Evaluation of the Integrated Domestic and Family Violence Service Program

Final report

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Glossary

CALD	Culturally and Linguistically Diverse
CBA	Cost benefit analysis
CEA	Cost effectiveness analysis
CRP	Central Referral Point
CUA	Cost utility analysis
DFV	Domestic and family violence
DVSAT	Domestic Violence Safety Assessment Tool
FACS	NSW Department of Family and Community Services
IDFVS	Integrated Domestic and Family Violence Services program
LCP	Local Coordination Points
NGO	Non-Government Organisation
ORS	Outcome Rating Scale
SAM	Safety Action Meeting
SHS	Specialist Homelessness Services
SHLV	Staying Home Leaving Violence
WDFVCAS	Women's Domestic Violence Court Advocacy Service
WHO	World Health Organisation

1 Executive Summary

This is the final report from the evaluation of the Integrated Domestic and Family Violence Service program (IDFVS), which was commissioned by the NSW Department of Family and Community Services (FACS). Researchers from the Gendered Violence Research Network (GVRN) and the Social Policy Research Centre (SPRC), both at UNSW Sydney, conducted the evaluation.

IDFVS provides a multi-agency, integrated and coordinated response to domestic and family violence (DFV) among high-risk target groups and in targeted communities. The program intervenes following the identification of DFV in a family. Identification usually occurs via Police, health services, child protection agencies, and/or support services such as family support programs. IDFVS provides adult, young people and child victims (male and female) with support to escape and recover from the abuse. The program provides ongoing practical and emotional support to both victims who remain in a relationship with the perpetrator, and victims who have ended the relationship. Child clients of IDFVS are considered as clients in their own right and direct services are provided to children. Direct services to children are negotiated and agreed by the parent client of the service (FACS 2016). Some IDFVS sites also provide interventions to perpetrators.

The purpose of this evaluation is to:

- strengthen the service model by documenting good practice across all projects
- provide strategic guidance for ongoing implementation and contribute to evidence in the area
- assess the value and critical elements for success of the integrated approach taken by IDFVS
- make recommendations on potential approaches to improve the program
- increase understanding of user needs, assess outcomes for clients, identify any gaps in creating partnerships and note where integrated service provision is lacking.

This is a mixed-method inquiry combining a synthesis of service monitoring data, validated scales and measures, as well as qualitative interviews and focus groups. The quantitative evaluation component is a retrospective data analysis based on program service delivery (portal) data for 24 months from July 2015 to June 2017 covering two complete financial years 2015-16 and 2016-17.

Service delivery and client profiles

- During the two-year study period the IDFVS program supported 4,907 clients at a relatively similar level (2,470 in 2015-16, 2,437 in 2016-17)

- Around two thirds (66.8%, n=3,277) of clients received case managed support compared to case coordinated services (33.2%, n=1,630)
- Consistent with domestic violence statistics IDFVS clients are mostly women, predominantly in the 26 to 40 year age group
- The program also assists high numbers of client's children with more children (6,806) than adult clients (4,907), an average of 1.4 children per client
- The program is reaching clients from all identified target groups including:
    - Aboriginal or Torres Strait Islander represented 8.4% of clients (n=386) with an increase from 7.8% (n=180) in 2015-16 to 9.1% (n=206) in 2016-17
    - High numbers of Aboriginal clients' children (880), an average of 2.3 children per Aboriginal client
    - High levels (43.5%) of clients affected by socio-economic disadvantage
    - A high proportion of clients born outside Australia with comparative high levels of languages other than English spoken at home representing 34.2%
- Clients also report being affected by high levels (34.0%) of social exclusion
- Victims with a disability represent 9.0% of clients, with a further 5.0% reporting they are the caregiver of a child with a disability
- Program referral sources reflect the integrated character of the service covering government and non-government organisations.
    - The close integration with police provides the highest proportion of program referrals (29.0%, n= 1,810), 8.8% (n=549) through FACS Community Services, and 6.7% for Women's Domestic Violence Court Advocacy Service (WDFVCAS, n=420) and Local Coordination Points (LCPs, n=416)
- The program provides referral to multiple external services with over half of all clients referred for community housing and counselling services
- There is substantial variation in services referred across projects which may reflect availability and capacity or available services in each location

Client interim outcomes

- A substantial proportion of clients have received multiple wraparound support including coordinated services through multiple program partner agencies. This reflects the integrated service model of IDFVS
- The program is providing a responsive pathway through various referral sources with predominately short periods between referral, assessment and entry including higher priority crisis cases being supported immediately
- Program client profiles reflect access by target groups as outlined in the previous client profile summary
- Client wellbeing as assessed through the Outcome Rating Scale (ORS. Miller et al 2003) is a simple, validated and widely used 4-item tool that

assesses individual feelings of wellbeing on four dimensions: individually, interpersonally, socially and overall. Analysis of ORS scores demonstrates that client wellbeing is increasing significantly from the time of program entry compared with the point of exiting the service. The ORS figures indicate a statistically significant reduction in mean ORS score of 12.5 ($p<0.001$) from levels considered to be below the boundary for a clinical range of psychological distress at entry, to a non-clinical 'normal' range at program exit.

- Client survey results indicate consistently highly positive feedback with around 80% of clients responding they agree or mostly agree with each survey question.
- Interviews with clients indicated that the support provided by IDFVS is highly valued and felt to improve safety and well-being.
    - The specialist knowledge of DFV and its impacts held by IDFVS staff was beneficial because it meant the clients' circumstances and needs were better understood, and there was a greater appreciation for how best to deliver services to them.
    - Qualities of the IDFVS that were most appreciated by the clients were how flexible, kind and considerate the service providers were.
    - The open ended and comprehensive support meant that clients most immediate and longer-term needs could be attended to by the service.
    - Clients were supported to access a range of other services

The services all commenced at different times and in different service contexts so the way the IDFVS developed has been dependent on the nature and types of services funded in the local geographic area. Their auspice agency (and the services they provide as wrap-around) and where they are co-located also influences the way in which the integrated service develops and the philosophical underpinnings of a particular IDFVS project.

Consequently, the ways in which the IDFVS describe integrated service provision is not consistent between each project which is not a surprise because there is little definitive guidance in the current literature or even in the service specifications, describing how an integrated DFV service should be offered. Definitions of integrated service provision in the literature are contested and various terms such as partnerships, collaborative arrangements, one stop shops are used interchangeably with integrated service provision. In fact, the diversity characterising IDFVS actually reflects the diversity noted in the current evidence base.

Good practice elements shared across IDFVS projects

There are clear shared strengths which position the IDFVS as providing a unique DFV service. The following shared program elements demonstrate that despite the

flexibility of IDFVS provision, there are innovative, good practice elements that contribute to the effectiveness of IDFVS provision.

- **Local context**

The importance of local context was stressed by all participants as being critical to shaping the nature of integrated service provision. While all IDFVS projects acknowledge their routine provision of referral, case coordination and case management, the way in which these services are provided, and the mix of local partners and services combine to provide a unique service opportunity via a pattern of referral pathways and integrated partnerships within the local geographic context. The balance of activities undertaken by each IDFVS are driven by perceptions of the needs and opportunities of the local context. As already noted each of the IDFVS projects provides information, support, referrals, and case coordination and/or case management. Aside from these core components, there are substantive differences between the sites in terms of services provided, co-location and auspice arrangements, use of brokerage, and provision of support to children and family members, and perpetrators.

- **Holistic response**

The IDFVS program guidelines (FACS, 2016) provide for flexibility around perpetrator work. Services are not required to provide this service but can where needed and where staff feel they have the expertise. IDFVS provide shared and separate services to different family members, not only the immediate victim. The issue of working with male perpetrators was treated differently in the IDFVS. There were a range of philosophical positions described around working with male victims, and some services referred perpetrators to other local services as a means to enhance the safety of the victim as well as monitor perpetrator risk. At least two of the IDFVS noted the potential to work with the perpetrator if they were willing to engage.

- **Working with women who remain in the relationship**

A unique program element that sets IDFVS apart from other DFV services is that they work with victims who remain in the DFV relationship or feel unable to leave at the point of service entry, focusing on maximising safety. Other DFV services such as refuges and Staying Home Leaving Violence services almost exclusively work with women who have already left. IDFVS also maintain support to women who return to the relationship or in circumstances where women cycle in and out of the relationship.

- **Client driven and focused on needs**

Assessment of client's needs determine the agencies who partner with or who provide part of the integrated service as well as determining referral pathways and whether they case coordinate or case manage a particular client.

- **Flexible duration and intensity of support**

IDFVS workers and managers all note that their services can provide intensive intervention when needed depending on client circumstances. The flexibility of being able to provide an intensive or less intensive service at different points in a client's journey is an important benefit. Stakeholders noted this to be particularly helpful if there is ongoing episodic violence and interactions with the criminal justice system and Family Court.

IDFVS is not time limited and there is substantial variation across projects for the proportion of exited clients as well as average duration in the program. Around 45% of clients have completed their support period and exited the program, with an average support duration of 5 months. The remaining 55% of clients are open support cases with around 5 times the average duration in the program of 26 months as at the end of the study period

- **Information sharing and risk assessment**

The notion of integration as information sharing is important and participants noted that this is consistent with the NSW DFV Reforms. The implementation of the DVSAT provides a common language of risk which may be shared amongst the local services and through SAMs when they are universally rolled out. The literature and some stakeholders noted certain limitations of the DVSAT.

- **Flexibility of local partnerships addressing specific population group needs**

Partnerships are designed to address specific needs of a population cohort. Monitoring and qualitative data suggest that projects do form partnerships with specific services to ensure that the IDFVS provides a tailored intervention for specific population groups

The innovative combination of these program elements has the potential to ensure good practice across IDFVS projects within the flexibility of the overarching IFDFVS model.

Program economic costs and benefits

- Domestic and family violence affects not only individuals but the broader community, with a reported substantial burden on services, hospitals, assaults, homicides, the criminal justice system and homelessness services
- Collectively these costs in Australia have been estimated at $13.6 billion each year and are projected to rise to $15.6 billion by 2021. NSW is estimated to account for over one third of the National figure with more than $4.5 billion annually

- For the two-year evaluation period the NSW government provided funding for the IDFVS program of $3.6 million in 2015–16 and $3.7 million in 2016-17 with a minor increase through annual indexing
- The IDFVS program is part of the wider NSW government DFV strategy with announcement in the 2017-18 budget which more than doubled the investment for domestic and family violence initiatives to more than $350 million over four years from 2017-18 to 2020-21
- The overall average cost per client is estimated at $1,457 per year in 2015-16 and a similar level of $1,518 for 2016-17
- The range and scale of costs related to domestic and family violence suggest that effective programs such as IDFVS aimed at reducing or avoiding incidents would plausibly offset substantial costs to related NSW government funded agencies and the wider economy
- In this overarching context the IDFVS estimated average cost per client of around $1,500 per year appears marginal
- Although there is inherent variation in estimated average client cost and significant uncertainty in longer term client pathways the interim outcomes show substantial improvements in client wellbeing, high levels of client satisfaction and indicate the program is delivering benefits. The program may also potentially be contributing to substantial additional longer-term benefits for program clients and their children, although this is beyond the scope of this evaluation.

Recommendations

The purpose of the IDFVS evaluation is to strengthen the service model by documenting common elements of good practice across all projects and make recommendations on potential approaches to improve the program, strengthen outcomes for clients and facilitating improved management of the program. The following recommendations provide strategic guidance for ongoing implementation of IDFVS and contribute to evidence of the effectiveness of the IDFVS response.

Recommendation One: *That FACS continue to review the extent and difficulty of data entry with the introduction of CIMs as well as the requirement for additional data entry imposed by auspice agencies*

Recommendation Two: *That a round of Outcome Rating Scale (ORS) training is provided to IDFVS service providers ensuring greater understanding of the tool and its implementation in practice. It may also provide an opportunity for service providers to share other outcome tools they additionally implement.*

Recommendation Three: Each IDFVS service report to FACS on their local partnerships and at the local level how the available services partner to best

effect for the population demographic. This requires improved consistency in the recording of external service referral and potentially website development.

Recommendation Four: *That consideration be given to funding specific workers with practice skills in working with children affected by DFV.*

Recommendation Five: *That FACS develop clearer guidelines to determine whether a case remains open or is closed, thereby allowing greater transparency of active client numbers.*

Recommendation Six: *That FACS develop clear guidelines on the component of brokerage in the funding allocation and brokerage use. This does not preclude projects leveraging other brokerage opportunities provided through local partnerships.*

Recommendation Seven: *That priority be given to employing Aboriginal workers as well as providing training on cultural safety and competency to other staff.*

Recommendation Eight: *That community education activities be properly resourced and strengthened to allow IDFVS projects to undertake more comprehensive community education with local partners and in the local community.*

Recommendation Nine: *That an IDFVS workforce development plan be developed to ensure the ongoing professional development of IDFVS service providers and managers.*

Recommendation Ten: *That FACS review procedures for recording IDFVS financial transactions in the corporate finance system to improve accuracy of funding provided to individual projects.*

2 Introduction

The NSW Department of Family and Community Services (FACS) has commissioned researchers from the Gendered Violence Research Network (GVRN) and the Social Policy Research Centre (SPRC), both at UNSW Australia, to evaluate the Integrated Domestic and Family Violence Service program (IDFVS). The evaluation has been designed to strengthen the service model by documenting common elements of good practice across all projects and makes recommendations on potential approaches to improve the program, strengthen outcomes for clients and facilitate improved management of the program. The data and accompanying recommendations both provide strategic guidance for ongoing implementation of the IDFVS and contribute to evidence of effectiveness of an integrated domestic and family violence (DFV) response.

2.1 Integrated service responses: Commonwealth policy priorities

Both victims and perpetrators of domestic and family violence (DFV) have diverse and complex needs, frequently requiring multiple interventions provided by a range of government and community-based services (Rees & Silove, 2014). Government and professional recognition of the complexity of these needs of women and children affected by DFV has acted as a catalyst for the growth of what is now referred to as 'integrated responses' (Coy et al., 2008). Indeed, this intention is echoed at the planning level, in the Commonwealth's '*Time for Action: The National Council's Plan for Australia to Reduce Violence against Women and their Children, 2009 – 2021'* (the National Plan) which explicitly states that its success "hinges on the success of the sixth outcome area – that the entire system join seamlessly and all its parts work together" (2009, p.15). The Third Action Plan (2016 – 2019) of the National Plan reinforces principles and actions to 'support, sustain and increase collective effort' (COAG, 2016, p1). The importance of integrated responses to DFV is emphasised in two of the four principles which underpin the three-year period of the Third Action Plan:

- 'When developing supports, services and systems, innovative solutions are explored, including integration and co-location of services and harnessing new and emerging technology
- Systems, services and agencies intervene effectively' (COAG, 2016, p3)

2.2 Integrated service responses: NSW policy priorities

The Government of New South Wales launched its own DFV Reform Package in 2014. *It Stops Here: Standing together to end domestic and family violence* is the

NSW Government's Domestic and Family Violence Framework for Reform. *It Stops Here* was designed to be a new approach to referrals, victim safety assessment, and service coordination by creating a coordinated, holistic response to victims and their children. Evidence suggests that victims and their children reported being referred on to a range of intervention contexts and were re-traumatised each time by having to re-tell their story to different workers. *It Stops Here* introduced a policy and practice response referred to as 'Safer Pathway' in which the safety needs of the victim and their children are positioned as central in the intervention. Through a Local Coordination Point (LCP) which constitutes a single contact point via a specialised domestic and family violence worker, the victim(s) will be linked with the services that best address their assessed needs.

The key components of Safer Pathway build on the existing service response in DFV agencies including IDFVS. These are:

- The implementation of the Domestic Violence Safety Assessment Tool (DVSAT) to better and consistently identify the level of domestic violence threat to victims. There is an expectation that all DFV agencies and Police routinely implement the DVSAT to monitor risk.
- A Central Referral Point (CRP) to electronically manage and monitor referrals
- A state-wide network of Local Coordination Points (LCPs) that facilitate local responses and provide victims with case coordination and support
- Safety Action Meetings (SAMs)in which members develop plans for victims at serious threat of death, disability or injury as a result of domestic and family violence
- Information sharing legislation that allows service providers to share information about victims and perpetrators so that victims do not have to retell their story multiple times, to hold perpetrators accountable and promote an integrated response for victims at serious threat.

The reforms particularly focus on safety and the importance of assessing the level of threat to the victim. NSW Police play a pivotal role and are required to refer any victim identified as at threat or serious threat to a state-wide CRP. Once the CRP receives the information, the case is allocated to the LCP closest to the victim so that the most appropriate DFV worker from the LCP will then contact the victim and coordinate their safety and service needs. Victims identified as being at serious threat can be referred to a Safety Action Meeting (SAM) which coordinates the involvement of government and non-government service providers and facilitates the information sharing needed to develop a safety plan that encompasses the interventions of the various services Safer Pathway started in Orange and Waverley in September 2014 and has been gradually rolled out across the State although at the time of writing, this roll out was not complete and not all the IDFVS services were located in geographic areas where there was a LCP or SAM operating.

A key element of the *It Stops Here* reforms is Safer Pathway, which outlines a new approach to victim safety assessment, referrals and service coordination. Under Safer Pathway, services are expected to work together to create a coordinated, holistic response to victims and their children.

Safer Pathway aims to position the safety of the victim and their children at the centre of the response. Victims are offered tailored support to meet their immediate and longer term safety, health and wellbeing needs. Victims have a single contact point, a specialised domestic and family violence worker, who links them with the services they need at the right time.

From December 2014, the Domestic Violence Safer Pathway reforms were progressively rolled out across NSW However, at the time of data collection only three IDFVS were located in a geographic area where Safer Pathway was rolled out. Two sites in Eastern Sydney (Bondi Beach Cottage and The Deli Family Support Service in Eastlakes) started in the Safer Pathway trial in 2014/2015. In 2015/2016, one IDFVS project, the Bankstown Domestic and Family Violence Support Service joined the roll out of Safer Pathway.

The most recent policy initiative informing IDFVS is the *NSW Domestic and Family Violence Blueprint for Reform 2016-2021: Safer Lives for Women, Men and Children.* Blueprint Action 3 specifically focuses on supporting victims and while acknowledging that the Safer Pathway Reforms have had some effect, there is also recognition of the complexity and lack of integration across the service system. The IDFVS projects are therefore required to be part of a system that is 'responsive to different types of client need and provides access to information and support at any stage of experiencing domestic and family violence. A networked and coordinated system that is able to wrap around the victim and address their varying and multiple needs' (NSW Ministry of Health, 2016, p6). Blueprint Action 5, Delivering Quality Services, underpins Blueprint Acton 3 with the explicit aim to develop mainstream and specialist service providers who are supported to provide consistent, high quality services to victims and perpetrators of domestic and family violence.

2.3 Integrated service responses: the evidence base

A meta-evaluation of integrated service provision in DFV and sexual assault evaluations (Breckenridge, Rees, valentine and Murray 2016) found promising indications for integrated approaches.

- The vast majority found that the interventions had changed ways of working for the agencies involved and increased collaboration, built professional respect and knowledge, and in many cases brought agencies closer to shared understandings of violence and risk.
- When client views were included, the evaluations found that clients valued the support they received.

Despite the optimism of these results, few of the evaluations had robust outcome measures and none were designed to assess the relative impact of specific components, so it was not possible to draw conclusions from the evaluation evidence on the effectiveness of program components or service models. A further limitation was that most of the evaluations did not analyse experiences or outcomes for diverse population groups including those from mainly non-English speaking backgrounds, women living with disabilities, or those living in rural and or remote geographical locations.

An important finding of the meta-analysis of evaluations was that the measurement of integration has been impeded by four key factors:

- The term integration is often applied loosely to describe networks or partnerships of a variety of types. It is not well defined.
- Where services or models have been specifically formulated and designed with the framework of integration as the centrepiece, evaluation commonly has focused on the success or otherwise of one or more of its program components, rather than on the effectiveness of integration itself.
- Integrated services that respond to DFV are often diverse in scope and lack uniformity in structure, commonly developing organically to target specific populations within specific contexts.
- Absence of universal characteristics or evaluation features necessarily renders the development of potential evaluation models difficult, if not impractical.

2.4 The Integrated Domestic and Family Violence Services program (IDFVS)

IDFVS provides a multi-agency, integrated and coordinated response to DFV among high-risk target groups and in targeted communities. DFV is defined as:

> any behaviour, in an intimate or family relationship, which is violent, threatening, coercive or controlling, causing a person to live in fear. It is usually manifested as part of a pattern of controlling or coercive behaviour (FACS 2016, p.6).

IDFVS aims to improve outcomes for adults and children affected by domestic and family violence, by:

- Increasing access to a suite of better coordinated services, for adult and child victims
- Supporting more proactive and co-ordinated responses by a range of agencies including justice agencies and support services
- Improving co-ordination and integration of the local service systems responding to domestic and family violence
- Providing community education and awareness raising

The key feature of services funded through this program is integration. This is achieved by coordinating the responses of different government agencies and non-government organisations, including the Police, courts, child protection workers, women's refuges, men's education and behaviour change programs, health and domestic violence support services.

Most of the individual IDFVS services have developed from pre-existing DFV services and all have different auspice arrangements providing different wrap-around services to IDFVS clients. The local context determines IDFVS partnerships and all these factors directly influence the way in which each IDFVS project has evolved.

IDFVS intervenes following the identification of DFV in a family. Identification usually occurs via Police, health services, child protection agencies, and/or support services such as family support programs. The IDFVS program provides adult, young people and child victims (male and female) with support to escape and recover from the abuse. The program provides ongoing practical and emotional support to both victims living through the abuse, and victims who have escaped the perpetrator. Child clients of IDFVS are considered as clients in their own right and direct services are provided to children. Direct services to children are negotiated and agreed by the parent client of the service (FACS 2016 p.6). Some IDFVS sites also provide interventions to perpetrators although this group is not well represented in the client demographic profile.

Services provided to children can include but are not limited to:

- Emotional and practical support
- Safety planning
- Risk assessment using the mandatory reporting guidelines
- Therapeutic support (where specialisation exists within the service).

IDFVS aims to improve outcomes for its target population over the long-term by influencing factors that contribute to the high-level result. At a population level, IDFVS seeks to contribute to reduced rates of domestic and family violence through reducing community tolerance of domestic and family violence, and by providing access to support services for adult and child victims.

In order to achieve the program results, the IDFVS program focuses on achieving the following interim results:

- Domestic and family violence victims are accepted into the program as clients and their children are provided a direct service
- Clients are empowered to keep themselves and their family safe
- Clients pursue prosecutions with support from the program
- Clients are provided with case plans following evidence-based risk and needs assessment of their family situation

- Clients meet their case plan goals
- Perpetrators are referred to domestic violence behaviour change programs that meet the minimum standards, where available
- The local community's understanding of and response to domestic and family violence improves
- The local community is informed about domestic and family violence, including legislation, rights and reporting (FACS 2016, p.10).

IDFVS delivery is intended to be provided in a way that is 'seamless' to the client. The core service provided through the IDFVS program is integrated case management. Case managers work with the client to assess needs and risk by using the Domestic Violence Safety Assessment Tool (DVSAT), plan service delivery and monitor the results by 'tracking' the client's progress. Services could be provided by single, multidisciplinary teams, or by multiple agencies under the supervision of a case manager. Case managers have access to 'brokerage' funds for purchase of services from other service providers, where necessary. The service model ensures that clients are supported appropriately and that there is a multi-agency response to their needs (FACS 2016, p.9). The IDFVS support period is not fixed. It is flexible, needs-based and family focused. A unique program element that sets IDFVS apart from other DFV services is that they additionally work with victims who remain in the DFV relationship or feel unable to leave at the point of service entry, focusing on maximising safety for this particular group of women and their children.

There are eleven IDFVS services operating across NSW (Table 1).

Table 1: IDFVS locations, services and provider agencies

Location	Service name	Agency
Bankstown	Bankstown Domestic Violence Service	South West Sydney Legal Centre
Bondi	Bondi Beach Cottage	Bondi Beach Cottage
Cabramatta	Integrated domestic and family violence service	Core Community Services
Central Coast	Central Coast Area Domestic Violence Integrated Case-management and Education	NSW Police (Note: auspice arrangements were changed during the evaluation period)
Eastlakes	The Deli Women and Children's Centre	The Deli Women and Children's Centre
Green Valley, Liverpool	Green Valley Liverpool Domestic Violence Response Team	South West Sydney Local Health District
Mt Druitt	Mt Druitt Family Violence Service	Family and Community Services
Mullumbimby	Mullumbimby Women's Services	Mullumbimby Women's Services
Nowra	Nowra Domestic Violence Intervention Service	YWCA NSW

Port Macquarie Hastings	Community Partnerships Against Domestic and Family Violence	Port Macquarie Hastings Domestic & Family Violence Specialist Service
Taree *	Catholic Care	Catholic Care

Note: * Taree Catholic Care commenced service during the evaluation period

2.5 Evaluation aims and questions

The purpose of this evaluation is to:

- Strengthen the service model by documenting good practice across all projects
- Provide strategic guidance for ongoing implementation and contribute to evidence in the area
- Assess the value and critical elements for success of the integrated approach taken by IDFVS
- Make recommendations on potential approaches to improve the program
- Increase understanding of user needs, assess outcomes for clients, identify any gaps in creating partnerships and note where integrated service provision is lacking

There are nine primary evaluation questions reflecting the primary purposes of the evaluation, supported by a series of sub-questions to further detail particular areas of interest.

1. What are the outcomes for clients assisted by the IDFVS (including children and young people)?
2. What services are delivered by IDFVS?
   - What are the characteristics of IDFVS clients?
   - What are the referral pathways to IDFVS?
3. How and to what extent does the IDFVS service model support effective service delivery towards the program goals?
4. What aspects of the IDFVS service model are common to all projects?
   - To what extent have the agreed core program elements been adopted for clients and families in different circumstances?
5. What are the strengths and challenges of local adaptations to the IDFVS model by individual projects?
   - What factors affect the extent to which the agreed core program elements been adopted across each project?
6. How do clients experience the support provided by IDFVS?
7. How are Aboriginal individuals and communities supported by IDFVS?
8. How and to what extent has IDFVS formed new partnerships and networks?
   - What are the facilitators and barriers to new partnerships?
9. What are the unit costs of each IDFVFS service and what is the overall economic cost of the IDFVS model?

3 Methodology

This is a mixed-method inquiry combining a synthesis of service monitoring data, validated scales and measures, as well as qualitative interviews and focus groups.

The setting and scope of this evaluation reflects the overarching perspective for the IDFVS program, the broader NSW government strategy and coordination with related blueprint initiatives. In terms of quantitative data, this evaluation focuses on interim outcomes and available program data sources for the two-year study period July 2015 – June 2017. It reports on specified interim client and program outcomes and the implicit contribution the program is making towards longer term client and systemwide endpoints.

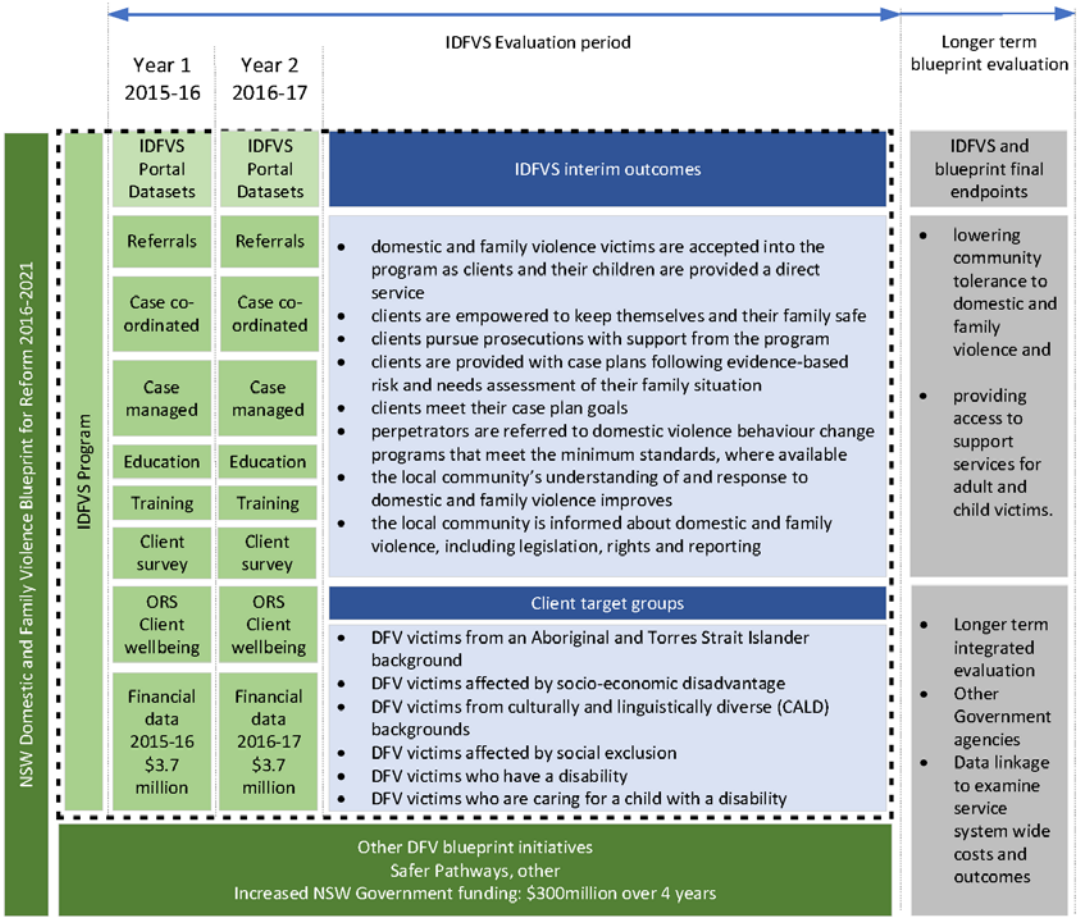
An application for approval from the UNSW Human Research Ethics Committee (HREC) was submitted in November 2016. Approval was granted on 13 Dec 2016, for a period of five years (HC16967).

Assessment of the impact of the IDFVS in the context of the broader strategy requires an evaluation perspective and framework to assess the diverse client pathways throughout the service system, the interrelationships with other agencies, related resource usage, and wider sector effectiveness and related cost effectiveness. From a scale and funding perspective, the NSW government more than doubled the investment in specialist domestic violence initiatives in 2016-17 to $300 million over 4 years to 2019-20. Of this total investment in coordinated services the IDFVS program represents $3.7 million per year, around 5 percent of total annual funding for blueprint programs. This wider longer-term assessment is incorporated in the blueprint strategy objectives to develop system wide performance metrics and data collection mechanisms across the service system and to embed evaluation into all NSW Government funded domestic and family violence services.

3.1 Evaluation scope: client outcomes

The evaluation of client outcomes aligns with available IDFVS program datasets over the two-year study period from July 2015 to June 2017, and the program interim outcomes across client target groups. There are implicit interrelationships between the current evaluation of IDFVS, other related FACS DFV programs, and the longer-term endpoints established in the overarching FACS reform blueprint (Figure 1). The black dotted area of the figure highlights the focus of the IDFVS evaluation positioned within the wider NSW blueprint strategy and longer-term outcomes of lowering community tolerance subject to longitudinal evaluation.

Figure 1: IDFVS data perspective and scope



Source: FACS DFV Reform Blueprint 2016-2021, portal datasets, IDFVS program guideline. Black dotted area reflects focus of the IDFVS evaluation.

In line with the wider blueprint perspective the evaluation aimed to identify aspects which would support improved data content in the context of this broader longer term evaluation framework for assessment of system wide outcomes. The evaluation of these longer-term endpoints will extend the perspective to potentially include government wide data linkage to examine client pathways, service system wide costs and outcomes, overarching program effectiveness and related cost effectiveness.

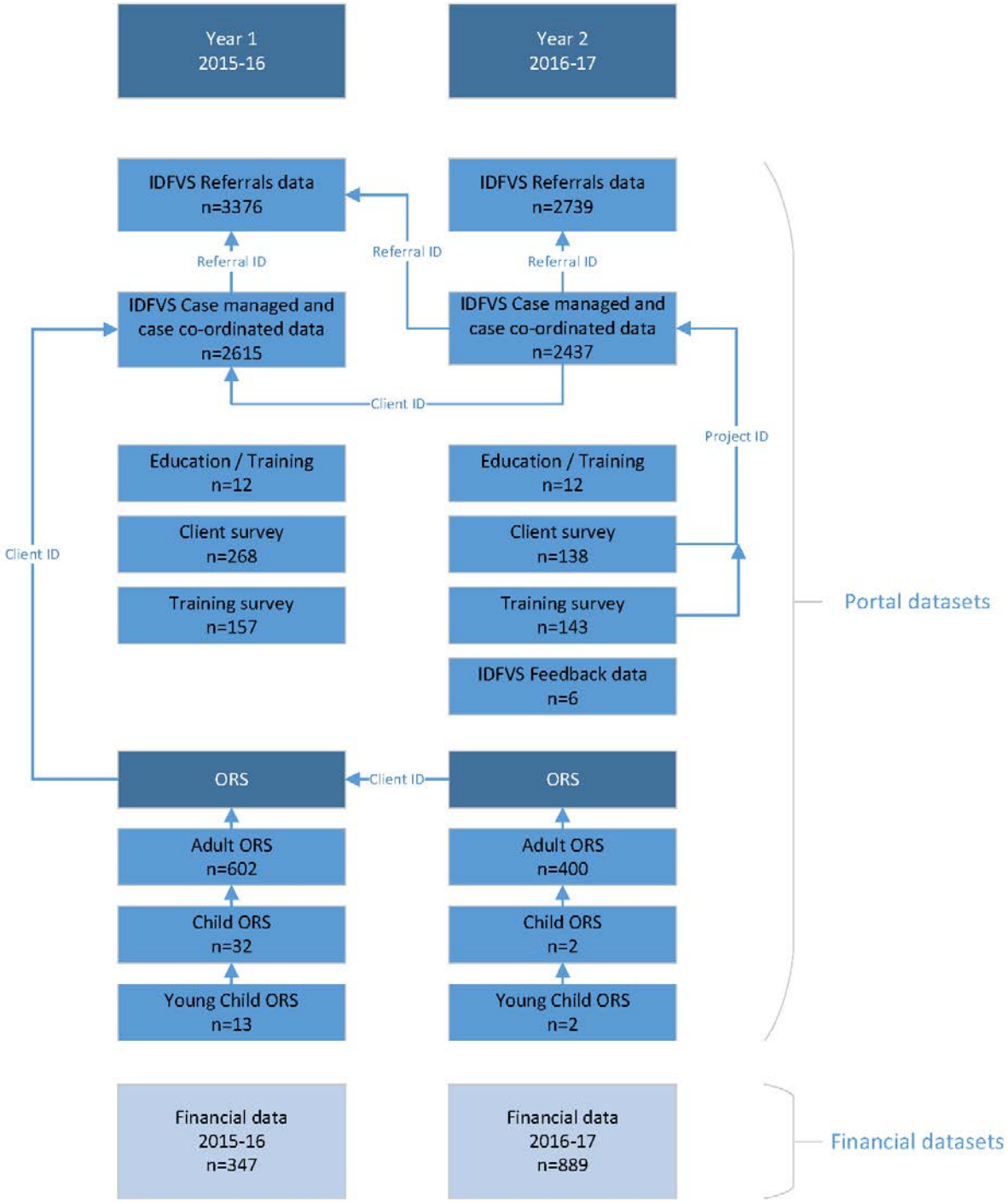
3.2 Data sources

3.2.1 Client outcomes data

The quantitative evaluation component is a retrospective data analysis based on program service delivery (portal) data for 24 months from July 2015 to June 2017 covering two complete financial years 2015-16 and 2016-17. Preliminary data preparation was undertaken by the research team to merge the multiple source datasets and support analysis of total program activity across both study period years, as well as enable comparative analysis for each year, Figure 2. The data

sources incorporate all available IDFVS portal content including program activity and ORS client wellbeing with program financial data to develop the core linked dataset for the program analysis.

Figure 2: IDFVS data structure and sample sizes



Source: FACS IDFVS portal datasets, ORS datasets, FACS Corporate finance.

IDFVS portal datasets

The IDFVS data portal is a program specific data management system used by each project to enter client demographic and service use information. This includes data on client referrals, profiles, assessment, support services provided and interim client outcomes. Referrals data record all referral activity including program contact that may be referral only, as well as client referral to case coordinated and case managed support services. The program datasets, client survey and training survey are reported under each project.

Portal data was de-identified prior to transfer by FACS to the research team. The source datasets do not provide a study control group and the evaluation scope does not include linkage to other NSW government programs or service sectors.

The portal records all program contacts including referrals received by each project and the support provided to each person. Further detailed information is recorded for cases where clients receive case coordinated or case managed client support. Data are also recorded for program education and training activity including the number of sessions delivered and number of participants attending. Training session attendees complete a survey covering the usefulness of the session content and whether participants felt their knowledge of dealing with domestic violence had improved as a result of attending.

Clients are offered a survey on exit from the program to assess the usefulness and value of the program, improved safety and overall satisfaction with IDFVS support. The survey responses are provided anonymously and therefore are not assessed in context of specific support services received but for general response to program services.

Portal data preparation and validation

The UNSW project team undertook preliminary collation, validation and merging of all portal datasets to develop a framework to assess activity across each study period year and merge additional content including the ORS datasets, Figure 2. The merged data were validated against previous IDFVS summary reports including key figures by case coordinated, case managed and referrals, against each financial year report. Minor differences of a few cases in some service providers were identified but are not considered material to the overall analysis. The source of variation results from the portal being an open database that continues to be updated following reporting points. In general, minor differences as examined during preliminary data checking are not seen as a material issue given the sample sizes are now typically several hundred records and average service delivery figures are relatively stable.

Separate to the figures examined during the evaluation, it was identified that retrospective figures could possibly change over time as new updates and additions

are made that influence existing and prior client data. This is because the portal data is compiled in reports based on a number of records and various dates, which when updated will result in records being included or excluded from the previous run figures, even if they are run for the same timeframe.

Specific data content is described in the service provider portal guidelines version (NSW Department of Family and Community Services, 2014).

Outcome Rating Scale (ORS)

Client wellbeing is assessed through the Outcome Rating Scale (ORS) questionnaire which is a formally validated and internationally accepted client outcome tool based on the work of Miller, Duncan et al (Miller, Duncan, Brown, Sparks, & Claud, 2003). The ORS assesses self-reported client outcome information including changes to client wellbeing across four dimensions:

1. Personal distress and individual functioning (personal well-being)
2. Interpersonal well-being (how well a client is faring in important relationships)
3. Social Role (satisfaction with work or school and relationships outside the home)
4. Overall self-assessment of client's general sense of well-being

It is recommended that the ORS tool should be administered by workers with their clients at service entry and exit, as well as at regular intervals in between or at the workers' discretion (every 3 months or after a critical incident). Additionally, a similar version of the instrument suitable for children, The Child Outcome Rating Scale and Young Child Outcome Rating Scale (CORS), is available for assessment of clients' children in cases where program staff feel it is appropriate. The CORS is used in especially sensitive circumstances for children immediately after the family leaves a violent relationship and requires careful assessment of the benefit as opposed to the potential risk of re-traumatisation. Consequently, similar to the Staying Home Leaving Violence (SHLV) evaluation, very few children (n=34) and young children (n=15) were included in the CORS data collection during the study period.

3.2.2 Client, staff, and stakeholder interviews

Site visits to each of the IDFVS organisations, to conduct interviews with clients and staff, took placed between February and July 2017. The evaluation team worked closely with FACS and IDFVS agencies to ensure that the timing of the visit was convenient for the agencies and to minimises disruption and respondent burden. The majority of IDFVS clients are women and their children and our interviews were almost exclusively of women who were either current or former users of IDFVS. Only one male perpetrator was interviewed which is consistent with the small number of male perpetrator clients and reflecting that only a few IDFVS offer services to perpetrators. Inclusion criteria were:

- people who have received support from a service funded through the IDFVS program
- people who have received support in the past 6 months,
- people who have sought but were declined support because of waiting lists or other capacity shortfalls.

Note: we did not interview anyone who had been declined support as services indicated that they supported all requests for assistance at least with information and referral.

Interviews and focus groups were undertaken with IDFVS managers, service providers and key jurisdictional stakeholders. Service providers included workers (aged 18 and over) who provide IDFVS to clients and their managers, and select stakeholders from other agencies which provide support to IDFVS clients. Inclusion criteria are staff/managers working at an IDFVS service, or a service that provides support to people experiencing domestic and family violence in a community where an IDFVS service is located.

We interviewed 45 clients, 36 IDFVS staff and 21 stakeholders (Table 2).

Table 2: interview sample

	Staff	Clients	Stakeholders	Total
Bondi Beach Cottage	3	4	3	10
Eastlakes	6	5	4	15
Green Valley Liverpool DFVS	5	5	3	13
Bankstown DFVS	6	6	5	17
Port Macquarie Hastings	2	4	1	7
Mullumbimby	3	9		12
Mt Druitt FVS	6	2	3	11
Core Community Services	3	6	2	11
YWCA Nowra	2	4		6
Total	36	45	21	102

3.2.3 Program funding and cost data

The funding figures have been provided from the FACS corporate financial system for the evaluation period, two complete financial years 2015-16 and 2016-17. The financial datasets from FACS finance are aggregate payment transactions generally monthly block funding to each project.

The figures were mapped to corresponding projects to align finance system transactions with portal data to the level the data would support. This provided aggregate program funding figures by project to align funding with each service provider and then examine the numbers of referrals, clients and the service delivery mix for each. As a result of aggregation in funding figures, cost data by project was

not sufficiently detailed to support robust client level comparative figures between projects. For this reason, average cost per client figures reported in the following sections are based on verified total funding and client activity per year and are reported as indicative cost across all projects.

The methodology is consistent with the evaluation of the SHLV evaluation which was also based on program data captured in the FACS portal (Breckenridge, Walden, & Flax, 2014).

3.2.4 Program economic evaluation

The NSW Government blueprint incorporates development of the evidence base for effective domestic violence programs and identifies the aim to develop and embed evaluation into all NSW Government funded domestic and family violence services (NSW Ministry of Health, 2016). In this context the economic component of the evaluation firstly carried out a brief review of Australian and international economic evaluation research for wider perspective and reference for assessment of the evaluation methodology and interim outcomes.

Similar to the overall approach of the evaluation, which focuses on interim outcomes in context of broader strategy, the economic evaluation component examines the interim outcomes aligned with available aggregate program budgets and costs.

The scope of the economic evaluation is to examine unit costs for IDFVFS and evaluate the economic costs and benefits of the program. These objectives similarly are limited by the scope of the evaluation and available data sources. The methodology for the program cost analysis and economic component is consistent with evaluation undertaken for the SHLV program (Breckenridge & Zmudzki, 2014).

Unit Cost Estimation

Service costing analysis approach is generally grouped as ‘top down’, allocating aggregate costs for a procedure based on a defined weighting index, or ‘bottom up’, where each client level resource item is recorded and individually costed. The average cost figures presented in this report are raw average cost estimates and mask considerable variation across clients and projects.

The total annual program cost is validated, but block funding transfers are unadjusted for commencement timing of new projects and resulting variation in client support levels. The client numbers do not reflect service hours, type of support, case coordinated or case managed, intensity of support over time, inactive support periods or clients that have not been formally exited despite a period of inactivity. For this reason, the total average cost per client per year is likely to be higher when aligned with actual service hours.

The total costs are also then examined in context of program outcomes and benefits.

3.3 Data analysis

3.3.1 Quantitative data analysis

All program and client outcome data were analysed using appropriate statistical tests depending on the sample sizes and quality of the data. ORS data were analysed through paired t tests using STATA Version 13 to compare change in mean ORS scores on entry to the program and following exit.

For the economic analysis a similar approach to that conducted for the SHLV evaluation was used to compare overall average client costs across all IDFVS services and examine this in terms of the total outcomes, total program funding and client profiles.

Client numbers via the portal have been used to estimate average cost per client. This is a more rigorous version of Coy, Lovett and Kelly's (2008) financial analysis of the per-client expenditure of the Independent Domestic Violence Advocacy (IDFV) Scheme in the UK where the cost of providing support to each victim/survivor was calculated by dividing worker salary plus on costs, by annual caseload to arrive at a cost per client.

3.3.2 Qualitative data analysis

With the permission of research participants, all interviews and focus groups were voice recorded. The recordings were transcribed by an external transcription agency which has signed a confidentiality agreement with UNSW, and transcripts were checked for accuracy and deidentified. The transcripts were then uploaded into NVivo, a qualitative data analysis software program.

Using the research questions, discussion guides and a random selection of transcripts, the research team developed a coding framework in NVivo to provide the basis for a thematic and narrative analysis of the data. The remaining transcripts were subsequently coded into NVivo and classified into themes which have been matched against the evaluation questions.

Illustrative quotes from transcripts are presented throughout to support the analysis These quotes have been edited for readability.

3.4 Limitations

As for all program evaluations the IDFVS program analysis includes several limitations:

Program portal datasets

The portal data include variation across source datasets including reporting gaps and blank responses and therefore accuracy and quality are difficult to evaluate. Variation may also result from interpretation of classifications and or reporting errors as well as variation of reporting practice across projects, for example the process for exiting clients from the program. This is understood to reflect routine client pathways and process and is only identified as a limitation in terms of some responses having low sample sizes and therefore a correspondingly low statistical significance. For this reason, response sample sizes are included on all relevant result tables for reference.

Examples of reporting variation are presented where identified as potential items for system review, reporting guideline development or potential areas of training.

The portal was established as an interim reporting mechanism and there has been identified variation across projects with portal reporting practices and consistency.

Evaluation scope

The evaluation scope did not include consideration of a comparison group for potential matching and control of program outcomes. This absence of a counterfactual and variations in the service network between project areas mean that it is not possible to assess the extent to which client outcomes are driven by the IDFVS and how important IDFVS is to referrals and service use.

The evaluation focuses on interim outcomes for the study period with longer term system wide outcomes subject to longitudinal validation. There are certain caveats that need to be considered when reviewing the data and proposed outcomes:

- There is no visibility of the intensity of support provided by IDFVS across case coordinated or case managed clients. The data does not show the complexity of certain cases or monitor the number of hours of support received per client.
- The evaluation scope does not include assessment of the number, type and availability of support and partner services in each region and the related interim outcomes of coordinated support may reflect limitations of the service network in the particular geographic area. The interview data suggest local support and partner agencies were a source of variation across projects.

- **It is not within scope of this evaluation to examine data linkage with other FDV programs or related service sectors. Therefore, it is not possible to triangulate other data with IDFVS data.**

- Specific assessment of the benefits of trauma informed care as a model of intervention or other therapeutic models is outside the evaluation scope
- The evaluation examines support services and outcomes for clients referred to the IDFVS program and as is characteristic for program focused assessment it is not possible to comment on the potential scale of unknown unreported DFV.

Program cost data

Program cost data are primarily block funding transactions to service providers with limited data on the level and intensity of client support during their time in the program. For this reason the estimated client costs assume an average share of funding for each client and provide preliminary broad reference average costs. The average cost per client figures therefore masks potentially substantial variation across the range of higher and lower service usage clients.

Please note:

- Financial data are generally aggregate figures with no routine reporting by service providers to indicate cost categories, for example brokerage provided to clients.

- Factors including variation in project client numbers and the proportion and timing of exits are reflected in estimated unit average costs.

Technical issues with portal

The IDFVS portal was developed as an initial framework to support program reporting and is now part of a wider redevelopment and migration to the FACS CIMS platform. Data used for the evaluation was provided from the established portal and reflects variation across projects in data submission processes, including Mt Druitt and Central Coast providing their data via excel spreadsheet. The data structure complexities as well as system feedback from projects on usability are expected to be resolved following completion of the CIMS implementation.

There were inconsistencies noted in monitoring practice across the IDFVS. Not all data were recorded and some agencies used excel to collect their data rather than enter it in the Portal. Worker perceptions of the burden of monitoring for the Portal and auspice agencies will be discussed later in the report. A separate portal issue affected referral data. For a significant period of the data collection timeframe, it was not possible to record referrals from WDFVCAS in the portal for most providers

Qualitative data

All worker and client participants were genuine volunteers and client interviews were arranged through each IDFVS to ensure the safety and confidentiality of the client and to enable immediate support on site should the interviews trigger distress. While there are obvious ethical benefits of this type of recruitment it is unlikely that client participants would represent the service experience of clients who were dissatisfied or whose needs were not met by the IDFVS. We were not able to interview all key stakeholders for each IDFVS service, as a number of potential participants were unavailable during the data collection period.

4 Client profiles

Recently published figures from the Australian Institute of Health and Welfare (AIHW) reconfirm the national profile of victims being predominantly women and frequently their children (Australian Institute of Health and Welfare, 2018). This section presents the number of IDFVS clients supported by the program, profiles for the overall group as all people affected by domestic and family violence, victims, their children, as well as the program priority access for target groups including:

- DFV victims from an Aboriginal and Torres Strait Islander background
- DFV victims affected by socio-economic disadvantage [1]
- DFV victims from Culturally and Linguistically Diverse backgrounds
- DFV victims affected by social exclusion
- DFV victims who have a disability
- DFV victims who are caring for a child with a disability

4.1 Number of clients supported

The number of reported program clients include all current and exited clients who received case coordinated or case managed support. There were a total of 4,907 clients during the two year study timeframe, with a similar level across each year, 2,470 in 2015-16 and 2,437 in 2016-17, Table 3. Around twice as many clients received case management (66.8%) compared to case coordinated support (33.2%) with the proportions of each also relatively stable for each year.

Table 3 Program clients 2015-16 and 2016-17

Support type	2015-16		2016-17		Total	
	Clients n	%	Clients n	%	Clients n	%
Case-coordination	789	31.9	841	34.5	1,630	33.2
Case-management	1,681	68.1	1,596	65.5	3,277	66.8
Total	2,470	100.0	2,437	100.0	4,907	100.0

Source: FACS IDFVS portal datasets 2015-16 to 2016-17

The client numbers report raw counts of program support by client distinguishing between case managed and case coordinated clients but do not reflect the level of support in hours or types of services provided. The figures also do not indicate the precise duration of the IDFVS service provided to clients in the program. Case Coordination usually suggests a shorter duration than case management but may not reflect the intensity of work required in the shorter service timeframe. For this reason, the client numbers are presented as summary indicative figures only.. As

[1] Definitions of social exclusion, socio economic disadvantage and disability can be viewed in the IDFVS service provider guidelines.

already noted previously, hours of client support are not recorded in the portal datasets therefore it is not possible to assess level of intensity for individual clients. To examine the duration clients remained in the program further figures were derived from the datasets and are presented in section 4.5.

As noted in the limitations section of the methodology, a further consideration for reported client numbers across each project may result from the integrated model and the relative availability and capacity of support services across different locations. Relative project outcomes may in part reflect availability of specific local support service capacity and the ability to case coordinate and case manage clients in each region and project location. Moreover, the qualitative data suggest that different population cohorts and different service constellations characterizing the various geographic IDFVS areas may contribute to the type, duration and intensity of service offered by the program. IDFVS activities towards capacity building activities for the service system, and interrelationships with other DFV initiatives, will also not be reflected in the raw client counts.

The further potentially confounding perspective may be short and medium-term increases in reported domestic violence and demand for support services as community awareness and tolerance change and victims feel empowered to report cases. Critical incidents of DFV reported in the media can also have an effect on reporting patterns. The relative impact that short term unmet demand and increased demand contributes to longer term outcomes requires longer term longitudinal evaluation to verify.

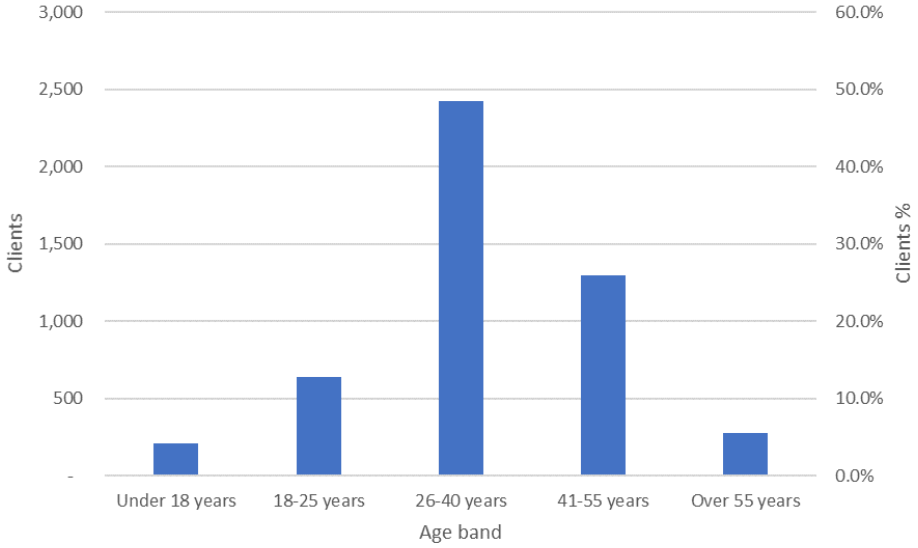
4.2 Client profiles

This section presents baseline characteristics for program clients for the combined portal datasets across the two-year study period from 2015-16 to 2016-17. Figures are generally presented as the merged complete study group to provide summary figures on maximum sample sizes. Figures have also been examined for each separate study year and are presented separately where notable changes or trends were identified between years.

Age

The age distribution of clients is normally distributed with almost half of all clients in the 26 to 40-year age group (Figure 3). The 41 to 55 year age band accounts for around a further quarter of clients with the 18 to 25 year age band making up around 12 percent of clients.

Figure 3: Client age distribution



Source: FACS IDFVS portal datasets 2015-16 to 2016-17

The remaining client proportions below 18 years and over 55 years are relatively small proportions of the total program at around 5% of clients in each band, although younger and older clients may require particular support needs. The under 18 years group were primary clients of the IDFVS, child clients of adult primary clients are reported separately later in this report.

The distribution of clients across age bands at each project was relatively consistent with the overall averages. There were a notable proportion of under 18year clients reported at Bondi Beach (n=70) representing 22.4% of total Bondi clients and a third of this age group for the program.

Gender

Consistent with established domestic violence statistics IDFVS clients are almost all women, 96.6% (n=4,699) over the two-year study period, with a similar high proportion in each year (Table 4). Men comprised 3.4% of clients (n=167) which include a small number of perpetrators (n=11).

Table 4 Client gender 2015-16 and 2016-17

Gender	2015-16		2016-17		Total	
	Clients n	%	Clients	%	Clients n	%
Female	2,379	96.9	2,320	96.2	4,699	96.6
Male	76	3.1	91	3.8	167	3.4
Total	2,455	100.0	2,411	100.0	4,866	100.0

Source: FACS IDFVS portal datasets 2015-16 to 2016-17

Relationship to perpetrator

The perpetrator relationships to IDFVS clients at the time the violence occurred are predominantly a current intimate partner 46.5% (n=507), former or ex partners 33.8% (n=368) or other family members 15.1% (n=165), Table 5. Each relationship group was relatively consistent across each year with an increase in former or ex partners from 31.9% (n=174) in 2015-16 to 35.6% (n=194) in 2016-17.

Table 5: Relationship between perpetrator and victim 2015-16 and 2016-17

Relationship	2015-16		2016-17		Total	
	Clients n	%	Clients n	%	Clients n	%
Intimate partner	253	46.4	254	46.6%	507	46.5
Former or ex-partner	174	31.9	194	35.6%	368	33.8
Other family member	83	15.2	82	15.0%	165	15.1
Other	35	6.4	15	2.8%	50	4.6
Total	545	100.0	545	100.0%	1,090	100.0

Source: FACS IDFVS portal datasets 2015-16 to 2016-17

Children and young people in care of client

It is well established that the impact of DFV extends beyond victims themselves to family, community and in particular to dependent children and young people in care of the client. The SHLV evaluation indicated high numbers of children in the care or partial care of clients with more children than program clients (Breckenridge, Walden & Flax, 2014).

The IDFVS study group report similar high numbers of children and more children than clients. Over the two-year study period there were 6,806 young people aged under 18 years in the care or partial care of clients (Table 6). Although some IDFVS clients did not have children, a high proportion of clients had more than 1 child with the average number of children recorded per IDFVS client of 1.4.[2] The number of children in care reflects the broader client distribution with around two thirds of all

2 6,806 children in care of total 4,907 program clients = 1.4.

children supported through Cabramatta, Liverpool, Eastlakes, Mt Druitt and Nowra. Again, the qualitative data suggest that IDFVS vary in the support provided to children: some have services for children offered via their auspice organisation, others have partners in the geographic area who specialize in working with children.

Table 6: Children in care of the client 2015-16 and 2016-17

Project	2015-16		2016-17		Total	
	Children n	%	Children n	%	Children n	%
Cabramatta	627	18.5	475	13.9	1,102	16.2
Liverpool	500	14.7	523	15.3	1,023	15.0
Eastlakes	407	12.0	328	9.6	735	10.8
Mt Druitt	403	11.9	486	14.2	889	13.1
Nowra	329	9.7	447	13.1	776	11.4
Port Macquarie / Hastings	387	11.4	248	7.3	635	9.3
Central Coast	281	8.3	340	10.0	621	9.1
Bankstown	202	6.0	264	7.7	466	6.8
Bondi Beach	170	5.0	136	4.0	306	4.5
Mullumbimby	87	2.6	76	2.2	163	2.4
Catholic Care	n/a	0.0	90	2.6	90	1.3
Total	3,393	100.0	3,413	100.0	6,806	100.0

Source: FACS IDFVS portal datasets 2015-16 to 2016-17
[3]

Of the high numbers of children in client care 17.1% of clients (n=616) were identified with a child at risk on entry to the program. It is not possible to determine how risk was assessed in these cases. Referral from FACS (8.8% of clients – see Referral Pathways 4.4) would suggest the assessment was made prior to service entry in some cases. In addition to the number of children in care, a further 4.8% of clients (n=217) identified as pregnant when referred to the program.

4.3 Client target groups

This section provides client numbers for each of the six program target groups. Given the raw client counts include variation including due to the number of clients

[3] In Nov 2016, Catholic Care took over Taree from CPADFV who were covering Taree/Port Maq/Hastings. The Taree service was shifted to another LGA under a re-structure and so was no longer in the same LGA as the Port Macquarie and Kempsey services. Originally Taree and PM and Kempsey were all considered part of the same service. Taree was excluded in 2016 and Kempsey was closed in May 2017. All are merged under Port Macquarie Hastings for this report

retained for extended periods rather than exited, the figures are presented as indicative. The comparative NSW figures provided in text are for general reference.

4.3.1 Aboriginal and Torres Strait Islander clients

For the two-year study period IDFVS clients identifying as Aboriginal or Torres Strait Islander represented 8.4% (n=386) with an increase from 7.8% (n=180) in 2015-16 to 9.1% (n=206) in 2016-17, (Table 7).

Aboriginal and Torres Strait Islander peoples represent 2.9% of the total New South Wales population (Australian Bureau of Statistics, 2016) with higher proportions living in larger cities and rural centres. The small IDFVS sample sizes limit population comparisons across locations, however with 8.4% of program clients the program is achieving reach into these communities. The figures indicate that the program is reaching Aboriginal communities and show that Aboriginal clients are likely to be over represented in the high concentration projects and marginally overrepresented in most. It is not possible to undertake more detailed analysis of Aboriginal populations by location, or to adjust for client numbers that may have been inactive for some time.

Table 7 Aboriginal clients 2015-16 and 2016-17

Identifying as Aboriginal	2015-16		2016-17		Total	
	Clients n	%	Clients n	%	Clients n	%
Yes	180	7.8	206	9.1	386	8.4
No	2,124	91.6	2,022	89.8	4,146	90.7
Not known	16	0.7	24	1.1	40	0.9
Total	2,320	100.0	2,252	100.0	4,572	100.0

Source: FACS IDFVS portal datasets 2015-16 to 2016-17

There is considerable variation in the proportion of Aboriginal clients across the services (Table 8). Catholic Care commenced operation during 2016-17 and reported 20 Aboriginal clients, 35.7% of their total clients. Port Macquarie / Hastings, Nowra and Mt Druitt support higher proportions of Aboriginal clients than other services, with 18.7% (n=64), 17.7% (n=99) and 14.4% (n=48) respectively.

Aboriginal client program support includes a higher number of dependent children and young people aged under 18 years old in the care or partial care of Aboriginal clients representing over twice the number of clients. There were 880 Aboriginal children in care of 386 Aboriginal clients over the two-year study period, with similar relatively high proportions in the high client services (Table 9). This represents a

substantially higher number of children than the total program group with an average number of children per client of 2.3 compared to 1.4 for the total study group.[4]

Table 8 Aboriginal clients by project 2015-16 to 2016-17

Project	Yes		No		Total	
	Clients n	%	Clients n	%	Clients n	%
Catholic Care	20	35.7	36	64.3	56	100.0
Port Macquarie /Hastings	64	18.7	272	79.3	343	100.0
Nowra	99	17.7	459	82.3	558	100.0
Mt Druitt	48	14.5	283	85.5	331	100.0
Liverpool	58	8.8	588	89.5	657	100.0
Mullumbimby	9	6.5	129	93.5	138	100.0
Central Coast	30	5.5	506	92.0	550	100.0
Bondi Beach	16	5.2	285	92.5	308	100.0
Eastlakes	29	5.0	552	95.0	581	100.0
Bankstown	3	1.2	237	98.3	241	100.0
Cabramatta	10	1.2	799	98.8	809	100.0
Total	**386**	**8.4**	**4,146**	**90.7**	**4,572**	**100.0**

Source: FACS IDFVS portal datasets 2015-16 to 2016-17
Notes: Minor differences between yes, no and total represents unknown responses
Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

Table 9: Aboriginal children in clients care 2015-16 and 2016-17

Project	2015-16		2016-17		Total	
	Children n	%	Children n	%	Children n	%
Nowra	105	26.4	136	28.2	241	27.4
Liverpool	70	17.6	79	16.4	149	16.9
Port Macquarie / Hastings	79	19.8	65	13.5	144	16.4
Mt Druitt	54	13.6	51	10.6	105	11.9
Eastlakes	39	9.8	30	6.2	69	7.8
Catholic Care		0.0	44	9.1	44	5.0
Cabramatta	23	5.8	21	4.4	44	5.0
Mullumbimby	9	2.3	15	3.1	24	2.7
Central Coast	8	2.0	15	3.1	23	2.6
Bankstown	5	1.3	17	3.5	22	2.5
Bondi Beach	6	1.5	9	1.9	15	1.7

[4] 880 Aboriginal children in care of a total 386 Aboriginal program clients = 2.3.

Project	2015-16		2016-17		Total	
	Children n	%	Children n	%	Children n	%
Total	398	100.0	482	100.0	880	100.0

Source: FACS IDFVS portal datasets 2015-16 to 2016-17
Note: Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

4.3.2 Victims affected by socio-economic disadvantage

High levels of clients indicate they are affected by socio-economic disadvantage. For the two year study period from 2015-16 to 2016-17 43.5% (n=2,136) of clients reported socio economic disadvantage, with over half of the projects reporting above 50% at each location (Table 10). Catholic Care commenced operation during 2016-17 and is a smaller client group, but reported 80.4% (n=45) affected.

Table 10: Client affected by socio-economic disadvantage

Project	Yes		No		Total	
	Clients n	%	Clients n	%	Clients n	%
Catholic Care	45	80.4	10	17.9	56	100.0
Mullumbimby	83	58.9	55	39.0	141	100.0
Bankstown	139	56.7	104	42.4	245	100.0
Cabramatta	455	55.9	276	33.9	814	100.0
Port Macquarie / Hastings	191	52.6	152	41.9	363	100.0
Eastlakes	308	52.3	278	47.2	589	100.0
Mt Druitt	259	44.7	320	55.3	579	100.0
Liverpool	302	43.8	347	50.4	689	100.0
Nowra	233	41.2	315	55.8	565	100.0
Bondi Beach	95	30.1	212	67.1	316	100.0
Central	26	4.7	524	95.3	550	100.0
Total	2,136	43.5	2,593	52.8	4,907	100.0

Source: FACS IDFVS portal datasets 2015-16 to 2016-17
Note: Minor differences between yes, no and total represents unknown response
Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

4.3.3 Victims from Culturally and Linguistically Diverse backgrounds

Almost 40% of clients (n=1,834) were born outside Australia, with around half of this group being in Australia for less than five years. This fairly high proportion of clients born outside Australia is reflected in comparative high levels of languages other than English spoken at home representing 34.2% (n=1,649) of program clients (Table

11). The highest proportions were reported at Cabramatta with 87.5% of clients (n=701) and Bankstown 59.3% (n=144) with these two projects representing half of all clients speaking a language other than English at home. Somewhat high proportions were also reported in Liverpool, Eastlakes, and Mt Druitt with around a third of clients in each speaking a language other than English at home. Bondi Beach also included around a quarter of its clients in this group.

Table 11: Language other than English spoken at home

Project	Yes		No		Total	
	Clients n	%	Clients n	%	Clients n	%
Cabramatta	701	87.5	85	10.6	801	100.0
Bankstown	144	59.3	86	35.4	243	100.0
Liverpool	246	36.9	303	45.4	667	100.0
Eastlakes	194	33.1	342	58.4	586	100.0
Mt Druitt	170	29.4	409	70.6	579	100.0
Bondi Beach	76	24.4	183	58.8	311	100.0
Central Coast	71	13.3	354	66.4	533	100.0
Mullumbimby	16	11.6	121	87.7	138	100.0
Nowra	20	3.8	539	96.1	561	100.0
Port Macquarie / Hastings	11	3.2	332	95.4	348	100.0
Catholic Care		0.0	55	100	55	100.0
Total	1,649	34.2	2,809	58.3	4,822	100.0

Source: FACS IDFVS portal datasets 2015-16 to 2016-17
Note: Minor differences between yes, no and total represents unknown response
Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

4.3.4 Victims affected by social exclusion

IDFVS clients also report being affected by high levels of social exclusion with 34.0% (n=1,615) overall (Table 12). The level of exclusion is consistently high across almost all projects with most above one third of clients, Port Macquarie / Hastings and Cabramatta above 40% and Catholic Care the highest affected project with 71.4% (n=40). This portal question asks whether clients indicated they are affected by social exclusion at all but does not measure levels of social exclusion.

Table 12 Victims affected by social exclusion 2015-16 and 2016-17

Project	Yes		No		Total	
	Clients n	%	Clients n	%	Clients n	%
Catholic Care	40	71.4	16	28.6	56	100.0
Cabramatta	355	48.1	383	51.9	738	100.0

Project	Yes		No		Total	
	Clients n	%	Clients n	%	Clients n	%
Port Macquarie / Hastings	141	41.3	200	58.7	341	100.0
Nowra	214	38.5	342	61.5	556	100.0
Eastlakes	219	37.3	368	62.7	587	100.0
Bankstown	89	36.9	152	63.1	241	100.0
Mt Druitt	211	36.4	368	63.6	579	100.0
Mullumbimby	48	34.5	91	65.5	139	100.0
Liverpool	208	31.7	449	68.3	657	100.0
Bondi Beach	66	21.2	245	78.8	311	100.0
Central Coast	24	4.4	526	95.6	550	100.0
Total	**1,615**	**34.0**	**3,140**	**66.0**	**4,755**	**100.0**

Source: FACS IDFVS portal datasets 2015-16 to 2016-17
Note: Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

4.3.5 Victims with a disability

Domestic violence victims with a disability are also a program target population with 9.0% (n=430) of IDFVS clients identifying they have a disability, Table 13. As for other client profiles the proportions were consistent across most projects, many above the overall average and the highest proportion reported at Eastlakes with 15.0% (n=87).

Table 13: Clients identifying they have a disability

Project	Yes		No		Total	
	Clients n	%	Clients n	%	Clients n	%
Eastlakes	87	15.0	493	85.0	580	100.0
Catholic Care	8	14.5	47	85.5	55	100.0
Mullumbimby	17	12.3	121	87.7	138	100.0
Nowra	60	10.9	490	89.1	550	100.0
Mt Druitt	62	10.7	517	89.3	579	100.0
Port Macquarie / Hastings	36	10.5	306	89.5	342	100.0
Bankstown	24	10.3	209	89.7	233	100.0
Central Coast	51	9.3	499	90.7	550	100.0
Liverpool	45	6.8	615	93.2	660	100.0
Bondi Beach	17	5.5	291	94.5	308	100.0
Cabramatta	23	2.9	757	97.1	780	100.0
Total	**430**	**9.0**	**4,345**	**91.0**	**4,775**	**100.0**

Source: FACS IDFVS portal datasets 2015-16 to 2016-17

Note: Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

4.3.6 Victims who are caring for a child with a disability

Further to the relatively high proportion of clients identifying they had a disability themselves, a further 5.0% (n=243) of clients reported they are the caregiver of a child or young person with a disability, Table 14.

Table 14 Victims caring for a child with a disability 2015-16 and 2016-17

Project	Yes		No		Total	
	Clients n	%	Clients n	%	Clients n	%
Port Macquarie / Hastings	49	14.3	294	85.7	343	100.0
Liverpool	48	7.3	614	92.7	662	100.0
Catholic Care	4	7.1	52	92.9	56	100.0
Eastlakes	40	6.8	547	93.2	587	100.0
Bankstown	15	6.2	226	93.8	241	100.0
Mt Druitt	28	4.8	551	95.2	579	100.0
Nowra	27	4.8	530	95.2	557	100.0
Bondi Beach	14	4.5	297	95.5	311	100.0
Mullumbimby	5	3.8	126	96.2	131	100.0
Cabramatta	12	1.5	769	98.5	781	100.0
Central Coast	1	0.2	549	99.8	550	100.0
Total	**243**	**5.1**	**4,555**	**94.9**	**4,798**	**100.0**

Source: FACS IDFVS portal datasets 2015-16 to 2016-17
Note: Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

4.4 Referral pathways

Referral pathways include the referral sources to the IDFVS program, and separately onward referral to other partner agencies and support services. As presented in the methodology, program data are collected through the portal in separate entry processes for referrals to program service providers, clients entering the program for case managed and case coordinated support services, and separately on exiting the program. Referral only program support includes assistance with onward referrals or information only support.

This section presents details of referral sources and services referred to for all referrals and provides additional review of case coordinated and managed clients.

Figures are presented from the consolidated two-year study period to show each year. Where years are not shown separately figures are combined for both years.

4.4.1 Referral sources

Referral sources into IDFVS services reflect its integrated character, covering government and non-government organisations (Table 15). Police are the highest proportion of program referrals (29.0%, n= 1,810), followed by 21.2% (n=1,326) self-referrals, 8.8% (n=549) through FACS Community Services, and 6.7% for Women's Domestic Violence Court Advocacy Service (WDFVCAS, n=420) and Local Coordination Points (LCPs, n=416).

It is important to note that workers were not able to choose an option for LCPs as it was not provided in the Portal. This combined with some LCPs not being operational at the same time across all areas may have resulted in under-reporting of LCPs as a possible response.

Table 15: IDFVS referral sources

Referred from	2015-16		2016-17		Total	
	Clients n	%	Clients n	%	Clients n	%
Police	997	28.8	813	29.2	1,810	29.0
Self-referred	684	19.8	642	23.0	1,326	21.2
Other	450	12.9	256	9.2	706	11.2
FACS CS Centre	337	9.7	212	7.6	549	8.8
WDFVCAS	229	6.6	191	6.9	420	6.7
Local Coordination Point (LCP)	232	6.7	184	6.6	416	6.7
NSW Health	66	1.9	66	2.4	132	2.1
Child Wellbeing Unit	88	2.5	33	1.2	121	1.9
SHS services / Refuge	54	1.6	63	2.3	117	1.9
Centrelink	58	1.7	58	2.1	116	1.9
Internal referral	51	1.5	63	2.3	114	1.8
Family support service	65	1.9	37	1.3	102	1.6
Family or friend	41	1.2	42	1.5	83	1.3
Hospital	33	1.0	49	1.8	82	1.3
Housing NSW	37	1.1	42	1.5	79	1.3
Local court/ Legal Service	35	1.0	35	1.3	70	1.1
	3,457	100.0	2786	100.0	6,243	100.0

Source: FACS IDFVS datasets 2015-16 and 2016-17.
Notes: Includes multiple referral sources for some clients. CS = Community Services

Additional referral sources include NSW Health (2.1%, n=132) which include both physical and mental health, Child Wellbeing Units, Specialist Homelessness Services (SHS), family networks, housing and legal system contacts. Referral sources under 'other' sources include educational institutions, medical practitioners, family relationship centres, probation and parole services, aged care services, or in response to a service provider letters, each representing less than 1% of total referral sources, 11.2% (n=706) combined.

The referral source figures in Table 15 present all contacts with the program including referral only support. The referral source of those assessed for more comprehensive support that enter the program as case coordinated or case managed clients were separately reviewed and reflect similar referral pathways. There may be multiple referral sources recorded for some individuals.

The qualitative data highlight the importance of 'word of mouth' referrals as an important means by which by which the reach of program referral sources is extended.

> There's a lot of people that come through and they say, "Oh, my friend…" or "My church friend…" or "My school…" because I think also with domestic violence, it's become more socially acceptable to talk about it. (service manager)

Interviews with clients and IDFVS staff also strongly emphasised that local context and the strength of interagency partnerships determine referral pathways.

> We also rely on other services to send through referrals to us, so it's important that we network, we attend interagency meetings. We work of course very closely with the police, because we're not the be all and end all of helping people leaving violence (service provider)

4.4.2 Services referred to

Once in contact with the program, multiple external services may be referred to, Table 16. Over half of all referred external services include community housing and counselling services.

Table 16: Referral from the program to external services

Referral source	2015-16		2016-17		Total	
	Clients n	%	Clients n	%	Clients n	%
Community housing NGO	650	31.1	575	27.4	1225	29.2
Counselling Services	449	21.5	489	23.3	938	22.4
No referral made	408	19.5	408	19.4	816	19.5
Police	105	5.0	112	5.3	217	5.2
Other	90	4.3	74	3.5	164	3.9

Referral source	2015-16		2016-17		Total	
	Clients n	%	Clients n	%	Clients n	%
Legal advice and representation	89	4.3	74	3.5	163	3.9
Housing NSW/ Community housing	63	3.0	63	3.0	126	3.0
Perpetrator program	52	2.5	53	2.5	105	2.5
WDFVCAS	60	2.9	32	1.5	92	2.2
Other NGO	35	1.7	46	2.2	81	1.9
Staying Home Leaving Violence	16	0.8	57	2.7	73	1.7
Centrelink	31	1.5	23	1.1	54	1.3
D&FV Group work sessions	12	0.6	38	1.8	50	1.2
	3,707	**100.0**	**3,273**	**100.0**	**6,980**	**100.0**

Source: FACS IDFVS portal datasets 2015-16 to 2016-17
Notes: Percentages do not necessarily sum to 100% as respondents could select more than one response. There were 3,376 clients referred in 2015-16 and 2,739 in 2016-17.

Others include NSW Health, Strengthening Families NGO, Other government agency, ADHC (Ageing, Disability and Home Care), Child Protection Helpline, Fewer than 1% of referrals were to educational institutions over the two-year period.

Services referred to, by project

On program exit, details are reported for external agencies the client was referred to during the support period that were known to actually have supported the client, Table 17. This may partially reflect service availability across projects with variation potentially related to local service capacity. As these details are only collected when clients are formally exited from the program, part of the variation also reflects patterns and proportions and timing of clients exited, discussed further in the following section examining duration in the program.

The high variation between projects provides a basis to investigate capacity building in those areas or to examine program management for improved consistency in the recording of external service referral.

Table 17: External agencies referred to by project

	Bondi Beach	Mt Druitt	Mullumbimby	The Deli	Central Coast	Cabramatta	Bankstown	Catholic Care	Port Macquarie	Nowra	Liverpool	Total
Counselling services	9	82	37	1	286	5	57	9	38		54	578
No referral made	83		22	38	47	14	12	9	121		171	517
Community housing NGO	6	252	3		150	5	4		14		9	443
Legal advice and representation	51	24	25	14	20	11	54	1	49		26	275
Housing NSW/ Community housing	3	37	13	4	54	18	44		31		31	235
Police	28	1	15	5	11	7	54	6	54		37	218
Other	9	65	22		1	1	10	4	43		21	176
Other NGO	8	18	8	2	6		25	6	62		24	159
WDVCAS	4	8	14		22	1	37	3	45		2	136
Centrelink	8		15	5	1	13	39		33		14	128
SHS services / Women's Refuge	1	4	15	1		18	4	5	70		10	128
Staying Home Leaving Violence	7	18		3	61		2		8		9	108
D&FV group work sessions	2		1		43	1	15		14		2	78
NSW Health (including mental health)	5		16	2		4	2	1	16		19	65
Educational Institution	2	37	1				4		7		3	54
Community Services	3	11	5		9	3	3	1	13		3	51
FACS Child Protection Helpline	8		5						25		11	49
Strengthening Families NGO	8	1	10	1	7	1		2	4		9	43
Other government agency	3	6				1	8		8		6	32
Perpetrator program	1	4			17		2		-		1	25
ADHC (Ageing, Disability and Home Care)		5			6		1		2			14
Total	**249**	**573**	**227**	**76**	**741**	**103**	**377**	**47**	**657**	**-**	**462**	**3,512**

Source: FACS IDFVS datasets 2015-16 and 2016-17
Note: Includes multiple referral sources for some clients. Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

4.5 Duration in the program

IDFVS is personalised and individual plans are developed around client circumstances with no specified program time limit. The client numbers presented in this report indicate all clients that have entered the program and remain as clients until formally exited, irrespective of ongoing activity.

To examine duration in the program, the number of months in the program were derived based on date referred for either case coordinated or case managed support and the exit date for clients recorded as having exited. This provided figures for exited client numbers and the percentage of total clients, compared to the percentage of total clients with open support cases.

The figures indicate around 45% (n=2,226) of all clients have completed their program support period and exited. There is substantial variation across projects of the proportion of clients recorded as having exited. Nowra has no clients recorded as exited, which may reflect a data issue. Cabramatta and Eastlakes have relatively low proportions of exited clients, 10.8% (n=88) and 12.4% (n=73) respectively. This may reflect their preferred method of practice such as a therapeutic intervention, or that a particular client demographic has multiple and ongoing issues requiring

management. All other projects are above the overall average with Port Macquarie Hastings 87.9% (n=319) and Central Coast 88.2% (n=485) reporting a majority of their clients as having exited.

The average duration in the program for exited clients is five months, again with considerable variation across projects. As described in the methodology, the IDFVS program is not time limited and average duration in the program may indicate variation in reporting consistency or exit procedures across projects. As the portal data do not record hours of support or any metric for level of effort, the variation in exited clients further limits estimation of project unit costs.

Conversely the projects that have relatively low proportions of client exits have equivalently high levels of clients with open cases. The case coordinated character of IDFVS typically reflects multiple service supports or referrals and may have related follow up for extended periods. The following example provided in an interview by one service provider illustrates the ways in which a woman may cycle in and out of the service with diverse needs at different points of time.

When first in contact with the service, the client provided information.

> We had a woman who had touched base with us, just a couple of times. The information was referral only, she was counted on two different occasions, just wanted to know about something. Then she contacted again later and she wanted some information about who she could talk to about family law cause she thought she might need to flee, so we made that referral. Information and referral again.

The next contact, however, was when the client was leaving the violent relationship and had more complex and intense support needs.

> The next time we heard from her, she was fleeing, She had spoken to the solicitor they'd said, "Go, you have all these grounds, all these reasons you can go, you can justify your safety need to sleep," so we spent the next two and a half days organising flights, organising somewhere safe for her to go to.

The service provided the support that the client needed, which also involved categorising it as a different kind of support.

> Now that was case managed, because when she came to see us, said, "This is what I need to do," we needed to contact other services, make inquiries out of area. So we went through the formality of consent forms and, "Okay, we're going to write this down so we're really clear," there were so many elements, we need to be really clear on what it is we are going to be doing, what it is you're going to be doing, so a case plan was developed. Effectively, we worked with her for two phone calls initially, then a little bit over the two and a half days in the next service event over two and a half days, but it was case management. (service provider)

This case study demonstrates the differences in practice between referral, case coordination and case management but also provides insight into why a case may not be closed because of the potential for case coordination to merge into case management over a longer service period.

There is no evidence in the data to suggest an optimal appropriate program duration. Instead, program flexibility is needed to develop individualized support plans, and this is reported as a strength of the IDFVS program. However, the management of open cases does show substantial variation across projects with Nowra, Cabramatta and Eastlakes having most of their clients as remaining open. The open cases also reflect a significantly longer duration with an average of over 2 years (26 months). Liverpool and Central Coast report particularly high average program duration for open case clients with 47 months (almost 4 years) and 42 months (3.5 years) respectively.

5 Client outcomes

The IDFVS program guidelines (FACS, 2016) specifies that the program aims to improve outcomes for its target population over the long-term, and that in order to achieve these, the program focuses on achieving the following interim results:

- clients are empowered to keep themselves and their family safe
- clients pursue prosecutions with support from the program
- clients meet their case plan goals
- clients are provided with case plans following evidence-based risk and needs assessment of their family situation
- domestic and family violence victims are accepted into the program as clients and their children are provided a direct service
- perpetrators are referred to domestic violence behaviour change programs that meet the minimum standards, where available
- the local community's understanding of and response to domestic and family violence improves
- the local community is informed about domestic and family violence, including legislation, rights and reporting'

This section describes interim client outcomes in terms of support services provided by the services and interim client outcomes, which are intended to meet these goals.

5.1 Support services provided

In addition to examining the types and mix of support services provided to clients, the evaluation is assessing core service delivery across services. For this reason, the multiple source datasets across each study period year have been merged and summarized to provide a high-level summary of the types and mix of services being provided across projects. Reflecting the integrated and coordinated character of the program, the services provide a central access point and combine referral to external services where appropriate as presented in section 4.4, as well as providing services to clients and their children through each project organisation directly.

The support services provided through each service reflect the variation in client circumstances and need, the local service context, individual IDFVS practice preferences but also demonstrates core services are being delivered across most services (Table 18). The services are sorted from highest numbers provided from top to bottom indicating consistent delivery of the core services of information and resources, risk assessment and advocacy with other services.

Table 18: Service provided by project

Service provided	Central Coast	Mt Druitt	Liverpool	Bondi Beach	Bankstown	Mullumbimby	Port Macquarie	Cabramatta	The Deli	Catholic Care	Nowra	Total
Information/ resources	510	403	353	165	125	99	307	81	52	30		2,125
Risk assessment	494	373	265	156	107	90	236	2	28	7		1,758
Advocacy with other services	376	259	187	82	107	67	230	53	12	12		1,385
Liaison with Police and prosecutors	353	259	79	22	54	26	86	5	2	11		897
Counselling services	46	77	249	148	4	82	1	41	72	1		721
Other	506	99	19	28	7	4	27		2	2		694
Court support	222	168	45	16	49	13	19		1			533
Brokerage funding	117	60	59	26	25	17	54	45		5		408
D&FV Group work sessions	22	8	55	6	3	12	10	1	12	3		132
No services	16	13	26	4			0	2	1			62
Clients represented at a SAM	1	21		15	23		0					60
Perpetrator program	1		1		1		1					4
Total	**2,664**	**1,740**	**1,338**	**668**	**505**	**410**	**971**	**230**	**182**	**71**	**-**	**8,779**

Source: FACS IDFVS datasets 2015-16 and 2016-17
Notes: Includes multiple services of individual clients, Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

Liaison with police and prosecutors and counselling services are also consistently provided across services. The comparative service delivery mix also reflects relative availability and capacity of services in each location and integration with externally referred support. Counselling services, for example, is one of the highest types of externally referred support. The portal data confirm that certain IDFVS services specialize in counselling interventions but need to refer out for other specialist services. Other IDFVS services refer clients out for counselling but may have a greater capacity to provide other services required by their client demographic.

The service delivery mix, while determined by contractual agreements with FACS, is also affected by service and worker intervention practice preference, the practice skills of the particular IDFVS worker, and the availability of local services including their auspice organisation.

The services categorised as ‘other’ are reported in the portal as free text and include a wide range of coordinated support types including webCOPS assessments, outreach, safety planning and ORS surveys. The ‘other’ category is a substantial component of overall service provision and almost half of service provision in Central Coast. This indicates the potential for improvement in data collection and categorisation to enable better understanding of the range of services provided.

The figures presented are based on reporting for exited clients and therefore reflect variation in exit processes and timing as presented in section 4.5. More consistent exit processing would potentially contribute further to the comparative project

service delivery reach and mix. Nowra services were not reported in the available portal datasets.

In addition to services provided to clients the IDFVS program delivers services for client's children (Table 19). The figures show substantial variation across projects in line with local service capacity and the relative proportion of clients with children. Safety planning and security equipment indicates a core support across most projects with referral and provision of child specific counselling and group work also provided with variation across projects.

Table 19: Services provided to client's children

	Bondi Beach	Mt Druitt	Mullumbimby	The Deli	Central Coast	Cabramatta	Bankstown	Catholic Care	Port Macquarie	Nowra	Liverpool	Total
Not applicable (no children)	19	314	13	12	74	2	21		48		59	**562**
Safety planning / security equipment	24	7	28	2	221		49	1	119		5	**456**
No services	33	9	17	30	18	12	27	1	74		172	**393**
Other	29	81	3	1	154	1	7	2	66		12	**356**
Referred to counselling/ group work	34	43	16	5	115	2	19	4	37		16	**291**
Provision of therapeutic support e.g. counselling/ group work	24	72	6	3	56	1	1		5		23	**191**
Brokerage funding	20	8	1		70	3	6	1	5		6	**120**
Advocacy regarding Family Law matters	16	-	10	3	1		11		76		2	**119**
Liaison with school/ childcare	16	7	11		13	3	9	2	22		14	**97**
Total	**215**	**541**	**105**	**56**	**722**	**24**	**150**	**11**	**452**	**-**	**309**	**2,585**

Source: FACS IDFVS datasets 2015-16 and 2016-17
Note: Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

Services for clients' children also covered limited support including brokerage, advocacy for family law cases and liaison with schools and childcare. The support reported through 'other' include liaison with FACS, group work, court support and a range of social, advocacy and safety related activities. It is also worth noting that auspice organizations may well provide services not recorded against IDFVS services provided.

The services all commenced at different times and in different service contexts so the way the IDFVS developed has been dependent on the nature and types of services funded in the local geographic area. Their auspice agency (and the services they provide as wrap-around) and where they are co-located also influences the way in which the integrated service develops and the philosophical underpinnings of a particular IDFVS project.

While all IDFVS projects acknowledge their routine provision of referral, case coordination and case management, the way in which these services are provided and the mix of local partners and services combine to provide a unique service opportunity within the local geographic context.

Service providers and managers were also able to detail very specific types of services that their IDFVS offered. Examples include: advocacy work with other service providers on behalf of the client and their children, information sessions in schools, education groups with adults and information sessions to other services, and court support.

The extent to which an IDFVS service would provide more than assessment and crisis counselling varies. A few of the IDFVS services do not claim to provide counselling, a few primarily offer therapeutic interventions and other IDFVS are somewhere on the continuum between these two positions.

Another pertinent factor in the type of services provided is the make-up of IDFVS staff. At different points staff may have different practice preferences and different disciplinary backgrounds. This can lead to a practice preference for counselling as opposed to crisis work or case management. For example, one service manager reported: 'Right at this moment, I would say that we probably have more case coordination than what we would normally have because of the current staff makeup'.

5.2 Brokerage

Brokerage funding is highly variable across projects with around a quarter of the total brokerage provided through Central coast while Eastlakes did not report providing any brokerage support. The majority of IDFVS reported having brokerage set aside in their budget and were able to specify the various ways in which they administered it. One provider indicated the diversity of uses to which brokerage funding is put: within their own program examples include store cards, removalist's costs, locksmith costs when locks need to be changed and school uniforms.

Another service described their brokerage system as an 'escape fund' which pooled brokerage funding, community donations and brokerage funding from other programs.

The services also talked about the way they leverage other forms of financial and material assistance in their local community contexts via food vouchers and even using services such as SHLV to provide security equipment and safety upgrades.

This shared pooling of brokerage funds and other forms of assistance including fundraising demonstrate the ways in which local partnerships or integrated service provision at the local level can be harnessed to maximise the effectiveness of the response to a woman's multiple needs.

However, a few IDFVS were unclear about whether there was a specific allocation in their budget or what amount of brokerage was included as part of their funding. Two services expressed the view that brokerage takes away from staff wages and in one

service the Manager additionally stated that brokerage imposed too great an administrative burden to be worthwhile.

5.3 Partner agencies and partner agency support

Assessing the integrated nature of the IDFVS program includes examining the engagements with partner agencies across projects. Program portal data reports partner agencies that worked with each project to support clients, defined as having had multiple discussions about the client to plan or coordinate services, that is, excluding minor partner agency contact.

Previous annual portal reporting has indicated ongoing improvements in partnerships with other organisations including increased referrals through Safer Pathways, self-referrals and other partnerships, creating new relationships with non-government organisations in their local community, stronger relationship with government agencies, NSW Police, Housing services, and local Health services (ARTD Consultants, 2017).

The combined portal datasets merged during the evaluation confirm the composition of partner agency support during the two-year study period (Table 20). From the highest number of partner agency support, top to bottom, the close relationship with police is consistent across projects. The high number of police cases for Central Coast relate to the project being provided through the local police service.

Table 20: Partner agency engagements supporting IDFVS clients by project

	Bondi Beach	Mt Druitt	Mullumbimby	The Deli	Central Coast	Cabramatta	Bankstown	Catholic Care	Port Macquarie	Nowra	Liverpool	Total
Police	44	145	21	8	436	6	41	4	67		56	828
Community Services	39	70	3	4	93	11	11	2	97		50	380
WDVCAS	14	35	13	3	146	4	52	9	83		8	367
SHS services / Women's Refuge	5	13	14	1	20	25	2	4	92		29	205
NSW Health/ Community Health	12	17	9	1	85	11	2	1	21		34	193
Housing NSW/ Community housing	6	66	9	1	103	12	27		29		31	284
Did not partner	54		26	33		20	36	7	57		103	336
Other	59	205	29	5	3	3	26	13	80		75	498
Community housing NGO	3	82	1	1	117	1	5		11		7	228
Total	**236**	**633**	**125**	**57**	**1,003**	**93**	**202**	**40**	**537**	**-**	**393**	**3,319**

Source: FACS IDFVS datasets 2015-16 and 2016-17
Notes: Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree, WDFVCAS = Women's Domestic Violence Court Advocacy Service

FACS and Women's Domestic Violence Court Advocacy Service (WDFVCAS) are also core partnerships across services, as are SHS and women's refuges. NSW

Health is a consistent partner agency providing physical and mental health support including community health services.

Housing support is also a core program integration point with partnering agencies across projects through Housing NSW and Community Housing NGO providers. The partner agencies grouped within 'other' include Brighter Futures (8% of 'other', n=42), Centrelink, Victim Services, SHLV, legal aid, community corrections and a range of NGOs.

5.3.1 Staff and stakeholder interviews: experiences of integration and collaboration

Staff interviews

As detailed in Section 3.2.2, we interviewed 45 clients, 36 IDFVS staff and 21 stakeholders across the ten services. In interviews, all IDFVS staff emphasised that in their experience, the provision of integrated support is dependent on strong relationships with local service providers. When asked what service integration meant in their local context, all interviewees responded by naming the organisations with whom they work closely, typically SHLV, police, legal aid, and local interagency groups.

Interviewees also responded to questions about integration by describing the support received by clients as 'integrated'. Clients can receive multiple services from IFDFVS, although these vary between projects, for example counselling and case management, or children's services and counselling, or groups and case coordination. These multiple services were described as important to an integrated service, as was the capacity to provide flexible, responsive support to meet individual needs, as indicated by following illustrative quotes.

> But for us with the integrated service I feel that what we do is we work with women who are still in the relationship, and […] empowering the women, as well as working with their children as well, through to in whatever their needs might be (service provider staff)

> So it's about family approach – a wraparound approach. So we're hoping that it's about counselling, it's about housing, it's about legal… it's about a lot of things, and it's about coordinating all of these services to help and assist this one client (service manager)

> Part of the integration of a service is looking at it holistically as a family where sometimes we do focus on the victim, mainly the spouse but there's always the children (service manager)

Stakeholder interviews

Staff from agencies who work with IDFVS services said in interviews that they worked with the services in different ways, including making and receiving referrals, joint membership on local committees e.g. SAM, partnering on group activities and projects, and joint case coordination. We asked about their familiarity with the IDFVS assessment and intake processes and overall, stakeholders were not very familiar with these. They described how they would contact the service to find out if the referral was appropriate and then proceed from there. The amount of information sharing varied across agencies as did the degree of formality involved in the referral.

Views on the perceived cultural safety of IDFVS services also varied between stakeholders. The lack of an Aboriginal worker at one services was a noted absence by several stakeholders, who described a couple of unsuccessful referrals and activities; and other services who do not have Aboriginal workers were also described as less accessible to Aboriginal clients than services that do. Stakeholders described positive support for CALD clients, especially in those services which support a high proportion of CALD clients.

The contributions of IDFVS services to an integrated service network are determined to an extent by the IDFVS, but also by the local service network and the impact of new DFV initiatives such as Safer Pathways. Stakeholders reported mixed views on the extent to which the local service sector and the IDFVS are integrated. Examples of barriers to integration were reported for individual IDFVS, although no one barrier was reported to affect all services and most barriers were reported as a challenge for only one IDFVS – possibly reflecting differences in local context. They included: competition between some local services, undeveloped referral practices between government agencies and NGOs, and low referrals from IDFVS. Views on the impact of Safer Pathway were also mixed, although stakeholders tended to be positive about the potential of the Local Coordination Points and Safety Action Meetings, whereas staff from some IDFVS projects reported more challenges than benefits, primarily around changes to referral pathways and participation in Safety Action Meetings.

The stakeholder sample was small, referred to the evaluation by IDFVS services and subject to selection bias, and not available in all areas, so the views of stakeholders cannot be taken as representative. However, there were notable differences between areas in how stakeholders described the contributions of IDFVS to an integrated network. In some cases, stakeholders expressed hesitations about IDFVS, in particular the capacity of one service to provide culturally safe support to Aboriginal families, but other stakeholders were very positive about the integration of DFV services in the local network and said that the IDFVS makes valued, flexible, and responsive contributions.

5.4 Support service composition and coordination

The previous sections confirm that although there is variation in client need and service delivery across projects, there is consistent coordination of core services and established relationships with partner support agencies. To examine program integration and coordination at a client level the number of services provided to each client were calculated to assess the proportion of cases that were receiving multiple, integrated support (Table 21).

The figures indicate a substantial proportion of clients are receiving more than one support service with substantial numbers receiving up to 5 coordinated services and some clients supported by more than 5 types of service where necessary. Around half the clients are receiving no services, i.e. information and referral only. As for service figures presented in section 5.1, support provided by the Nowra service was not reported in the portal datasets.

Table 21: Services per client by project

	Number of services per client										
Project	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**Total**
Cabramatta	727	16	24	24	21	2					814
Liverpool	225	126	94	93	61	53	25	10	2		689
The Deli	516	17	20	23	10	2	1				589
Mt Druitt	152	22	76	68	74	98	57	22	10		579
Nowra	565										565
Central Coast	37	1		19	139	170	105	64	13	2	550
Bondi Beach	114	36	16	61	44	32	10	3			316
Bankstown	119	3	10	42	26	26	11	8			245
Port Macquarie	44	28	77	118	55	32	8	1	-	-	363
Mullumbimby	42	1	5	26	34	19	8	6			141
Catholic Care	24	6	18	4	3	1					56
Total	**2,565**	**256**	**340**	**478**	**467**	**435**	**225**	**114**	**25**	**2**	**4,907**

Source: FACS IDFVS datasets 2015-16 and 2016-17
Note: Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

The number of partner agency supports per client were also calculated to examine the level of program integration and coordination (Table 22). The figures indicate a substantial number of clients receive integrated support through partner agencies and a proportion of clients are receiving support from more than one and several agencies where needed. This confirms established relationships and program integration with service support partners where appropriate.

As for figures in the previous section, these support and partner details are collected at program exit and reflect variation in exiting process and timing across projects. The figures are also based on reporting of cases where there were multiple discussions about a client to plan or coordinate services. This focuses on a minimum support episode and excludes cases of minor contact with program

partner agencies. The figures include the merged two-year study period with the relatively low contacts for Catholic Care due to the project commencing operation in 2016-17, year 2 of the study timeframe.

Table 22: Partner agencies per client by project

	Number of partner agencies per client							
Project	**0**	**1**	**2**	**3**	**4**	**5**	**7**	**Total**
Cabramatta	752	44	9	6	2	1		814
Liverpool	388	232	54	9	4	2		689
The Deli	539	45	3	2				589
Mt Druitt	152	307	61	39	13	7		579
Nowra	565							565
Central Coast	80	143	192	77	45	13		550
Bondi Beach	136	133	38	9				316
Bankstown	120	70	36	16	3			245
Port Macquarie	46	183	82	28	16	7	1	363
Mullumbimby	50	69	14	5	2	1		141
Catholic Care	24	25	6	1				56
Total	**2,852**	**1,251**	**495**	**192**	**85**	**31**	**1**	**4,907**

Source: FACS IDFVS datasets 2015-16 and 2016-17
Note: Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

5.5 Program responsiveness

As shown in previous sections there are a range of referral pathways into the IDFVS program. To examine the responsiveness of the service the client referral dates were reviewed and compared with the decision date to enter the program to assess the time between initial referral and entering the program.

Overall, the program appears responsive, with an average duration between referral and commencing case coordinated or case managed services of 8.9 days (n=2,559). Of all program clients 93.7% (n=2,399) were accepted in less than 30 days, 78.4% (n=2,006) in less than 14 days, and 42.7% (n=1,093) were accepted within one day or the day of referral.

The program is demonstrating responsive intake across groups of clients across assessment and acceptance in general as well as immediate intake in crisis cases.

5.6 Aboriginal client outcomes

The client profiles in section 3 present the proportion of program clients identifying as Aboriginal or Torres Islander people with a total over the two-year study period of 8.4% (n=386). In addition to the overarching setting of this evaluation regarding integration with IDFVS and other NSW government DFV programs and the focus on

interim outcomes, there are established considerations specific to Aboriginal communities.

Previous research has reported the levels of Aboriginal family violence are likely to be under-reported due to local primary health responses, significant under-reporting to police by victims, and inconsistent data collection of perpetrators' cultural backgrounds (Closing the Gap Clearinghouse (AIHW & AIFS), 2016). These aspects may also influence IDFVS engagement and reporting by Aboriginal clients, however the support services provided across projects indicate the program is reaching Aboriginal clients, Table 23.

Table 23: Aboriginal clients by project for 2015-16 and 2016-17

Project	2015-16		2016-17		Total	
	Clients n	%	Clients n	%	Clients n	%
Nowra	43	23.9	56	27.2	99	25.6
Port Macquarie / Hastings	37	20.6	27	13.1	64	16.6
Liverpool	23	12.8	35	17.0	58	15.0
Mt Druitt	27	15.0	21	10.2	48	12.4
Central Coast	16	8.9	14	6.8	30	7.8
Eastlakes	16	8.9	13	6.3	29	7.5
Catholic Care		0.0	20	9.7	20	5.2
Bondi Beach	7	3.9	9	4.4	16	4.1
Cabramatta	6	3.3	4	1.9	10	2.6
Mullumbimby	4	2.2	5	2.4	9	2.3
Bankstown	1	0.6	2	1.0	3	0.8
Total	180	100.0	206	100.0	386	100.0

Source: FACS IDFVS portal datasets 2015-16 to 2016-17
Port Macquarie Hastings includes Port Macquarie, Kempsey and Taree

Higher proportions of Aboriginal clients are being supported in Nowra (25.6%, n=99), Port Macquarie (16.6%, n=64), Liverpool (15.0%, n=58) and Mt Druitt (12.4%, n=48).

Based on the merged portal datasets, the reason client service periods ended for Aboriginal clients was reported as 43.1% (n=81) having case goals met and no further assistance required. This is approaching the level reported for clients overall with 47.5% responding that case goals were met.

Further portal data analyses were limited by the relatively small sample sizes across some projects. The client survey results are anonymous and cannot be assessed across subgroups.

5.7 DVSAT results at program entry and exit

The Domestic Violence Safety Assessment Tool (DVSAT) is routinely used as the standard program assessment instrument. The assessment is undertaken at entry to the program and clients are reassessed using the tool on exit from the program.

The variation in the proportion of clients not formally exiting the program as discussed in section 1.13 may mean that clients are not routinely reassessed or that the results of this re-assessment are not entered in the portal because the client has not been formally exited. Other DVSAT assessment points are optional and the DVSAT may be implemented following a significant episode, or at a specified number of months in the program, however these additional assessment points reported relatively small groups of clients.

A high proportion of clients are assessed on entry to the program (n=3,203) and results indicate fairly consistent levels of reported threat across each study year, 2015-16 and 2016-17 (Table 24). The majority of around 85% of clients are assessed as being at threat with around one third of clients (32.6%, n=1,044) reporting as being at serious threat.

Table 24 initial DVSAT results at program entry 2015-16 to 2016-17

Threat level	2015-16		2016-17		Total	
	Clients n	%	Clients n	%	Clients n	%
Serious threat	520	33.2	524	32.0	1,044	32.6
At threat	817	52.2	886	54.1	1,703	53.2
No threat	228	14.6	228	13.9	456	14.2
Total	1,565	100.0	1,638	100.0	3,203	100.0

Source: FACS IDFVS portal datasets 2015-16 to 2016-17

Around 14% of clients reported a DVSAT level of no threat. DVSAT reassessment was undertaken prior to exit from the program for approximately a third of clients that exited the program (32.7%, n=729), Table 25. The DVSAT scores on exit indicate a reduced proportion of clients reporting serious threat levels from 32.6% at entry to 25.9% at exit. Most clients reducing from 'serious threat' level continued to report ongoing DVSAT level 'at threat', resulting in the at threat proportion of clients increasing by a corresponding proportion. The DVSAT scores are a broad tool to identify significant threat levels and guide appropriate responses in developing client case management plans. It is not surprising that high levels of clients remain in fear of their circumstances, even if at reduced levels.

It is also the case that perpetrators may continue to be violent and harass their partners after the relationship has finished. Equally, given that just under half the clients [46.6%] were still in a relationship with the perpetrator it is not surprising that

despite sometimes multiple interventions, no matter how effective, that a woman may remain at risk of further violence and abuse.

Table 25 Re-assessment DVSAT results at program exit 2015-16 to 2016-17

Threat level	2015-16		2016-17		Total	
	Clients n	%	Clients n	%	Clients n	%
Serious threat	120	31.8	69	19.6	189	25.9
At threat	217	57.6	225	63.9	442	60.6
No threat	40	10.6	58	16.5	98	13.4
Total	377	100.0	352	100.0	729	100.0

Source: FACS IDFVS portal datasets 2015-16 to 2016-17

On exit there was notably higher variation between DVSAT levels during each study period year, compared to entry scores that were consistent across years. This may be partly due to consistency of exit procedures across projects and the composition of the exit DVSAT score sample (n=729), representing a third of total exited clients (n= 2,226). It is not possible to ascertain whether the number of exited clients is responsible for the variation in DVSAT levels during each study period year or whether the variation reflects changed practices in relation to risk assessment.

5.8 Outcome Rating Scale (ORS)

The evaluation examined changes in clients' wellbeing using the Outcome Rating Scale (ORS) of IDFVS clients on entry and exit from the program. The Outcome Ratings Scale (ORS; Miller et al 2003) is a simple, validated and widely used 4-item tool that assesses individual feelings of wellbeing on four dimensions: individually, interpersonally, socially and overall. A total of 424 ORS scores were obtained from clients on entry to the program, and 186 score from clients at exit. The ORS may be undertaken at four response points during the support period:

1. At commencement of service
2. At a given number of weeks/ months in the program
3. After a key or critical incident
4. At service exit

The largest proportion of ORS scores were collected on entry, a reduced group of less than half the entry sample size was collected on exit with relatively small groups of clients reporting ORS at the remaining response points.

The average wellbeing score of clients when they exited the IDFVS program was significantly and substantially higher than the average wellbeing of clients commencing the service. Based on the available paired sample of clients that

responded on entry and exit, the wellbeing of clients almost doubled during their involvement with the program from 15.0 on entry to 27.5 on exit (Table 26). Although there was a relatively small before and after paired analysis client sample (n=86), the ORS scores indicate a statistically significant reduction in mean ORS score of 12.5 (p<0.001).

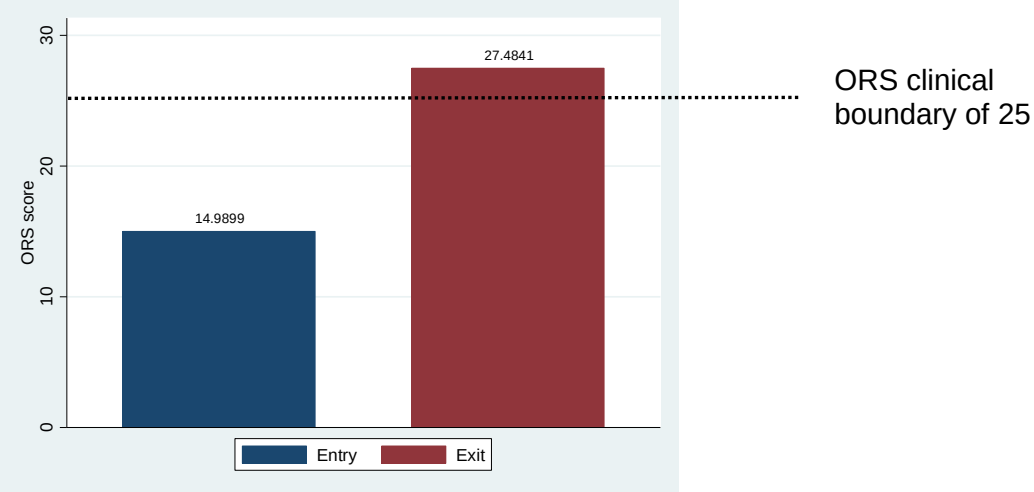
Table 26 ORS scores at service entry and exit

ORS score	n	Mean	95%CI Lower	95%CI Upper
Program entry	86	15.0	13.1	16.9
Program exit	86	27.5	25.7	29.3
Difference	86	12.5	10.3	14.6

Source: FACS IDFVS ORS dataset, paired t-test, p<0.001

Notably, the improvement in client wellbeing also exceeded the clinical cut-off of 25 (the boundary between 'clinical' and 'normal' levels of distress; Miller et al 2003). The clinical cut-off score of 25 is considered to represent the boundary between individuals assessed as within a clinical range of psychological distress and those who are judged to be in a non-clinical 'normal' range (Figure 4).

Figure 4: ORS scores at program entry and exit



Source: FACS IDFVS datasets 2015-16 and 2016-17

Although there are potential confounding factors that may have influenced the before and after scores and limit the determination of whether the increases were solely due to client engagement with the IDFVS service, qualitative evidence confirmed a strong association made by clients between their involvement in the program and improvements in their perceptions of wellbeing over time. It is also important to recognise that ongoing perpetrator violence and harassment will affect client wellbeing despite what may be an excellent service/set of interventions.

There was a significantly lower proportion of client responses in comparison to the SHLV portal data collection. Some services had chosen not to implement the ORS scale because they felt it was not conducive to their intervention style or practice intervention method. Other services talked of implementing the scale as a way of structuring their practice but also pointed out that they may choose not to implement the scale, particularly after a critical incident, if it wasn't conducive to the intervention with the client. Interviews also indicated that some IDFVS workers were not conversant with the administration of a scale such as the ORS and were not certain how to incorporate the implementation of the ORS into their client practice.

ORS scores are occasionally taken following critical incidents and were reported for a small group of clients (n=11), Table 27. This smaller group also indicates a statistically significant improvement in mean ORS scores, from 9.1 at entry to 18.8 following the critical incident (p=0.035). The different mean entry score is due to the use of a paired sample of before and after clients that reported a critical incident ORS.

Table 27 ORS scores at service entry and after a critical incident

ORS score	n	Mean	95%CI Lower	95%CI Upper
Program entry	11	9.1	3.9	14.2
After critical incident	11	18.8	12.1	25.4
Difference	11	9.7	0.8	18.6

Source: FACS IDFVS ORS dataset, paired t-test, p=0.035

ORS scores are also optionally reported during the program period which provided an additional paired sample of 37 clients, Table 28. Consistent with each before and after client subgroup, the ORS also indicates a statistically significant improvement from 15.2 at entry to 20.4 during the program (p<0.001). Collectively all 3 paired sample groups confirmed significant wellbeing improvement from program entry to each ORS response point.

Table 28 ORS scores at service entry and during program period

ORS score	n	Mean	95%CI Lower	95%CI Upper
Program entry	37	15.2	11.7	18.7
During program period	37	20.4	16.9	23.8
Difference	37	5.2	2.6	7.6

Source: FACS IDFVS ORS dataset, paired t-test, p<0.001

Due to the small sample sizes further subgroup analyses were not possible to examine client demographic features or service features associated with increased

wellbeing ORS scores. Sample sizes were also insufficient to examine client target groups, including Aboriginal women and women with a disability, who may report lower ORS scores at entry.

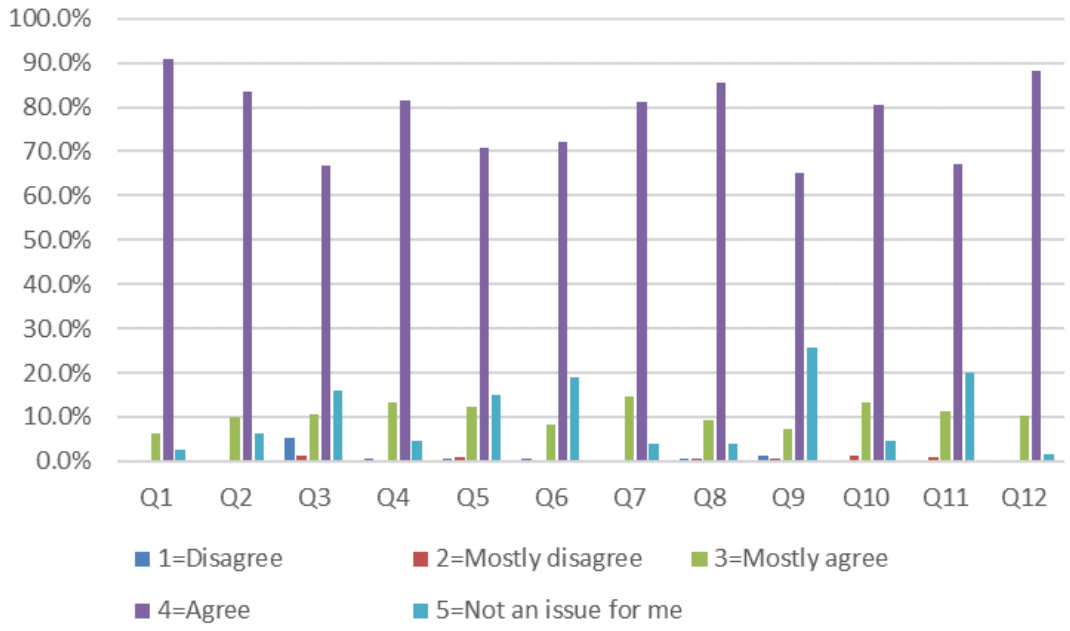
Due to the small number of child ORS scores collected (n=34) it was not possible to assess the program influence on children's feelings of wellbeing and safety.

5.9 Client Survey

A separate client survey is offered to clients on exit from the program of which 406 responses were received during the two-year study timeframe. The client survey responses are provided anonymously and are therefore not linked directly to other client data. The client survey questions are provided in Appendix A and the client survey results for each question in Appendix B.

The client survey indicates consistently positive feedback with around 80% of clients responding they agree or mostly agree with each survey question (Figure 5). This group of survey questions from 1 to 12 cover helpfulness of the program, accessibility to case workers, feeling treated with respect, clients feeling they and their children feel safer, and overall happiness with the program.

Figure 5: Client survey responses by survey question



Source: FACS IDFVS datasets 2015-16 and 2016-17, n~400

6 IDFVS service model

The current evidence base indicates that both victims and perpetrators of domestic, family and sexual violence have diverse and complex needs, frequently requiring multiple interventions provided by a range of community-based services to better ensure immediate and ongoing safety for women (Rees & Silove, 2014). Government and professional recognition of the complexity of these women's needs has acted as a catalyst for the growth in what is referred to in many global Western jurisdictions as 'integrated responses' (Coy et al., 2008). Indeed, this intention is echoed nationally in 'The National Plan to Reduce Violence against Women and their Children 2010-2022' (the National Plan) which states that its success "hinges on the success of the sixth outcome area – that the entire system join seamlessly and all its parts work together" (2009, p.15). At the State level, NSW launched its DFV Reform Package in 2014 – 'It Stops Here: Standing together to end domestic and family violence' which is premised on integrated service provision.

'Integration' is a term that continues to be used interchangeably with others including 'multi-agency', 'interagency', 'partnership', 'collaboration' and 'coordinated response' (Healey et al., 2013; Wilcox, 2010), although definitions vary in different contexts (Dowling et al., 2004; Wilcox, 2010). Healey et al. note that "partnerships can range from those with loose networks of interagency update meetings, through streamlined referral systems to more tightly woven, single integrated systems across a range of sub-unit services" (2013, p. 2). However, the literature generally accepts that integration most often requires acknowledged partnerships between agencies and the explicit sharing of service provision principles and approaches at the local level.

A recent meta-evaluation of existing interagency partnerships, collaboration, coordination and/or integrated interventions and service responses to violence against women (Breckenridge et al., 2016a, 2016b) found that the evaluated programs show limited evidence of effectiveness, although there were acknowledged promising signs of improved service delivery. Breckenridge et al. (2016, p.9) argue that despite clear limitations to the evidence base, integrated responses are generally accepted by government, policy-makers, and service providers as best practice for service delivery. Evidence from the evaluations identifies the importance of governance structures; organisational leadership; policy direction and guidance; data-collection and information-sharing mechanisms that protect privacy; and sustainable funding for effective integration at the system-level.

The report acknowledged that recognised benefits of integration to clients include:

- simplified coordinated response to multiple client needs;
- client centred intervention strategies;
- multiple entry points for intervention; and

- minimisation of secondary victimisation.

These stated benefits are evident in the provision of the IDFVS program and the following discussion focuses on core program elements and local adaptions to more closely explore the implementation of the program.

6.1 Core program elements and local adaptations

The strongest program elements shared by all IDFVS programs are integration based on collaboration and coordination, and flexible client-centred responses.

6.1.1 Integration based on collaboration

The current evidence on just what constitutes an integrated service provision is contested and there is no one definition or understanding of what integration means in practice (Breckenridge, Rees, valentine and Murray 2015). Clients who have experienced DFV may experience a range of effects including but not limited to physical and mental health concerns, financial insecurity, homelessness and precarious tenancies, difficulties with children, ongoing legal concerns related to their safety and family court matters. It would be difficult for one service to comprehensively provide for all needs. Therefore, partnerships with other organisations provide the most comprehensive response to an individual's needs. One service provider encapsulated this in an interview, stating

> It's the collaboration. You do have different kind of services however, one service cannot do it on their own. You need the specific key players, who the women choose to work within their lives, key players to do it together service provider)

The importance of local context was stressed by all participants as being critical to shaping the nature of integrated service provision.

> I certainly see us as part of broader integrated system. We don't see it as being just a little extra something that our organisation offers. I wouldn't view it as a project within our organisation, but a project within community (service manager)

> Integration meaning that we form part of a community service network that's going to I guess share the risk around clients and share the service provision to clients and not just that. That's the practical aspects of it" (service provider)

While all IDFVS projects stressed the importance of strong and effective local partnerships, some noted that their understanding of integration also encompassed different services offered within the same overarching organisation

> It's an integrated service because we provide counselling and casework. That's a big part of it. So we have those two hats on. It's also because of the

> fact that we use playgroup in terms of supporting the women and also as a soft entry point, (service manager)

Another IDFVS manager noted the helpfulness of their location within a more comprehensive DFV service

> For instance, if we look at specifically our own organisation, we've got different service streams. we've got outreach services, we've got our crisis accommodation, transitional housing, which goes under SHS, so Specialised Housing Services, our service program. In our organisation, having those different service streams, it also broadens and provides different opportunities for women (service manager)

The ways in which the IDFVS describe integrated service provision is not consistent between each project which is not a surprise because there is little guidance in the current literature describing how an integrated DFV service should be offered. Definitions of integrated service provision in the literature are contested and various terms such as partnerships, collaborative arrangements, one stop shops are used interchangeably with integrated service provision. In fact, the diversity characterising IDFVS actually reflects the diversity noted in the current evidence base.

6.1.2 Flexible responses

The balance of activities undertaken by each IDFVS are driven by perceptions of the needs and opportunities of the local context. As already noted each of the IDFVS projects provides information, support, referrals, and case coordination and/or case management. Aside from these core components, there are substantive differences between the sites in terms of services provided, co-location and auspice arrangements, use of brokerage, and provision of support to children and family members, and perpetrators.

The descriptions of each service indicate this flexibility (Table 29).

Table 29 Service descriptions

Service	Description
The Deli Women & Children's Centre	We are a specialist domestic violence family support service, delivering these services through 2 service streams – Children's Services and Therapeutic Services. We offer trauma specialist Counselling, Casework and Groupwork as well as Supported Playgroups with a trauma informed domestic violence support and assessment focus, parenting groups and parenting support. Our holistic model includes a variety of soft and direct entry points for clients to engage with our services. Each service stream cross pollinates with referrals and offers support to each set of clients. We also host external services where possible including currently a Legal Aid Family Law Clinic and in the past Housing Caseworkers and Child Therapists, as well as the Education Centre Against Violence. Our Children's Services team are in great demand by other services and we have a 6 year relationship with a local Aboriginal young mums group. We provide Counselling and Casework Outreach in the local Aboriginal community and will be expanding to other locations in 2017 through fundraising activities.
Bankstown Domestic Violence Service	Case management services that focus on long term need based for women and children affected by DFV
YWCA NSW Domestic Violence Intervention Service (DFVIS)	The DFVIS provides: information, support, referral, case coordination and crisis response to victims of family violence in partnership with NSW Police, Shoalhaven LAC. DFVIS Supports male victims and children 16 years and under
Mt Druitt Family Violence Service	Information/ referral/ training/ community development/ education/ specialist in-house services/ legal/ DFVCAS/ schools/ Rosie's Place/ Collette/ Research Paper/ NGOs (see sheet)
Mullumbimby District Neighbourhood Centre: Womens Resource Service	Multi-program locally based org with Brighter Futures, Community Support/ Emergency relief, community builders, Parent Support Program, SHLV. Highly developed integrated practice across funded programs and outreach and co-located services. Outreach/co-located services: Centrelink, Housing NSW, Financial counselling, Legal Aid
Core Community Services	Case management and brokerage support, emotional support/crisis counselling, community education/ engagement
Green Valley Liverpool DFVS	Case management and counselling for victims of DFV, including children and young people. Can see victims who are currently living in violence
Community Partnerships Against Domestic and Family Violence	Case management, case coordination, safety assessment and security upgrades, community and service education, service for children, registered men's DFV behaviour change program.
Central Coast Area Domestic Violence Integrated Case-Management	CC ADFVICE has been used to target 'At Serious Threat' victims of Domestic & Family Violence as it has been recognised that there was a specific gap in this community. CC ADFVICE are able to work with male and female clients of any age.

and Education (CC ADFVICE) *	The mission of the CC ADFVICE team is to break the cycle of DFV and enable a victim of DFV to transition into a safe & health life. This is undertaken through detailed case management which will include: • Advocacy with partner agencies (Housing, Centrelink Etc), • Goal setting to allow the victim to create their own path to safety, • Providing risk assessment and risk mitigation support (safety planning etc), • Providing a link to NSWPF personnel and programs, • Providing education to victims during and post DFV through support programs such as Lotus Group, Shark Cage & Breaking Free, • Providing education to partner agencies, such as Health, Corrections & Housing on DFV victims needs & environment.
Bondi Beach Cottage	To provide case management and counselling support for women and children who are affected by domestic violence; To provide occasional childcare for both clients as well as members of general community

* not included in fieldwork, qualitative data not available

Source: provided by IDFVS services

6.2 Strengths and challenges of the IDFVS service model

There are clear shared strengths which position the IDFVS as providing a unique DFV service. The following shared program elements demonstrate that despite the flexibility of IDFVS provision, there are innovative, good practice elements that contribute to the effectiveness of IDFVS provision.

6.2.1 Shared good practice elements

Working with women who remain in the relationship

Many of the participants distinguished the IDFVS from other DFV services as having the capacity to work with women who at the point of service are remaining in a violent/abusive relationship as opposed to services such as refuges and Staying Home Leaving Violence services. These almost exclusively work with women who have already left.

> We work with women who are still in the relationship, and talking about safety planning, and empowering the women, as well as working with their children as well. (service provider)

> We have a Vietnamese support group and a Cambodian support group. So for those clients, even if they're not ready to leave, just also introducing them to those support groups and seeing others who have gone through that cycle of experiences. (service provider)

IDFVS also can work with women who return to the relationship or where women cycle in and out of the relationship which is a unique service offering. One service provider described working with a client over an extended period of time:

> She didn't necessarily engage first time, not very well, she went back to the relationship, but we've kept it, and there was just a shift. So that for me is the really important kind of work that we need to do. (service provider)

Client driven, focusing on needs

All IDFVS services commented on their service primarily being client focused with longer-term intervention possible, determined by clients' need

> Philosophically the idea of long term needs, case management work that's client focused, client centred" (service provider)

Assessment of client's needs determine the nature of collaboration and integrated working.

> Depending really upon what the client's needs are, we might be collaborating with the court's process, DFVCAS, or we might be liaising with Housing or Health (service provider)

Needs assessments also determine whether a client receives case coordination or case management support.

Flexibility in duration and intensity of support

IDFVS workers and managers note that their services can provide intensive intervention when needed depending on client circumstances.

> So even just checking in daily – "How are you going today? What happened last night? What do you need to do? What supports do you need today?" (service provider)

The fact that IDFVS are not time limited is highly valued and reported as beneficial to clients. Moreover, clients may return for repeat assistance.

> It's based on the client's needs. If they feel that they need support, we're there; if they feel that they've gotten what they want from us, that's fine. And so they might go home, apply the strategies or whatever it is, and everything's working fine; and then maybe in a year's time, things aren't, and they come back. So it's really up to them, you know? (service provider)

Information sharing

Information sharing for the benefit of clients was noted as is important and is consistent with the NSW DFV blueprint.

> And I think one of the things I've seen coming into the service, fairly recently, is the fact that if we integrate correctly and work together correctly, then our client doesn't have to keep saying the same things over and over again. There is that sharing of the information so that the get as seamless a service as possible, and that then helps them to be in the right position to initiate change. (service manager)

In addition, one service manager crystallised a theme mentioned by other interview participants; that of the effectiveness of presenting as a collaborative team working in the best interests of the clients.

> [Services should] present themselves to the community and councils as one unified entity as well, rather than a whole small amount of smaller services. [This supports] advocacy as well, because there's some weight behind it, there's a recognised larger body as well between non-government, government and private sector too, which is important". (service manager)

Flexibility of local partnerships addressing specific population group needs

Partnerships are designed to address specific needs of local communities. One IDFVS with a high CALD population detailed partnerships with legal services (beyond the usual criminal justice responses such as AVOs and breaches)

> A lot of [my clients] are newly-arrived migrants and most of them come on partner visas. So I work closely with immigration to help them obtain for instance permanent residence, so like declaring domestic and family violence in the relationship. (service provider)

Holistic support

Another variation of integrated service provision was the concept of providing shared and separate services to different family members.

> Sometimes we do focus on the victim, mainly the spouse but there's always the children that also have sometimes some issues that develop because they're learning some behaviour in the home (service provider)

The issue of working with male perpetrators was treated differently in the IDFVS. There were a range of philosophical positions described around working with male victims, and some services referred perpetrators to other local services as a means to enhance the safety of the victim as well as monitor perpetrator risk. At least two of the IDFVS's noted the potential to work with the perpetrator if they were willing to engage.

Referring perpetrators to other services in the area was seen as a means to enhance the safety of the victim as well as monitor perpetrator risk. As an excellent example of an integrated response at the system level, one service provider

described referring perpetrators to a local men's behaviour change program and also working directly with Corrective Services:

> We have quite a good relationship with [NGO], which run the men behavioural change program, so we make a call referral. And also sometimes for instance with the Corrective Services work with the husband, also then they refer the women to the victim of DFV from their understanding, so then we actually work with the women as well as working with the Corrective Services in that sense to ensure the safety of that client. We collaborate with Corrective Services in working with the male, and in the same time we also support the women (service manager)

6.2.2 Partnerships and networks

Each of the IDFVS services has developed over time and optimises relationships within their local context. As services within the geographic community and staff change, the ways in which local agencies leverage one another's services also shifts. The strength of the IDFVS is that they are responsive to the local context, they maximise partnerships with organisations in their area and develop integrated interventions to address the needs of the population demographic.

Most IDFVS services are co-located with other related services (for example Police, FACS and even Health) or are auspiced by services that may host other DFV programs or services that may be of assistance to IDFVS clients. for example, groups, children's groups and youth outreach:

> So, the only reason I believe it can operate and do the work well, is because it's embedded in a bigger service in the organisation. What we might do is the women who originally start with the integrated project, once things settle down for ongoing, it might still be working towards some kind of family law outcome or they might still need some emotional support, might want to be linked in with support programs. Then they can be introduced and moved across to outreach, so that's freeing up the integrated program for the higher, more risk, complex cases. That's what it does best" (service manager)

Some services offer outreach services at other organisations or arrange for specialist workers to come to them.

7 Client experiences of support

To report on clients' experiences of support, this section draws on interviews conducted with clients from each of the IDFVS services.

7.1 Types of support received

All of the clients we interviewed received various forms of practical support from the IDFVS and other service providers.

Clients reported being provided with funds to pay for groceries, petrol, utilities, school fees, children's toys and other day to day items. IDFVS workers also helped clients access financial support from other agencies, including vouchers and rental subsidies (Start Safely) and some clients received funds for removalists and to address safety concerns in their homes through installing cameras and other equipment.

Practical support also included accompanying clients to appointments, help with filling in forms, referral to other relevant services (see below).

Counselling was a common form of emotional support, and clients valued the opportunity to speak about domestic violence and its impact on them and their children from counsellors who understood domestic violence, and to receive relevant advice and information and referral to other counsellors for themselves and, in some cases, their children.

> I feel like if it wasn't for her [IDFVS worker] noticing how broken and scared I was, to say you need to go here, you need to go to a safe place - because you're not okay. If it wasn't for her saying that, I'm not sure I would - I think I would have just gone back home, and get dealing with it. So or even still I might have found a place and moved out, and then that would have just gone really bad, because he would just have turned up on my door, and it would have just been messy. (client)

A small number of clients said that they received only counselling from the IDFVS, though many received multiple types of support. An important point about counselling made by two clients was that it may not be sufficient for victims of domestic violence, with one client describing how she spent years in counselling learning to cope with the violence, instead of leaving it. For these clients, it was a combination of counselling, education and legal action that helped.

> I guess the main help is developing my sort of confidence and ability to deal with a very domineering and aggressive ex-partner, and really the strategies how to support my kids and help all of us through that, and for me to get myself to a safe place and be able to deal with different situations, because they constantly occur in regard to my ex-partner. So, I've gone to individual

> counselling, I've done group counselling, I have done workshops with mindfulness, and been guided into parenting workshops as well. (client)

Many clients said they also received information and education about domestic violence that helped them identify and understand their situation and learn about the trauma and other impacts of violence on them and their children, and taught them strategies for staying safe.

The referral and advocacy provided by the IDFVS was also very helpful to clients. Client feedback is that IDFVS workers effectively advocated to Housing NSW, Victims Services, Centrelink and the police to obtain the relevant services and support required by their clients. They appreciated the workers' persistence with services.

> I keep telling [IDFVS worker] everything, everything that happens, and she used to ask or even in the housing she called and she helped, she gave my phone number and everything. I didn't know anything about my case with Housing and she keeps supporting me there until they approved. (client)

A small number of clients said they participated in groupwork activities, including therapeutic, parenting, art and craft and yoga/mindfulness groups. One client noted that the craft groups were important to her developing a network of support and rebuilding her self-esteem. Other clients spoke about how the therapeutic groups were helpful in reducing their isolation and increasing their well-being.

> I learned from the group that not everything is important. Not everything is worth the anguish. There are things that are just crap, 'Don't worry about it, move on', you know, whereas before I think I was just jumpy at everything. I think this is trauma too. I was like, "Oh please, let's not argue. Do what you want." I just can't cope listening to arguing. Now I think clearer. I'm very grateful that I went to the group, very, very grateful. (client)

7.2 Quality of the support provided

Clients said that the IDFVS workers specialist knowledge of domestic violence and its impact (psychosocial, emotional and practical) on families was a real help because, unlike some of the other more generalist services that had less in-depth knowledge, it meant the clients circumstances and needs were better understood, and there was a greater appreciation for how best to deliver services to them.

Qualities of the IDFVS that were most appreciated by the clients were how flexible, kind and considerate the service providers were. Many of the clients recalled how much they had to do for themselves and their children when preparing to and leaving the domestic violence, and the services willingness to for example, reschedule appointments at late notice, the open invitation to recontact the service at any time, and the timely response from workers when clients made contact were much appreciated. Some clients said that having workers check in with them from time to time to see how things were and offer support was also helpful.

> They even asked if I needed locks changed, if I needed security lights or if there was anything they could do with the real estate. In any of the properties that I was in, they always asked if there was any security that I needed to help with the safety of the house. They were always asking what they could do, so if there was anything I needed. Every time you spoke to [IDFVS worker], it was, “Do you need anything? What can I do?” That was always in the conversation there, “What do you need from me? What can I do to help you? What can I look for?” It was like that constantly, which was just such a relief because when you did need something, it didn’t feel like you were putting her out. It didn’t feel like it was a big deal. Because it was offered all the time, you didn’t feel bad about asking. (client)

The open ended and comprehensive support meant that clients most immediate and longer term needs could be attended to by the service. All these characteristics of the support led to the clients feeling that they got to prioritise the type and intensity of support they received.

> I can choose to leave if I want to. I don’t have a set time or set limit. So, if I choose to stay, I can stay for years if I want. She [IDFVS worker] doesn’t really say anything, she just listens to what I say. She advises me on things. She advocates for me when I ask her to. She hasn’t really pushed anything onto me. (client)

Clients also appreciated the depth and breadth of IDFVS workers knowledge about useful local services, the various resources and programs available to clients including Start Safely, Victims Services, therapeutic programs for the children, parenting programs, the police and legal processes, housing applications and so on.

Some women said the combination of group work and individual counselling/case management helped reduce their isolation through connection with others in similar circumstances. For many clients, the group or individual counselling provided much needed information and education about the cycle of violence, staying safe and the impact of violence on themselves and their children.

> I suppose the thing that really shone out for me was they were kind of saying to me, "I bet your ex did X, Y, Z. And I bet this is what" - and I was looking at them thinking, "How - shit, how have you been in my life," because they had experience of the same kind of things over and over again. It was almost like they were reading the story of my existence. That was invaluable to me because it made me realise that I'm not alone, you know, it's - this is a profile of an abuser. It's not because of a fault of mine. (client)

7.3 Support to find and use other services

Clients were supported to access a range of other services. Supported referral is so important because, as clients explained, there is a great deal to be done in leaving domestic violence and becoming safe, and having a service provider take the first few steps with the client, or on their behalf is good support. The other very important

reason for supported referrals is that clients need to be able to trust other service providers for the protection of themselves and their children.

> They've been really good with talking to me about things and also not having to repeat myself to other places like Centrelink. Yeah, they'll write a letter, or they'll speak to them on my behalf. I'm not having to constantly talk about all the bad stuff. (client)

The types of support included letters of support to Housing NSW for priority housing and rent assistance, help with applications to Victims Services, and referrals to local community services, psychologists and counsellors.

> So, you weren't just walking into a service asking for help, they'd already done that groundwork and the service knew that you were coming. Otherwise it's very intimidating walking into somewhere and asking for help, especially when you're already vulnerable, you're already nervous and scared whereas when they do the groundwork and they say, "We've spoken to these people. You go in there and ask for this person. They're expecting you" and it's like, "Okay, they know what's going on and I don't need to re-live it all and go through everything again" (client)

Many clients said it was very useful when IDFVS workers helped them fill in application forms, made phone calls to connect them to other services, provide transport, accompany them to appointments and, especially, advocated for resources, including financial support and housing.

> It's just nice knowing that if the shit hits the fan, well particularly back when there was a lot of stuff going on, that I could just call [IDFVS worker]. It was very comforting just to go, I know I can call on her because I know I can rely on her to suitably advocate on my behalf. Not patronise me, not do those sorts of things, but to be able to just say, look, this woman is very capable, but these are the things that have been going on and these are the supports that are needed. (client)

7.4 Experiences of other services

Clients spoke about their experiences with other services, both prior to and since being in contact with the IDFVS. Some clients had primary contact with and case management from another service, for example, Brighter Futures, that linked them to the IDFVS. For other clients, it was the reverse, with the IDFVS case managing.

Clients received various forms of support from these other services, including financial support, counselling, family support, parenting courses, court support and housing.

Some clients said the support they received from other services was very good and that the services were well coordinated.

> Yes, I was very lucky too and I think that's a big part of - all of the services are connected. So even though as we discussed they may not be connecting my personal information, they're definitely connected in that they all know about each other and they have that ability to refer, and even again back each time you speak to the police. (client)

Others had less success in having their needs met, in particular, services that promised some kind of support (such as vouchers) but not following through. For other clients, their experience of coordination was less than satisfactory.

> So, it was kind of all over the place and I think I requested a case conference because it just felt like there was 100 heads and none of them were talking to each other. I was just like, 'I just need them to understand that like, we've gone through a lot. Because I don't have the correct answer or I don't understand what they're asking me doesn't mean that I'm an idiot.' (client)

Another concern is the apparent lack of culturally appropriate support that some clients experienced, especially from the police, with one client stating that she had been discriminated against by the Police because of her religion, noting that she did not seem to have the same rights as Australian born people seeking help.

7.5 Suggestions for Improving services

Clients called for increased public awareness of domestic violence and more promotion of the services and supports available to people leaving violence. This included much more advertising in doctors waiting rooms, Centrelink and housing services and the need for increased awareness of and sensitivity to domestic violence and its impact on families amongst a wide range of service providers, including police, doctors, housing support workers. Increased cultural awareness was also suggested by several clients.

Some clients identified the need for much more education about domestic violence in schools, amongst counsellors and psychologists, and in the community more generally, to dispel myths such as that it is just physical violence.

> Because there was no physical bruising or visible stuff it just - it just kind of didn't get there. And yet, you know, I was talking to counsellors. I was talking to my doctor about the level of anger and extreme reactions and expectations and, you know, all of that sort of stuff. So it would be, yeah, if we could somehow educate the professionals to look for the more subtle cues that would be really useful. (client)

Clients also made suggestions for how IDFVS services could be improved. In contrast to those clients who said that referrals to other services were supportive and made it easy to use those services, some clients found the referral process unhelpful. It is likely that the very high caseloads of some IDFVS services contributes to this variation in experience.

> I feel that it would have been a bit better if they had a little bit more time to actually go hand in hand with the person and take them to other services that are out there. I know I didn't do a lot of things, I have a lot of like business cards just given to me. When you're in that state of mind, you don't really - those business cards just get left in the car and you don't use them. (client)

Several clients identified the need for more awareness of and sensitivity towards women living in and/or leaving domestic violence, and how vulnerable and overwhelmed they can be by the situation and the systems involved. Two clients also said that the police, courts and legal aid, need to be more inclusive of women from a non-English speaking background. One client expressed a genuine sense of discrimination based on religion.

A client suggested more art and craft group activities at the IDFVS services, as these had been beneficial to building self-esteem and connection in a relaxed atmosphere. Another client suggested that the group activities sometimes be held in coffeeshops to foster community participation and reduce isolation.

Court support is provided by IDFVS and other services including WDVCAS, and clients reported that this is highly valued. Several clients identified the need for more court support for victims of domestic and family violence.

8 Economic analysis

This section presents the IDFVS funding in context of the wider NSW initiatives to address DFV, the program costs and estimated average cost per client. The costs are examined in terms of program interim outcomes, based on the merged portal datasets presented in earlier sections. The combined cost and outcomes provide the basis for assessing the economic cost of the model in broad terms.

8.1 Program funding

For the two-year evaluation period the NSW government provided funding for the IDFVS program of $3.6 million in 2015–16 (FACS Budget 2015-16), and $3.7 million in 2016-17 with a minor increase through annual indexing (FACS Budget 2016-17). As presented in the introduction the IDFVS program is part of the wider NSW government DFV strategy with announcement in the 2017-18 budget which more than doubled the investment for domestic and family violence initiatives to more than $350 million over four years from 2017-18 to 2020-21 (FACS 17/18 budget fact sheet).

The NSW government responses to DFV are part of the NSW Domestic and Family Violence Blueprint for Reform 2016-2021. This provides the setting for the IDFVS evaluation with a focus on interim outcomes, with a broader contribution the program may be making to longer term endpoints beyond the current study period. The IDFVS model as an integrated and coordinated service may incorporate clients'

pathways across the NSW government reform framework including Start Safely rental subsidy support, men's behaviour change programs, SHLV, and increased capacity of SHS to respond to women and children escaping domestic and family violence.

8.2 Program costs

Program cost data for the evaluation was provided from FACS corporate finance systems including block transfer payments to service providers, generally monthly, as well as head office costs for staff and other expenses. The aggregate figures confirm the IDFVS program has operated within budgeted funding of $3.7 million per year.

The aggregate program costs have been aligned with program activity to the level the data allow. Most projects are operated by non-government service providers with the exception of Mt Druitt which is operated directly by FACS and has overlapping costs with head office and program management, and Central Coast which has been operated by NSW Police.

8.2.1 Total cost of program services and average cost per client

The aggregate program funding data have been aligned by the number of case coordinated and case managed clients for each study period year. This provides an overall estimated average cost per client based on available aggregate funding and the total number of clients (combined case coordinated and case managed) reported for each funding year.

As described in the methodology there are inherent limitations with estimating average client cost including the aggregation of periodic cost transfers, the timing of client intake and program exit, and the variation in intensity of support for case coordinated or managed clients. For these reasons average cost estimates could not be developed on a sufficiently robust basis for comparison between individual projects.

The figures presented in this section combine available aggregate costs reported for some projects with remaining unallocated program overhead costs to derive the overall total program cost for each year. The resulting total program costs were combined with total clients per year providing an indicative average cost per client per year.

In 2015-16 total program costs were in line with the budgeted $3.6 million with the program supporting 2,470 clients for the year (Table 30). Of the total clients for the year around twice as many receive case managed (n=1,681) compared to case

coordinated (n=789) support. The overall average cost per client for 2015-16 is estimated at $1,457 per year.

Table 30 IDFVS Program funding and average cost per client 2015-16

	CM clients n	CC clients n	Total clients n	Total Cost $	Average cost per client $
Total project funding	1,681	789	2,470	3,600,000	1,457

Sources: FACS IDFVS portal datasets, FACS Corporate finance data, FACS Budget
Notes: CM=Case managed, CC=Case coordinated

In 2016-17 program funding increased slightly to $3.7 million in line with annual program indexing at the established FACS rate of approximately 2.5% per year (Table 31). Total program clients remained at fairly similar levels for this second study period year (n=2,437) with a similar proportion of case managed (n=1,596) at around double the number of case coordinated clients (n=841). In 2016-17 the overall results were relatively similar with a total average cost per client of $1,518 compared to the previous year of $1,457.

Table 31 IDFVS Program funding and average cost per client 2016-17

	CM clients n	CC clients n	Total clients n	Total Cost $	Average cost per client $
Total project funding	1,596	841	2,437	3,700,000	1,518

Sources: FACS IDFVS portal datasets, FACS Corporate finance data, FACS Budget
Notes: CM=Case managed, CC=Case coordinated

Across both years the available program data limit more detailed estimation of average client cost, in particular the intensity of support provided to each client is not reported or captured in the number of support hours. This means there is no distinction between clients who may have been completing their support and exit in the first month of the year, new clients that required more intensive initial support, or clients that may have open cases but had not engaged with the service for some time. The program cost figures also do not reflect related support for the reported high number of clients' dependent young people and children. In the absence of level of support client data, the average cost per client is not known for case managed versus case coordinated clients. It is plausible that the average cost may be higher per case managed client and lower per coordinated case. Average cost also reflects duration in the program and the variation in processes for exiting clients that have reduced support needs and program contact for extended periods.

The average unit cost figures presented in this section have focused on total costs and total program activity as the two sets of validated base figures. Further analyses were undertaken to examine more detailed project specific costs but reflect variation

related to relative proportions of case coordinated and case managed clients, which are not recorded in the program datasets. Without details of client hours and intensity of support average unit costs cannot meaningfully be derived further.

8.3 Program outcomes

As outlined in the methodology, specialist human service programs such as IDFVS are characterized by a spectrum or outcomes, often with a variable lag from the point of support and commonly diffused across a wide range of longer term endpoints. The scope of this evaluation focuses on measurable, interim outcomes achieved during the study period. The program has demonstrated positive results across the specified outcomes as presented throughout this report.

The program is likely to be generating additional outcomes and benefits outside the scope of this evaluation. This provides the context for the program costs and interim outcomes for assessment of program effectiveness and related cost effectiveness in broad terms.

8.4 Cost effectiveness

In health and human services evaluation, the term ‘cost effectiveness’ is often used in a general sense to refer to any comparison of program costs against program or client outcomes. In health economics and the economic evaluation of human service programs, related methodologies are more clearly defined as Cost Benefit Analysis (CBA), Cost Effectiveness Analysis (CEA) or Cost Utility Analysis (CUA). These methods are not within the scope of this evaluation but provide useful context for the evaluation perspective presented in this section, as well as reference to the limited economic research that has been undertaken into domestic and family violence programs.

8.4.1 The scale and economic cost of domestic violence

Internationally and in Australia there is growing evidence of the impact of DFV on victims as well as their dependent children across multiple sectors including physical and mental health, justice, welfare, education and employment, and across multiple perspectives for individuals, families, communities and society. The World Health Organisation (WHO) world report on violence and health outlined a strong case for violence prevention concluding that violence prevention was complex, but possible. (Krug et al., 2002).

Subsequent WHO work extended the perspective to examine the economic dimensions of interpersonal violence and highlighted the enormous economic costs, further strengthening the case for investing in government interventions, and examining the limited but compelling evidence for the cost effectiveness of

prevention programs (Waters et al., 2004). These reports identified the most commonly reported costs as medical care, judicial system, policing and incarceration and noted deeper far reaching costs related to psychological costs and life pathways.

These WHO reports emphasised the scale of the problem, and the substantial gaps in information related to interpersonal violence, but identified preliminary evidence that programs aimed at reducing and preventing this type of intimate partner violence were cost effective. This work also established the variation in methods to assess interpersonal violence and the importance of incorporating multiple perspectives including societal viewpoints. The complexity of individual cases and the coordinated responses require appropriate broad perspectives and methodologies to evaluate client pathways and longer-term outcomes.

In Australia, more recent research has continued to examine the substantial burden of intimate partner violence to individuals, families and governments and the need to develop the evidence base through increased economic evaluation to inform policy including through experimental randomized control trials as well as economic modelling methods (Gold et al., 2011).

8.4.2 The cost of domestic violence in Australia

The impact of domestic and family violence affects not only individuals but the broader community, with a reported substantial burden on services, hospitals, assaults, homicides and the criminal justice system AIHW (Australian Institute of Health and Welfare, 2015). Collectively these costs in Australia, including sexual assault, have been estimated at $13.6 billion each year and are projected to rise to $15.6 billion by 2021 (KPMG 2009). NSW is estimated to account for over one third of the National figure with more than $4.5 billion annually (NSW Audit Office, 2011).

Further cost modelling work based on these estimates positions the cost of DFV program inaction and that for every prevented episode of domestic violence, costs across affected groups of $20,766 are potentially avoided, noting that these estimates, as for other domestic violence research is based on reported incidents only. (Australian Commonwealth Government, 2009).

Mortality figures are also salient in DFV settings. Of 510 homicides in Australia from 2008 to 2010, 36% were domestic homicides of which 122 (68%) were committed by an intimate partner, the majority of almost three quarters of victims killed were female (Chan & Payne, 2013).

In NSW the rate of domestic and family violence has been increasing over the past five years and is reported to be one of the most important drivers of demand for FACS services, and a major cause of homelessness. (NSW Department of Family and Community Services, 2015-16) The reason clients accessed specialist homelessness services indicate a rise in the proportion experiencing family and

domestic violence, with 2 in 5 (40%) of clients Nationally receiving support because of family and domestic violence, (Australian Institute of Health and Welfare, 2017)

8.4.3 Costs to Aboriginal and Torres Strait Islander populations

Research into intimate partner violence has been estimated to contribute 1.6% to the total burden of disease for Aboriginal and Torres Strait Islander, five times the disease burden rate for non-Indigenous Australians (Closing the Gap Clearinghouse (AIHW & AIFS), 2016). This work also reports an independent evaluation of the long-term Cross Border Indigenous Family Violence Program using limited linked, criminal justice data which found some reduction in reoffending and recidivism, and that the program had been cost effective, given the costs of imprisonment and health care for victims.

Recent DFV figures from the Australian Institute of Health and Welfare confirms higher rates in Aboriginal and Torres Strait Islander communities than in the general population (Australian Institute of Health and Welfare, 2018). This report indicates Aboriginal and Torres Strait Islanders as having increased risk factors for family violence, including poor housing and overcrowding, financial difficulties and unemployment, and Indigenous women are 32 times, and Indigenous men 23 times, as likely to be hospitalised due to family violence as non-Indigenous women and men.

8.4.4 Potential cost effectiveness of IFDFVS

The range and scale of costs related to domestic and family violence suggest that effective programs aimed at reducing or avoiding incidents would plausibly offset significant costs to related NSW government funded agencies and the wider economy. This is emphasised through the estimated cost of over $20,000 for each DFV episode avoided.

In this overarching context the IDFVS estimated average cost per client of around $1,500 per year appears marginal. There is inherent variation in the estimated average cost across services, however the program is achieving the specified interim outcomes across target population groups. Although there is uncertainty in longer term client pathways the interim outcomes show substantial improvements in client wellbeing and high levels of client satisfaction and indicate the program is delivering benefits compared to the program funding. The program may also potentially be contributing to substantial additional longer-term benefits for program clients and their children.

9 Conclusion and recommendations

The purpose of the IDFVS evaluation is to strengthen the service model by documenting common elements of good practice across all projects and make recommendations on potential approaches to improve the program, strengthen outcomes for clients and facilitating improved management of the program. The following summaries of key findings, and recommendations, provide strategic guidance for ongoing implementation of IDFVS and contribute to evidence of the effectiveness of the IDFVS response.

Recommendation One: *That FACS continue to review the extent and difficulty of data entry with the introduction of CIMs as well as the requirement for additional data entry imposed by auspice agencies*

Analysis of the monitoring and outcome data suggest that recording of client and service data on the portal is not consistent. Examples of reporting variation have been presented as potential items for review, including changes to reporting or potential areas of training. The high variation between projects provides a basis to investigate capacity building in those areas or to examine program management for improved consistency in the recording of external service referral. In addition, IDFVS workers unanimously noted the onerous nature of reporting requirements with many having to report on 2 or more data systems with different reporting requirements.

Recommendation Two: *That a round of Outcome Rating Scale (ORS) training is provided to IDFVS service providers ensuring greater understanding of the tool and its implementation in practice. It may also provide an opportunity for service providers to share other outcome tools they additionally implement.*

The ORS is an internationally validated outcome tool which is potentially easy to implement. The greater uptake of the ORS tool in SHLV projects than IDFVS may reflect the effectiveness of a round of training offered to service providers prior to implementation of the tool. The SHLV training provided information about the tool as well as how to integrate the implementation of the tool into assessment and counselling practice.

Recommendation Three: *Each IDFVS service report to FACS on their local partnerships and at the local level how the available services partner to best effect for the population demographic. This requires improved consistency in the recording of external service referral and potentially website development.*

Recommendation Four: *That consideration be given to funding specific workers with practice skills in working with children affected by DFV*.

The portal data confirms that children are the largest client group of IDFVS projects. In particular, there is a relatively high proportion of Aboriginal children seen by

IDFVS projects. While some IDFVS projects offer services to children via their auspice organization, or through referral, this is potentially an area of unmet need.

Recommendation Five: *That FACS develop clearer guidelines to determine whether a case remains open or is closed, thereby allowing greater transparency of active client numbers.* Program duration is a strength of the IDFVS model and there is no suggestion that there is or should be an optimal appropriate program duration, with program flexibility needed to develop individualized support plans. The number of open cases do however, show substantial variation across projects with some IDFVS projects having the majority of their clients remaining as open cases.

Recommendation Six: *That FACS develop clear guidelines on the component of brokerage in the funding allocation and brokerage use. This does not preclude projects leveraging other brokerage opportunities provided through local partnerships.*

Brokerage funding is highly variable across projects. The majority of IDFVS reported having brokerage set aside in their budget and were able to specify the various ways in which they administered it. However, a few IDFVS were unclear about whether there was a specific allocation in their budget or what amount of brokerage was included as part of their funding.

Recommendation Seven: *That priority be given to employing Aboriginal workers as well as providing training on cultural safety and competency to other staff.*

Views on the perceived cultural safety of IDFVS services varied between stakeholders. The lack of an Aboriginal worker available at least in one service was a noted absence by several stakeholders, who described unsuccessful referrals and activities and that IDFVS services may be perceived as less accessible to Aboriginal clients than services that do offer an Aboriginal worker. The high number of Aboriginal child clients also underscores this challenge.

Recommendation Eight: *That community education activities be properly resourced and strengthened to allow IDFVS projects to undertake more comprehensive community education with local partners and in the local community*.

Clients, service providers and stakeholders stressed the importance of increasing public awareness of DFV and the range of behaviours constituting DFV, and more promotion of the services and supports available to people to manage or leave violent/abusive relationships. Increased cultural awareness was also suggested as a way to improve the support provided by IDFVS services.

Recommendation Nine: *That an IDFVS workforce development plan be developed to ensure the ongoing professional development of IDFVS service providers and managers.*

The variation of skills and disciplinary backgrounds of IDFVS service providers is marked and can determine the nature of the interventions provided and preferred practice model implemented by particular IDFVS projects.

Recommendation Ten: *That FACS review procedures for recording IDFVS financial transactions in the corporate finance system to improve accuracy of funding provided to individual projects.*

This would provide improved visibility of funding across projects and support improved levels of detail in budget and service planning processed. The indicative high-level figures presented in this report suggest the program is providing positive client outcomes and further detail would potentially support more robust evidence of program effectiveness and related cost effectiveness.

10 Appendix A – Client Survey Questions

Q1 I was treated with respect by staff of the service
Q2 The service has helped me find out about other services to help me and/or my family
Q3 Since attending the service I have started using another service to help me and/or my family
Q4 Since attending the service I am more likely to share feelings or seek advice on dealing with problems
Q5 Other services I was referred to were useful to me
Q6 The staff and I discussed options for me to stay in my own home or move to different accommodation
Q7 I have improved my knowledge about dealing with domestic and family violence
Q8 I was able to contact my caseworker when I needed to during business hours
Q9 The service supported me through legal processes (e.g. exclusion orders, family court, property settlement) related to domestic and family violence
Q10 Because of the assistance I received I feel safer
Q11 Because of the service I feel my children are safer
Q12 I am happy with the service I have received
Q13 Are you living in safe long-term accommodation?
Q14 Are you of Aboriginal or Torres Strait Islander origin?
Q15 Do you speak a language other than English at home?
Q16 If yes, which language?
Q17 Do you identify as lesbian, gay, bisexual, intersex, transgender and/or queer?
Q18 Do you have a disability?
Q19 How long have you been using this service?
Q20 If you have further comments about the service, please write them down here.
Q21 Do you consent to being followed up in an evaluation of the program?

11 Appendix B – Client Survey Results

Question 1: I was treated with respect by staff of the service

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Agree	236	88.1%	130	94.2%	366	90.1%
Mostly agree	21	7.8%	5	3.6%	26	6.4%
Not an issue	8	3.0%	2	1.4%	10	2.5%
Blank	2	0.7%	1	0.7%	3	0.7%
Disagree	1	0.4%		0.0%	1	0.2%
Total	268	100.0%	138	100.0%	406	100.0%

Question 2: The service has helped me find out about other services to help me and/or my family

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Agree	216	80.6%	121	87.7%	337	83.0%
Mostly agree	31	11.6%	9	6.5%	40	9.9%
Not an issue	18	6.7%	8	5.8%	26	6.4%
Blank	2	0.7%		0.0%	2	0.5%
Disagree	1	0.4%		0.0%	1	0.2%
Total	268	100.0%	138	100.0%	406	100.0%

Question 3: Since attending the service I have started using another service to help me and/or my family

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Agree	174	64.9%	94	68.1%	268	66.0%
Not an issue	46	17.2%	18	13.0%	64	15.8%
Mostly agree	32	11.9%	11	8.0%	43	10.6%
Disagree	10	3.7%	11	8.0%	21	5.2%
Blank	4	1.5%	1	0.7%	5	1.2%
Mostly disagree	2	0.7%	3	2.2%	5	1.2%
Total	268	100.0%	138	100.0%	406	100.0%

Question 4: Since attending the service I am more likely to share feelings or seek advice on dealing with problems

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Agree	212	79.1%	117	84.8%	329	81.0%
Mostly agree	38	14.2%	16	11.6%	54	13.3%
Not an issue	14	5.2%	4	2.9%	18	4.4%
Disagree	2	0.7%	1	0.7%	3	0.7%
Blank	2	0.7%		0.0%	2	0.5%
Total	268	100.0%	138	100.0%	406	100.0%

Question 5: Other services I was referred to were useful to me

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Agree	187	69.8%	99	71.7%	286	70.4%
Not an issue	43	16.0%	18	13.0%	61	15.0%
Mostly agree	32	11.9%	18	13.0%	50	12.3%
Mostly disagree	3	1.1%	1	0.7%	4	1.0%
Disagree	2	0.7%	1	0.7%	3	0.7%
Blank	1	0.4%	1	0.7%	2	0.5%
Total	268	100.0%	138	100.0%	406	100.0%

Question 6: The staff and I discussed options for me to stay in my own home or move to different accommodation

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Agree	185	69.0%	107	77.5%	292	71.9%
Not an issue	55	20.5%	22	15.9%	77	19.0%
Mostly agree	26	9.7%	7	5.1%	33	8.1%
Disagree	2	0.7%	1	0.7%	3	0.7%
Blank		0.0%	1	0.7%	1	0.2%
Total	268	100.0%	138	100.0%	406	100.0%

Question 7: I have improved my knowledge about dealing with domestic and family violence

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Agree	209	78.0%	121	87.7%	330	81.3%
Mostly agree	48	17.9%	11	8.0%	59	14.5%
Not an issue	11	4.1%	5	3.6%	16	3.9%
Mostly disagree		0.0%	1	0.7%	1	0.2%
Total	268	100.0%	138	100.0%	406	100.0%

Question 8: I was able to contact my caseworker when I needed to during business hours

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Agree	221	82.5%	126	91.3%	347	85.5%
Mostly agree	30	11.2%	8	5.8%	38	9.4%
Not an issue	12	4.5%	4	2.9%	16	3.9%
Mostly disagree	3	1.1%		0.0%	3	0.7%
Disagree	2	0.7%		0.0%	2	0.5%
Total	268	100.0%	138	100.0%	406	100.0%

Question 9: The service supported me through legal processes (e.g. exclusion orders, family court, property settlement) related to domestic and family violence

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Agree	179	66.8%	83	60.1%	262	64.5%
Not an issue	64	23.9%	40	29.0%	104	25.6%
Mostly agree	20	7.5%	10	7.2%	30	7.4%
Disagree	3	1.1%	2	1.4%	5	1.2%
Blank	1	0.4%	2	1.4%	3	0.7%
Mostly disagree	1	0.4%	1	0.7%	2	0.5%
Total	268	100.0%	138	100.0%	406	100.0%

Question 10: Because of the assistance I received I feel safer

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Agree	203	75.7%	121	87.7%	324	79.8%
Mostly agree	44	16.4%	10	7.2%	54	13.3%
Not an issue	13	4.9%	5	3.6%	18	4.4%
Mostly disagree	4	1.5%	1	0.7%	5	1.2%
Blank	3	1.1%	1	0.7%	4	1.0%
Disagree	1	0.4%		0.0%	1	0.2%
Total	268	100.0%	138	100.0%	406	100.0%

Question 11: Because of the service I feel my children are safer

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Agree	171	63.8%	100	72.5%	271	66.7%
Not an issue	53	19.8%	28	20.3%	81	20.0%
Mostly agree	38	14.2%	8	5.8%	46	11.3%
Mostly disagree	3	1.1%	1	0.7%	4	1.0%
Blank	2	0.7%	1	0.7%	3	0.7%
Disagree	1	0.4%		0.0%	1	0.2%
Total	268	100.0%	138	100.0%	406	100.0%

Question 12: I am happy with the service I have received

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Agree	231	86.2%	125	90.6%	356	87.7%
Mostly agree	32	11.9%	10	7.2%	42	10.3%
Not an issue	3	1.1%	3	2.2%	6	1.5%
Blank	2	0.7%		0.0%	2	0.5%
Total	268	100.0%	138	100.0%	406	100.0%

Question 13: Are you living in safe long-term accommodation?

Response	2015-16		2016-17		Total	
	Clients	%	Clients	%	Clients	%
Yes	214	79.9%	121	87.7%	335	82.5%
No	48	17.9%	16	11.6%	64	15.8%
Blank	6	2.2%	1	0.7%	7	1.7%
Total	268	100.0%	138	100.0%	406	100.0%

Client survey questions 14 to 21 relate to client profile aspects rather than program assessment and satisfaction.

12 Appendix C – SAM locations and launch dates

It is important to note that workers were not able to choose an option for SAM involvement as it was not provided in the Portal. This combined with some SAMs not being operational at the same time across all areas may have resulted in under-reporting of SAMs as a possible response.

SAM launch date	Site location
September 2014	Orange
	Waverley
June 2015	Bankstown
	Broken Hill
	Parramatta
	Tweed Heads
November 2016	Blacktown
	Broken Hill (expanded intake area)
	Coffs Harbour
	Deniliquin
	Far South Coast
	Mt Druitt
	Newcastle
	Newtown
	Nowra
	Taree
	Wagga Wagga
	Wollongong
	Wyong
March 2017	Bourke
	Campbelltown
	Griffith
	Hunter Valley
	Lismore
	Northern Beaches
	Parramatta (expanded intake area)
	Queanbeyan
	St George
	Tamworth

SAM launch date	Site location
September 2017	Albury
	Armidale
	Dubbo
	Illawarra
	Liverpool
	Penrith
	Port Macquarie
March 2018 (announced only)	Bathurst
	Blue Mountains
	Burwood
	Gosford
	Goulburn
	Moree
	Sutherland
	Toronto
	Walgett

Source: FACS

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