			41
42	Victim notification			42
43	Victim or witness preparation			43
44	Other: Violence prevention services (Please list)			44
45				45
46				46
47				47