UNSW SYDNEY

Gendered Violence Research Network

Staying Home Leaving Violence Evaluation

Final Report

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Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ANROWS	Australia's National Research Organisation for Women's Safety
CIMS	Client Information Management System
DCJ	Department of Communities and Justice
DFV	Domestic and Family Violence
DVSAT	Domestic Violence Safety and Assessment Tool
GVRN	Gendered Violence Research Network
IPV	Intimate Partner Violence
KWSITH	Keeping Women Safe In Their Homes
LCP	Local Coordination Point
LGA	Local Government Area
ORS	Outcome Rating Scale
SAH	Safe at Home
SAM	Safety Action Meeting
SHLV	Staying Home Leaving Violence
SHS	Specialist Homelessness Services
UNSW	University of New South Wales, Sydney
VS INSP	Victims Services Immediate Needs Support Package
WHO	World Health Organisation

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Glossary

Case Coordination

Case coordination in the Staying Home Leaving Violence program involves the provision of services to a client on multiple occasions, without the development of case plans or case management responsibility (Department of Communities and Justice, 2020).

Case Management

Staying Home Leaving Violence case management involves one worker as a key worker for a particular client. Case management incorporates direct client service, based on sound assessment and support planning, and coordination of access to, and delivery of, a range of other support services (Department of Communities and Justice, 2020).

Disability

According to the Australian Bureau of Statistics (ABS, 2016a), a person is considered to be living with disability if they have one or more limitation, restriction or impairment, which has lasted (or will last) for at least six months and which places restrictions on their everyday life. For example: physical, intellectual, and psychological disabilities; disabilities resulting from injury, stroke, traumatic brain injury; and sight, hearing and speech disabilities. There are varying degrees of disability, which range from having no or very little impairment or limitation, to a complete loss of functioning (Australian Institute of Health and Welfare (AIHW), 2019).

Domestic & Family Violence

It is acknowledged that there is no universal definition of 'domestic and family violence' (DFV). The term 'domestic and family violence' is used in this Report as an umbrella term under which 'family violence', 'domestic violence' and 'intimate partner violence' may fall. The distinctions between the subsequent terms account for the context of abuse or violent acts. In Australia, DFV is primarily a gender-based form of violence which affects women at higher rates.

The United Nations favours the term 'domestic abuse' to describe 'a pattern of behaviour in any relationship that is used to gain or maintain power and control over an intimate partner,' further expanding the victim-survivor category to include a child or other relative, or any other household member' (United Nations, 2020).

The Australian Bureau of Statistics (2018) defines DFV as covering a wide range of abusive behaviours, including:

- physical and sexual violence or abuse
- emotional and psychological abuse
- verbal abuse and intimidation
- economic abuse
- social deprivation and controlling behaviours
- damage to personal property
- abuse of power

Which occur in the following types of relationships:

- intimate partner relationships
- other family and co-habitation relationships
- carer relationships
- cultural and kinship relationships
- foster care relationships
- blood relatives who do not co-habit, such as elder abuse.

Intimate Partner Violence

Intimate partner violence (IPV) is amongst the most common forms of DFV and is disproportionately committed against women. IPV can take the form of violent or non-violent behaviours including physical, sexual and/or emotional abuse and controlling behaviours by an intimate partner or former intimate partner with the intention to intimidate, control or cause harm (World Health Organization (WHO), 2012). IPV is a narrower term than DFV.

Family Violence

Family violence is a broad term referring to violence against people within familial relationships, de facto or intimate relationships, co-habiting relationships, relationships through culture or religion, including kinship ties, and relationships of dependency such as those involving carers or financial or personal commitment. This can expand beyond IPV to include instances of child abuse, elder abuse, financial abuse, or other forms of abuse or neglect in a family context (ABS, 2009).

Family violence can be direct or indirect; for example, a child witnessing violence in the home is a form of indirect family violence and maltreatment. Family violence is often seen as the preferred term for violence committed by or against Aboriginal and/or Torres Strait Islander people as it accounts for the complexities of kinship and cultural relations.

Housing Stability

An implicit understanding of housing stability is that it is the antithesis of homelessness, and indicators of housing instability include challenges such as difficulty paying rent, overcrowding, frequent relocation, staying with relatives, or spending the majority of income on housing (Aubry, Klodawsky, & Coulombe, 2012; Frederick, Chwalek, Hughes, Karabanow, & Kidd, 2014). Housing instability is a risk factor for homelessness (Darab & Hartman, 2013); however, it is also often conceptualised as an extension of homelessness in the literature.

Older Women

The benchmark age for being considered an 'Older woman' varies considerably in the literature, with little consensus on the threshold of what being an 'older' adult is (McFerran, 2009). Some studies use 45+ years of age as an ageing benchmark (Carthy & Taylor, 2018; McGarry, Ali, & Hinchliff, 2017), the Australian Personal Safety Survey has used 55+ years (Cox, 2015), while others use 60-65+ years (e.g., Miszkurka, Steensma, & Phillips, 2016; Policastro & Finn, 2017; Poole & Rietschlin, 2012; Tetterton & Farnsworth, 2011; Wydall & Zerk, 2017). In this Evaluation Report, unless otherwise stated, 45 years and older has been adopted to define Older women.

Safety

Safety is a term which is widely used but frequently not defined or poorly defined in the literature. It can refer to a reduction or cessation of violence and abuse or threats of violence and abuse. However, safety can refer to more than being physically safe. 'Feeling' safe from violence or the threat of it (violence could be psychological, verbal, physical, sexual, reproductive control, social, financial, property damage, stalking, image based or technological abuse) is an important component of wellbeing and can be supported by a number of intervention strategies. Definitions of safety should encompass cultural safety, accessibility and non-discrimination for people who are more likely to experience discrimination and inequality in Australia.

Executive Summary

The Department of Communities and Justice (DCJ) commissioned researchers from the Gendered Violence Research Network (GVRN) at the University of New South Wales (UNSW Australia) to undertake a formal evaluation of the Staying Home Leaving Violence (SHLV) program. The focus of the evaluation was to examine the service delivery processes and outcomes of the SHLV program in New South Wales (NSW). The overarching aims of the evaluation were to measure the effectiveness of the SHLV program, measure the effectiveness of the personal duress alarm response system, and provide recommendations to improve both response elements.

The SHLV Program

The SHLV program is a specialised domestic and family violence (DFV) program in NSW that assists women and their children to stay safely in their own home or a home of their choice after leaving a violent relationship. The service delivery model is based on intensive casework, which is needs-based and long-term (Department of Communities and Justice, 2020). Limited brokerage is available to SHLV clients which specifically targets client safety by upgrading home security provisions (Breckenridge, Walden, & Flax, 2014). The SHLV program has two key outcomes goals (Department of Communities and Justice, 2020, p. 6):

1. clients are free from DFV in their own home and remain so over time; and
2. clients will experience long term stability in housing, income, education and healthy relationships.

Further, SHLV service providers aim to address barriers which commonly prevent women from leaving and/or remaining separated from their violent partner, including but not limited to addressing housing instability, financial insecurity and domestic violence awareness education. DCJ currently commissions organisations to deliver the SHLV program across 33 separate locations (Department of Communities and Justice, 2020).

Methodology

The SHLV Evaluation utilised a mixed-method inquiry, drawing on a range of data sources, methods and strategies, including analysis of monitoring and outcome data from services providing SHLV responses, and 58 interviews with stakeholders, service providers (managers and staff), and service users (clients). Quantitative data were collected across all 33 service locations and qualitative comment was provided by ten services providing SHLV responses, including the five new services funded since 2019. Research limitations are discussed in the methodology.

Key Findings

Data provided for this Evaluation shows that between 1 July 2019 and 30 June 2021, 7079 individuals were referred to the SHLV program for the first time. Detailed analysis was possible for 2201 unique case managed clients, who received an SHLV service within the study period (1 July 2019 to 30 June 2021). The dataset provided information on client demographic characteristics and the services they accessed, as well as an indication for some clients (n

=664) of wellbeing measured by the Outcome Rating Scale (ORS), and the number of service goals achieved. The remaining key results relate to case managed clients only.

Client characteristics

1. The average age of clients was 30 years old. Fewer than 20 per cent (16.8%) were 45 years or older.
2. Almost one in four clients identified as Aboriginal and/or Torres Strait Islander.
3. Most clients were born in Australia (81.5%) and were Australian citizens (82.4%).
4. Of clients for whom data were recorded and available, 18.1 per cent indicated that they had a disability or impairment.
5. Where clients provided data regarding sexual identity, the majority identified as heterosexual (97.9%).
6. Almost 60 per cent of clients were reported as experiencing socio-economic disadvantage.
7. Approximately one in two clients were categorised as experiencing social exclusion.
8. Most women were living in private rental accommodation or in their own home (53.7%) and a small number of women were homeless (6.1%) at service intake.

Service outcomes

1. The most common types of safety/security related services women received were individual safety plans (67.5%) and safety audits in the home (57.4%).
2. Only 7 per cent of clients were issued with personal duress alarms. Importantly, these clients were three times more likely to achieve their goal of enhanced safety than clients who did not receive a duress device.
3. Just under half (46.8%) of the clients received brokerage at their first referral. The average amount of brokerage received by clients was $998.13.
4. Overall, clients experienced significant improvements in their measured wellbeing scores (ORS) over time:
    i. 49.6% improvement in overall wellbeing
    ii. 56.8% improvement in individual wellbeing
    iii. 40.4% improvement in interpersonal wellbeing
    iv. 40.5% improvement in social wellbeing.
5. Client characteristics of citizenship status, disability status, level of socio-economic disadvantage or social exclusion, housing stability at service entry, and employment status appeared to be some of the strongest determinants of improved wellbeing at service exit.
6. When clients were asked whether they had achieved a specific service goal, the most significant results were: improved knowledge about dealing with DFV (68.5%), increased stability for children (66.6%), increased community engagement and access to support (65.9%), improved health for the victim and their children (61.2%), and improved parenting capacity/skills (54.3%). Just under half the clients with data available

indicated that they fully achieved their goal of improving the management of finances (45.8%).

7. Pre-existing demographic factors, specifically Aboriginal and/or Torres Strait Islander status, age, disability status, citizenship status, and level of socio-economic disadvantage, appeared to be some of the strongest determinants of whether different service goals were achieved. Most clients exited the SHLV program because they met all their goals or no longer needed additional assistance (64.6%).
8. At service exit, most SHLV clients had obtained sustained housing or accommodation (54.2%).

Comparison of new and existing services

1. Clients who were not Australian citizens (including but not limited to those from culturally and linguistically diverse communities) and clients who experienced socio-economic disadvantage were significantly *more* likely to attend a new service than an existing service.
2. Clients aged 45 years or older or clients with disability were significantly *more* likely to attend an existing service than a new service.
3. Clients who attended one of the new services were less likely to receive a safety audit in the home, to receive safety equipment and/or to receive a security upgrade, compared to clients who attended one of the existing services.
4. However, after controlling for demographic factors, clients attending one of the new services were *more* likely to receive a risk/lethality assessment and were *more* likely to receive a safety audit in the home, compared to clients who attended one of the existing services.
5. After controlling for demographic factors clients attending one of the new services were less likely to receive security upgrades, compared to clients who attended one of the existing services.
6. Improvement in social wellbeing (ORS) scores was significantly greater for those who attended one of the new services, compared to clients who attended one of the existing services.
7. Clients who attended a new service were less likely to achieve the goal of improving knowledge about DFV and were less likely to achieve the goal of sustained housing/accommodation, compared to clients who attended one of the existing services.
8. Clients who attended one of the new services were *more* likely to achieve the goal of regaining parental responsibilities, relative to clients in the existing services.
9. Importantly, a similar proportion of clients in the new (63.4%) and existing (65.5%) services exited the program because they met their case goals or no longer needed further assistance.
10. Approximately 20 per cent (22.8%) of clients across both new and existing services exited the program because they disengaged with the program or were lost to follow up.

Interviews with Clients and Service Providers

Overall, the SHLV program was regarded very highly by all interviewees. Service providers and stakeholders described SHLV as an integral component part of NSW's overall response to DFV.

Positive Outcomes Reported by Clients

1. All clients interviewed reported feeling safe or safer in the home as a result of the support provided.
2. Clients told us that without the housing and financial support they may not have been able to leave the relationship and live independently long-term.
3. Referrals to other supports and services were highly regarded by clients. Clients discussed referrals to counselling, legal aid, and court support.

Positive Program Elements

1. Service providers felt that the program is well-designed, has clear aims and embodies the stated strategic values in the provision of SHLV support.
2. Service providers emphasised that the program is effective in supporting clients from specific population groups. They said that case management is often more intensive for this cohort, noting that these clients face higher risk and more barriers to help-seeking, including fewer appropriate services available for their referral. Case co-ordination and interagency work were identified as effective methods of support.
3. Service providers discussed the importance of developing longstanding relationships with local services which can streamline referrals and benefit case coordination for clients who are being supported by multiple services. A strong relationship with local Police was identified as a key component to successful client outcomes. Some service providers and clients did, however, discuss difficulties with limited DFV knowledge and response from local Police. Clients who experienced a poor Police response told us that this was a fundamental barrier to their safety.
4. Numerous program strengths were shared across existing and new SHLV services, including the importance of a positive relationship between client and case worker, ongoing case management and specialised support, the provision of DFV awareness education, and flexible brokerage designed to meet the specific safety needs of each client.

Feedback on the Personal Duress Alarm Response

- Clients who received the personal duress alarm reported significant improvements to their sense of safety and comfort in the home and in the community.
- Service providers spoke highly of the personal duress alarm response. They emphasised that the new devices supplied by mCareWatch are more user-friendly and reliable than the previous devices.
- The eligibility requirement of a current protection order limits the security and safety of some women, including those who are unable to obtain an order, those who are waiting for the approval of an order, and women from some population groups (such as Aboriginal and Torres Strait Islander women) who do not wish to engage with the criminal justice system due to a lack of trust or prior negative experiences.
- Service providers told us that there are relatively few activations of the duress alarms in NSW. Therefore, there is no comprehensive data on deterrence or successful apprehension of the perpetrator. Service providers and clients discussed instances in which the device was successfully activated, and the perpetrator was apprehended by Police.

Challenges and Future Design Considerations

1. Staff reported difficulties finding affordable and accessible training programs to orient them to DFV service provision and the SHLV service delivery model, and to assist with their ongoing professional development. The lack of available training for staff resulted in some staff feeling unconfident in their role and forced to learn on the job.

2. Service providers described the funding strategy as ad hoc and inefficient, noting that a streamlined strategy for funding which integrates existing funding across the multiple programs would benefit the overall DFV response in NSW.
3. Services reported an overwhelming demand for support, which can make it difficult to provide intensive case management and keep up with new referrals. In some regional areas, the SHLV program is the only specialist DFV program available and therefore services feel a responsibility to work beyond capacity to meet community needs.
4. The ongoing housing crisis in NSW, particularly in regional areas, continues to affect the housing stability of women and families. Service providers have found that clients are unable to move on from crisis or transitional accommodation because there are no rental or government housing properties available, or they are unaffordable.
5. Services reported difficulty finding appropriate trauma-based counsellors for clients and children, particularly in regional areas.
6. Service providers found that it can be difficult to have the time and resourcing to support children through SHLV.

Taken together, the quantitative and qualitative data indicate that the SHLV program effectively contributes to the long-term safety and housing stability of women and families who have left a violent and abusive relationship.

The report makes 17 recommendations:

1. Consider improving data collection.
2. Consider how to streamline reporting requirements for SHLV workers.
3. Consider providing further training in use of CIMS for service providers, including the benefits of robust data collection for service planning.
4. Consider revision of SHLV entry criteria to ensure it is clear that SHLV services are provided to all women and children affected by DFV, not only those experiencing IPV.
5. Increase resourcing to ensure that staffing and brokerage requirements are both met, rather than one being prioritised over the other.
6. Strengthen brokerage by continuing to encourage flexible use of funds. This enables tailored and targeted practical support for victims. An increase in brokerage funds would similarly increase the potential effectiveness of brokerage.
7. Consider greater access and budget for staff training which encompasses both specialised DFV training and SHLV-specific training.
8. Ensure that decisions about resourcing of the SHLV program take into account the intensive work that is required in managing clients across numerous programs, and case coordinated clients.
9. Recognise children as clients in their own right and ensure all SHLV programs provide more formalised supports and program funding options for children.

10. Invest in further research to determine the effectiveness of SHLV for different populations, and identify and appreciate the factors which facilitate or hinder achieving service goals and the extent to which the service is effective for different cohorts.
11. Develop a formalised strategy for service integration to enable greater collaboration between services in NSW and between different SHLV auspice services.
12. Invest in local affordable housing and build opportunities for housing partnerships with SHLV providers, state government agencies, real estate agents, Specialist Homelessness Services, and the private sector.
13. Consider specific training for staff and clients to enhance their knowledge of and ability to use technology.
14. Consider SHLV-specific contractors for safety upgrades.
15. Consider removing the requirement for a protection order for a safety alarm to be issued.
16. Ensure security upgrades factor in the capacity and mobility of the client.
17. Create a formal agreement between the security monitoring company and the Police regarding the exchange of information.

Introduction

Staying Home Leaving Violence (SHLV) is a specialised New South Wales (NSW) based domestic and family violence (DFV) program designed to assist women and their children to stay safely in their own home or a home of their choice after leaving a violent relationship. The SHLV program is administered and funded by NSW Department of Communities and Justice (DCJ) and is implemented via a range of local service providers. It was piloted in three sites, and progressively rolled out across NSW following formal evaluation. Expansion of both the number of sites and the geographical coverage of current sites is ongoing.

The SHLV program contributes to multiple NSW and Australian Government policy strategic commitments. The *National Plan to Reduce Violence against Women and their Children 2010–2022 (*the *National Plan)* was produced in 2011 by the Council of Australian Governments. Ongoing expansion of the SHLV program aligns with National Outcome 4 of the *National Plan*, which aims to achieve an 'increase in the access to, and responsiveness of, services for victims of DFV and sexual assault.'

The *National Plan* identified the need to 'improve and expand cross-agency support for women and children to remain safely in their homes and communities while the perpetrator is removed' as a key first phase action for implementation during 2010–2013. In the Third Action Plan (2016–2020), National Priority Area 3, Action 3.3 recommends that accommodation options and supports for women and their children escaping violence be strengthened.

Recently, the SHLV program received additional funding through the Keeping Women Safe in Their Homes (KWISTH) grant program, an initiative under the Fourth Action Plan of the *National Plan*. KWISTH funding was designed to complement and strengthen existing safe at home responses offered in each jurisdiction.

In addition, the *NSW Homelessness Strategy 2018–2023* sets out the NSW Government's five-year plan for a comprehensive approach to prevent and improve the way that the NSW Government responds to homelessness. Included is Action 2.3, to provide choice and the right supports for people to address the issues putting them at risk of homelessness and to reduce repeat homelessness. Contributing to Action 2.3, in 2019, five new SHLV services (delivered in six locations) were funded under the *NSW Homelessness Strategy 2018–2023.* Recently, the 2021–22 NSW Budget provided funding to continue the new sites through to 2024–25.

DCJ currently commissions organisations to deliver the SHLV program across 33 locations in NSW which includes the five new services.

The SHLV Program

The Safe at Home (SAH) response in New South Wales is the SHLV program, which is a specialised DFV program designed to assist women and their children to stay safely in their own home or a home of their choice after leaving a violent relationship. The program is aimed at promoting victims'/survivors' housing stability, and preventing their homelessness (Department of Communities and Justice, 2020). The SHLV program is intended to operate in collaboration and coordination with existing services, and to complement existing services. The SHLV program has two key outcomes goals (Department of Communities and Justice, 2020, p. 6):

- clients are free from DFV in their own home and remain so over time, and
- clients will experience long term stability in housing, income, education and healthy relationships.

The target population for the SHLV program is women aged over 18 years (and their children) who have separated from a violent partner or family member and who choose to remain in their own home or a home of their choice. A priority target population with SHLV is women who have separated from a violence partner but continue to experience violence. In addition, priority is given to women who have a higher likelihood of experiencing DFV, or who may have greater difficulty accessing support, including:

- DFV victims from an Aboriginal and/or Torres Strait Islander background
- DFV victims affected by socio-economic disadvantage
- DFV victims from culturally and linguistically diverse backgrounds
- DFV victims affected by social exclusion
- DFV victims with disability
- DFV victims who are caring for a child with disability
- DFV victims aged 16–18 years old for referrals only.

A number of partner agencies participate in formal referral and/or case management agreements with SHLV. When referred, DFV victims take up the referral and choose to be SHLV program clients.

The SHLV program is evidence-based and the service delivery model is based on intensive casework, which is needs-based and long-term (Department of Communities and Justice, 2020). The provision of the SHLV program is non-time limited and delivers integrated service

provision with key professional partnerships including the Police, Women's Domestic Violence Court Advocacy Services, health services, Housing NSW and a range of non-government organisations (NGOs), to ensure the delivery of a flexible range of services to clients (Department of Communities and Justice, 2020). Limited brokerage is available to SHLV clients which specifically targets client safety by upgrading home security provisions (Breckenridge, Walden, & Flax, 2014).

SHLV Program activities include:

- individual lethality and comprehensive risk assessment and safety planning for clients
- security upgrades of the victim-survivor's home (using brokerage funding and personal duress alarm)
- the development of case plans to meet client needs
- casework and advocacy to address legal, financial, counselling, group work, tenancy, emergency relief and other support needs, including ensuring early links (via facilitated referral) to agencies that address these needs
- support and resourcing of clients at family court proceedings
- where necessary, court support and advocacy (in collaboration with the Women's Domestic Violence Court Advocacy Service) in relation to applications for Apprehended Domestic Violence Orders
- liaison and partnership with DCJ Housing, NSW Police and Women's Domestic Violence Court Advocacy Service (Department of Communities and Justice, 2020).

The SHLV program was developed as an outcome of the 2004 SHLV research project carried out by the Australian Domestic and Family Violence Clearinghouse and the Centre for Gender-Related Violence from UNSW (now known as the Gendered Violence Research Network) (Edwards, 2004).

Following positive indicators from the evaluation of three pilot programs between 2004 and 2009 (in Bega, South East Sydney & Blacktown/Mt Druitt), which were developed from the recommendations in the SHLV Research Report (Prenzler & Fardell, 2017), the NSW government has funded the progressive rollout of SHLV across NSW. In 2011, the NSW Department of Family and Community Services (now DCJ) engaged the Centre for Gender Related Violence Studies from UNSW to develop an Evaluation Framework for the SHLV program. The framework was designed to enable evaluation that would:

- strengthen the SHLV service model by documenting good practice across all SHLV services
- strengthen the focus on key results and enable improved management of the SHLV Program
- document and analyse service partnerships and the integrated nature of the SHLV service model, and
- assess the value and critical elements for success of the integrated approach taken by SHLV.

In 2014, based on the *Staying Home Leaving Violence Evaluation Framework,* UNSW conducted an independent evaluation of the SHLV program in NSW (Breckenridge et al., 2014). At that time

SHLV was provided by 18 services across 22 separate locations. Using 12 months of data collection from 2012 to 2013, the 2014 Evaluation findings provided evidence of the effectiveness of the six main elements of the SHLV program:

1. Service flexibility, which may vary in intensity and duration according to clients' individual circumstances
2. A basis in early intervention and prevention principles
3. An innovative response to homelessness
4. A concentration on legal protection and home security to enable women and children to remain safely at home
5. A focus on local partnerships with other key agencies
6. Access to an SOS Response System Alarm to improve DFV victim/survivors' sense of safety.

The 2014 Evaluation (Breckenridge et al., 2014) examined client exit survey data and interview and survey group data with clients and service providers, and found:

- the SHLV program was successful in achieving housing stability for women and children affected by DFV (93.3% of respondents reported they were living in a home they believed was safe over the long-term; 52.5% were still living in their home; and of those who moved, 84.7% said they had chosen to move), and
- the SHLV program increased the feelings of safety for women and their children who engaged in the program (87% felt safer at home than when they entered the program and 83% said their children were safer).

In 2017, the GVRN was commissioned by the Department of Social Services to conduct a National Audit of SAH responses. This included an evaluation of the SHLV program (currently under embargo), with data collected between 2014 and 2018 by 23 providers. The Audit found again that the SHLV program effectively contributes to the safety of women over time and to the housing stability of women involved in the program.

Since the 2014 SHLV Evaluation and the 2017 SAH National Audit, additional funding from the NSW Government (including under the NSW Homelessness Strategy 2018–2023) has expanded the provision of SHLV across NSW. DCJ currently commissions organisations to deliver the SHLV program across 33 separate locations (Department of Communities and Justice, 2020).

The SHLV Evaluation

Commencing in June 2021, researchers from the Gendered Violence Research Network (GVRN) at the University of New South Wales (UNSW Australia) were engaged by DCJ to undertake a formal evaluation of SHLV. This involved an evaluation of the service delivery processes and outcomes of all 33 SHLV project locations delivering the SHLV program, to build the evidence base of what works well in SHLV service delivery processes and outcomes in NSW. This Report provides recommendations where improvements could be made and identifies where gaps are occurring in service provision. These recommendations will be considered and will inform the future direction of the SHLV program.

More specifically, this Report will comprehensively address six related research/evaluation questions detailed further in the methodology section, with reference to: SHLV project monitoring data; measures of client wellbeing; and interviews undertaken with clients, SHLV workers and key stakeholders.

A snapshot of the evidence and the ways in which the SHLV program has developed from the evidence base is provided in the next section. This review provides the foundation for the presentation of evaluation findings.

The SHLV evaluation findings will be structured around the stated goals of the evaluation, which are to:

1. **Measure the effectiveness of the SHLV program.**
2. **Measure the effectiveness of the personal duress alarm response system.**
3. **Make recommendations to improve both the delivery of the SHLV program and the implementation of the personal duress alarm response system.**

In addition, the current Evaluation is a commitment under the *NSW Homelessness Strategy 2018-2023* and is aligned with the evaluation of the *NSW Homelessness Strategy 2018-2023 Framework*. In line with this, the five new services (in six locations) were separately evaluated in comparison to the more established SHLV services.

2. SHLV and the Current Evidence Base

DFV and Homelessness

Data from the 2016 National Personal Safety Survey (ABS, 2017c) indicate that since the age of 15, approximately one in six Australian women (17%) and one in 16 men (6.1%) have experienced physical or sexual violence from a current or previously cohabiting partner. Further, approximately one in four women (23%) and one in six men (16%) have experienced emotional abuse from a current or previous partner. Evidence demonstrates that experiences of domestic and family violence (DFV) contribute to a range of physical and mental health consequences, as well as a break down in social networks, outcomes that may endure long after the abuse ends (E. N. Adams et al., 2021).

DFV is recognised as a major contributing factor to homelessness and housing instability or insecurity, particularly for women and children (Daoud et al., 2016; Dichter, Wagner, Borrero, Broyles, & Montgomery, 2017; Flanagan, Blunden, valentine, & Henriette, 2019; Kaspiew et al., 2017; Klein, Chesworth, Howland-Myers, Rizo, & Macy, 2021; Martz, Romero, & Anderson, 2020; Patterson, 2020; Spinney, Blandy, & Hulse, 2013). The 2016 ABS Personal Safety Survey revealed that more than 50 per cent of women who left a violent relationship reported that they, not their partner left the home they shared (ABS, 2017c). DFV is the main reason women and their children leave their homes, and women who experience DFV are at a higher risk of homelessness, housing stress, and financial insecurity (Tually, Faulkner, Cutler, & Slatter, 2008).

Housing is recognised as critical for victim/survivors to achieve long-term stability (Gezinski & Gonzalez-Pons, 2021). Victim/survivors who experience homelessness or housing instability may be more vulnerable to retaliation from the perpetrator (Klein et al., 2021). Studies examining women's experiences of DFV have shown that a key reason why many women stay in or return to DFV relationships is the lack of safe, independent and affordable accommodation (Blagg et al., 2018; Breckenridge, Chung, Spinney, & Zufferey, 2016; Flanagan et al., 2019; Horn, 1992; Morley, 2000). Therefore, housing plays a significant role in maintaining the safety of women and their children.

It is estimated that 8.5 to 11.7 per cent of the Australian population aged 15 years and over are at risk of homelessness (Batterham, Nygaard, Reynolds, & de Vries, 2021). Those who are at risk of homelessness are more likely to be female, Indigenous, and/or living in a single person household. Further, they are more likely to experience poor health, to be low-income, unemployed, and to have lower levels of education when compared to the national population (Batterham et al., 2021).

In Australia, there is no official definition of homelessness risk (Batterham et al., 2021). Batterham (2019) considers a person at risk of homelessness if they are living in rental housing and experience at least two of the following: low-income; vulnerability to discrimination; low social resources and supports; need for support to access or maintain a living situation; and a tight housing market context. It is also the case that definitions of homelessness do not always encompass women experiencing 'housed homelessness,' because their home is unsafe (Tually et al., 2008; valentine & Breckenridge, 2016). Many women who require homelessness services do have a home; they are just not able to live in it because of the violence they experience from their partner (Breckenridge et al., 2016; valentine & Breckenridge, 2016).

There are several ways in which homelessness is defined, and definitions of homelessness are at times contested (Zufferey & Chung, 2015). However, most definitions of homelessness incorporate rough sleeping and emergency, temporary or transitional accommodation for those who would otherwise not have shelter (Edgar, Edgar, Doherty, & Meert, 2004; Henry et al., 2016; Kaleveld, Seivwright, Box, Callis, & Flatau, 2018).

In the Australian homelessness sector, a cultural definition of homelessness has been widely adopted (Kaleveld et al., 2018), in which homelessness is regarded as residing in a non-shelter or in accommodation that would be considered below minimum acceptable community standards.

Homelessness is further categorised (Chamberlain, 1999) as:

- Primary homelessness, where individuals are without conventional accommodation, and are living in improvising dwellings (e.g., garages, sheds, cabins) or sleeping rough (e.g., on the streets, in parks, in a car).
- Secondary homelessness, where individuals are moving from one form of temporary accommodation to another, such as such as staying with friends and relatives, and/or accessing homelessness services (e.g., emergency and transitional accommodation or short-term boarding).
- Tertiary homelessness, where individuals are living in boarding houses on a medium to long-term basis (13+ weeks).

In 2011, the ABS revised its definition of homelessness to incorporate elements associated with broader cultural interpretations of *home*, such as a sense of security, stability, privacy, safety and control over living space (ABS, 2012). A lack of one or more of these elements that represent *home* constitutes homelessness under the current ABS definition of homelessness:

> **When a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement: is in a dwelling that is inadequate; or has no tenure, or if their initial tenure is short and not extendable; or does not allow them to have control of and access to space for social relations. (ABS, 2012)**

In Australia, the Specialist Homelessness Services (SHS) Collection (SHSC), managed by the Australian Institute of Health and Welfare (AIHW), collects data nationwide about people who are experiencing homelessness or who are at risk of experiencing homelessness and are receiving support from SHS. The definition of homelessness used by SHSC aligns with the cultural definition of primary and secondary homelessness (AIHW, 2016).

Under the SHSC, a person is defined as homeless if they are living in: non-conventional accommodation (e.g., living on the streets, sleeping in parks, squatting, staying in cars or railway carriages, living in improvised dwellings, living in the long grass) or *sleeping rough* or in short-term or emergency accommodation (e.g., refuges, crisis shelters, couch surfing, living temporarily with friends and relatives, insecure accommodation on a short-term basis, or emergency accommodation arranged by a support service) (AIHW, 2016; Kaleveld et al., 2018).

In addition, homelessness is associated with a lack of social relationships, reduced privacy and security, poor emotional and physical well-being, and reduced independence (Mayock, Bretherton, & Baptista, 2016).

Women Affected by DFV Who Use Homelessness Services

Three quarters of women and children living in homelessness accommodation report that DFV is their reason for requiring these services (AIHW, 2018). In 2020-21, 42 per cent of clients that received assistance from SHS had experienced DFV (AIHW, 2021). Of these, 90 per cent were women. More than one-third (39%) of all clients who had experienced DFV presented to SHS experiencing homelessness, while 63 per cent were at risk of homelessness.

Further, the 2020-21 SHS data showed that although Aboriginal and/or Torres Strait Islander people make up 3.1 per cent of the Australian population (ABS, 2019), 28 per cent of the clients (an estimated 73,300 clients) assisted by SHS identified as Aboriginal and/or Torres Strait Islander (AIHW, 2021). Further, almost two in five (37%) Aboriginal and/or Torres Strait Islander SHS clients had experienced DFV.

Importantly, requests for housing assistance are not always able to be met because accommodation is not readily available. The 2020-21 SHS data showed that, although close to 61 per cent (n = 67,400) of clients who needed short-term or emergency accommodation (n =111,100) were provided with assistance, of clients who requested long-term accommodation (n = 109,200), only 3.4 per cent (n = 3700) were provided with assistance (AIHW, 2021). This highlights the substantial unmet need for long-term stable accommodation encountered by SHS clients.

SHS have also indicated that the demand that is placed on DFV services can lead to premature case closure for clients. As a result, former clients of DFV services then access SHS when they can no longer sustain the financial contribution to their housing (Patterson, 2020).

Contexts of Risk Contributing to Homelessness Among DFV Victim/Survivors

There is no single pathway to homelessness for victim/survivors of DFV (Tually et al., 2008); however, there are contexts of risk that have been identified which contribute to homelessness and housing insecurity.

Australian research has found that there are major financial barriers for women leaving violent relationships (Breckenridge et al., 2016). When leaving DFV relationships, finding and/or maintaining safe, available and affordable accommodation post separation was identified as the biggest concern for many women (Braaf & Barrett-Meyering, 2011). For women leaving a violent relationship, this often means leaving their home, relocating and finding new accommodation, re-establishing their family, and providing for and furnishing their new home, which can place strain on financial resources (Bell & Kober, 2008; Burnham, 2018).

Accessing affordable accommodation can be difficult for women who have experienced DFV. Experiences of DFV often result in victim/survivors having a poor rental history, which can be due to perpetrators intentionally limiting their victim's ability to leave them (Bomsta & Sullivan, 2018). Further, perpetrators of DFV may destroy property, cause disruptions that lead to evictions, or fail to pay rent. Neighbour complaints can lead to poor references and multiple

moves can make victim/survivors appear to be unreliable tenants (Bomsta & Sullivan, 2018; Martin & Stern, 2004).

Further, women may experience ongoing DFV in the form of financial abuse in an attempt to control and limit their independence, whereby perpetrators wilfully ruin the financial stability of their partners (Bomsta & Sullivan, 2018). Financial abuse can include withholding financial support, stealing savings, interfering with a woman's ability to get a job and to earn money, preventing access to funds or destroying property (E. N. Adams et al., 2021). Women who experience financial abuse may have poor employment histories and limited financial resources, which make them less attractive to potential landlords (Bomsta & Sullivan, 2018)

Women are often not able to remain in their homes due to financial abuse experienced during their relationships and financial insecurity after leaving DFV relationships. Hooker, Kaspiew, and Taft (2016) reported that financial abuse escalates or occurs for the first time after separation. This includes ex-partners refusing women access to finances or misuse of money. Such experiences may mean that a woman is unable to afford to remain in her home (mortgage repayments or rent) as a single person (Breckenridge et al., 2016).

Housing affordability in particular affects how long women can remain in their own house once they leave a DFV relationship (Spinney et al., 2013). If a partner leaves the home, victims/survivors can experience increasing financial burden and stress, particularly those who are not in well paid employment (ANROWS, 2019). Some victim/survivors who remain in their own home experience ongoing housing vulnerability for years following separation from a violent relationship (Cortis & Bullen, 2016).

Obtaining stable employment can also be a challenge for DFV victim/survivors. Job instability plays a mediating role in the relationship between DFV and homelessness and housing insecurity, which can last for several years following the end of a violent relationship (A. E. Adams, Tolman, Bybee, Sullivan, & Kennedy, 2012; Klein et al., 2021).

Supporting the enhancement of victim/survivors' choices and options as they seek greater housing security is key in empowering survivors after they have experienced DFV (Goodman et al., 2016). This may include interventions that incorporate a focus on improving financial empowerment, self-sufficiency and self-efficacy among DFV victim/survivors (Klein et al., 2021).

Safe at Home Responses

Community-based initiatives have long played a major role in responding to DFV and supporting victim/survivors of violence in Australia. Traditional models of support have included crisis responses, such as women's refuges for women and their children to seek alternative accommodation (Burnham, 2018). Refuges have been an important specialist service option for many women experiencing and escaping DFV, particularly for those without independent income and/or alternative accommodation options. While this type of crisis accommodation option is the most well-known DFV housing model in Australia, and remains important for many, it is not an option that suits everyone, nor is there capacity in the system for all women and children escaping DFV to be accommodated in this way (Breckenridge et al., 2014; Diemer, Humphreys, & Crinall, 2017; Martz et al., 2020).

When women and children move out of their home and into crisis accommodation, significant disruptions are likely to be caused to their lives. Being removed from their family home may cause vulnerable women and children to become disconnected from supportive relationships, community connections, and the routines of everyday life, including work or education. It can be difficult for women to access affordable and appropriate housing options when trying to exit crisis accommodation (Spinney, 2012; valentine & Breckenridge, 2016). Further, choosing to leave the home (into crisis accommodation or otherwise) to escape a DFV relationship can bring with it practical difficulties, including a lack of appropriate housing, transience and a lack of stability, loss of belongings, difficulty maintaining employment, poverty, disrupted social life and isolation from supportive social networks (Hartwig, 2016). In these circumstances, many women may have no choice but to return to their home and to their DFV relationship, where they are likely to face continued violence.

Many women, however, wish to remain with their children in their home and to remain connected to their existing social networks, extended family, employment and their children's school (Breckenridge et al., 2016). Whilst crisis accommodation and transitional housing will continue to be a necessary part of service response to DFV for many women and their children (Tually et al., 2008), a broader range of services and support options needs to be available to those affected by DFV. As a result, international and Australian governments have been implementing policy measures that are designed to expand the range of support options available to women experiencing DFV (Diemer et al., 2017; Spinney, 2012; Tually et al., 2008). This has included placing emphasis on the option of women choosing to remain safely in their home, while removing the abusive partner from the home. These are broadly known as 'safe at home' (SAH) responses. SAH responses emerged in the 1990s to provide an important option to support victim/survivors of violence to remain in the family home or a home of their choice while the perpetrator is excluded (Spinney & Blandy, 2011).

SAH responses are broadly defined as[1]:

> **Interventions, strategies, or programs that aim to support women and children to remain safely in their home or home of their choice, community or community of their choice where it is safe to do so.**

Securing safety for a woman and her children to remain in her own home or a home of her choice is essential to stabilising their housing options when leaving a DFV relationship. Doing so helps to maintain community, social, employment, and education networks (Hartwig, 2016). SAH responses do not and are not intended to replace the need for refuge and SHS. Instead, they are one option in a suite of interventions that women may choose from according to their circumstances.

The provision of SAH responses to women and children who have left a violent and abusive relationship has been evident in Australia and several other countries for nearly two decades as an alternative to refuge and SHS or supported accommodation. SAH responses may also be a more appropriate response for Aboriginal and Torres Strait Islander women who are wanting to remain connected to their family and land, and for women who are from culturally and linguistically diverse backgrounds who wish to remain within their community networks (Diemer

[1] This definition of SAH was discussed and agreed upon by the Safe At Home Operational Framework working group, which included representatives from all states and territories including NSW.

et al., 2017; Edwards, 2004; Murray, 2008). They may also be more appropriate for Older women experiencing DFV who wish to remain in their own home, and who are not suitable for refuge accommodation.

Philosophical Underpinnings of Safe at Home Responses

SAH responses challenge the greater entitlement of men to their home, particularly men who use violence. Instead of asking, 'Why doesn't she leave?', SAH asks 'Why doesn't the violence leave?' (Hartwig, 2016). SAH responses have been premised on two core beliefs:

1. Perpetrators should be held accountable for their violence.
2. There is an historical injustice in the expectation that women should be forced to leave their home or community to leave the violence.

SAH practitioners are supported by a shared philosophical understanding of the drivers, impacts and effects of domestic and family violence, and the best ways to provide safety to clients, including:[2]

- **Human rights:** Domestic and family violence is a violation of human rights, and the Australian Human Rights Commission (n.d) outlines a number of principles informing a rights-based approach that can be applied to SAH responses.
- **Gender equality**: Gender inequalities are an underlying driver for gendered violence, which is an expression of power and control over individuals or groups because of their gender. SAH responses recognise women and children are disproportionately affected by gendered violence.
- **Social justice:** Experiences of domestic and family violence can be compounded by inequitable systems and services, resulting in continuing disadvantage. SAH responses challenge the socially unjust expectation that women and children should leave a home or a community because of perpetrator violence.
- **Strengths-based**: The opportunity for individuals to be co-producers of services and support, rather than solely consumers of those services, is promoted.

The strategy of SAH responses is that it is the victim/survivor, not the perpetrator, who should be entitled to stay in their home, or a home of their choice, should they choose to. By providing women with a choice to remain safely in their home or a home of their choice, such responses ensure that women are less financially disadvantaged (Burnham, 2018). Further, SAH responses provide an effective way of minimising and avoiding the social and economic consequences of escaping DFV, such as homelessness, disconnection from social support networks, unemployment, and disruptions to education (Edwards, 2004; Murray, 2002; Tually et al., 2008).

[2] The four philosophical underpinnings of SAH and the four pillars of SAH responses were discussed and agreed upon by the Safe At Home Operational Framework working group, which included representatives from all states and territories including NSW.

The Pillars of Australian Safe at Home Approaches

Each state and territory currently has a SAH response (see Appendix A), which addresses some or all of the conceptual pillars identified in the 2016 meta-Evaluation of SAH Responses.

The conceptual development of the four pillars of SAH responses was updated as part of the National Audit.[3] These pillars are:

1. **A focus on maximising women's safety** – using a combination of criminal justice responses and technology options such as protection orders and legal provisions to exclude the perpetrator from the home, both of which protect victim/survivors from post-separation violence, proactive policing to support women and children, safety/duress alarms, CCTV for home security and other home security upgrades, and personal technology advice and security sweeps. Safety planning and consistent risk assessment must be a central feature of SAH responses. Working alongside perpetrator interventions as part of a holistic response can support victim/survivor safety.

2. **A coordinated or integrated response** – involving partnerships between local services to best address an individual client's needs. This may include, but are not limited to, referral for counselling, medical and health care, services for children, court support and police response to perpetrators. Strong service coordination is required to properly address the needs of children and different population groups.

3. **Safe at Home as a homelessness prevention strategy** – ensuring women are informed about their housing options before the time of crisis and at separation and providing support for women to maintain their housing afterwards or seek alternative accommodation of their choice in the community of their choice. These programs are housing focused but are not housing constrained.

4. **Enhancing women's economic security** – including assistance to maintain or enter employment or further study and increase financial literacy. Financial management strategies and advice may allow women and their children to remain independent and separate from the perpetrator. The use of brokerage funds to enhance financial security is also important.

How SHLV Addresses the Four Pillars

In previous studies (Breckenridge, Walden & Flax, 2014; Breckenridge et al., 2016), SHLV has been shown to directly address each of the four pillars, which were derived from a comprehensive review of the evidence base. The following discussion includes reference to the current evidence base and the specific ways in which SHLV addresses each of the pillars.

SHLV Focuses on Maximising Women's Safety

To maximise women's safety, SAH responses include risk assessment, safety planning, and the provision of safety upgrades and technology options, and take into consideration women's DFV violence risks and their needs over time.

The management of women's risk and safety within SHLV includes careful safety planning, the implementation of safety modifications, the provision of safety upgrades within a

victim/survivor's home and the provision of technology, including personal duress alarm devices. In the process of safety planning, strategies used previously by victim/survivors to respond to DFV are examined, and new strategies are introduced that maximise the victim/survivor's safety and protection in the event of further violence (Department of Communities and Justice, 2020). Increasingly technology options and home safety upgrades are a core component of SAH responses as outlined in the next section.

The Domestic Violence Safety Assessment Tool (DVSAT) is used by SHLV services in an ongoing way to assess the level of threat posed by the perpetrator to the victim/survivor. It is to be used for case coordinated and case managed SHLV clients (Department of Communities and Justice, 2020). The use of DVSAT is intended to ensure that SHLV partners have a common language for understanding the level of risk for a client.

Technology Contributing to Safety

There are a number of personal safety alarm schemes that have been introduced in Australia and internationally for women experiencing DFV (Breckenridge et al., 2014), for example:

- Victoria – SafeTCard and Bsafe (the Bsafe scheme is no longer operating)
- Queensland – SafeTCard and technology trials
- United States and Holland – ADT Abused Women's Active Response Emergency (AWARE) system
- Canada – ADT Domestic Violence Emergency Response System (DVERS – similar to the AWARE system)
- UK, Spain, Hungary, Italy, Portugal – TecSOS
- Argentina – panic button (scheme name not known).

The intended purpose of personal safety alarm schemes for DFV varies between programs and jurisdictions. They include: the provision of support and protection to victim/survivors of DFV so that they may remain in their own home or a home of their own choice (Breckenridge et al., 2014); deterring breaches of or enforcing compliance with restraining orders (Paterson & Clamp, 2014); and facilitating the detection and apprehension of DFV perpetrators (Römkens, 2006).

Existing evidence indicates that the use of personal or fixed home safety alarms increases feelings of safety. Using outcome measures, the evaluation of the SOS alarm used by the SHLV program clients in NSW found that women reported a greater sense of safety and experienced an increase in hopefulness and a decrease in fear. However, as the women were also receiving the SHLV program concurrently, it was not possible to attribute the changes solely to the alarm (Breckenridge et al., 2014).

The findings from the SHLV 2014 evaluation have been mirrored in more recent research. Queensland Keeping Women Safe in Their Homes technology trial which began in Cairns, Ipswich, Rockhampton and Caboolture in 2016 was part of the Commonwealth Government funded Women's Safety Package. A recent evaluation (Gendera, Jops, Broady, valentine, & Breckenridge, 2019) found that women who were issued a personal duress alarm reported improvements in their sense of safety over the 6-month evaluation period. Further, mothers reported that the personal duress alarm had increased their child's safety.

SHLV Provides a Coordinated and Integrated Approach to Service Delivery

The evidence suggests that, to have their needs met when leaving a DFV relationship, women require a coordinated approach facilitated by interagency collaboration and partnerships. From its establishment, the SHLV Program has been premised on the importance of partnerships where government and non-government services coordinate their efforts and work in collaboration to ensure the most effective outcomes for clients (Breckenridge et al., 2014). Key partnerships include those with the Police, Courts and NSW Women's Domestic Violence Court Advocacy Services, health services, Housing NSW and relevant NGOs (Department of Communities and Justice, 2020).

Each SHLV project develops key partnerships with agencies in its local geographic area, signing a Memorandum of Understanding (MOU) with each partner to guide how they will work collaboratively together in supporting SHLV clients. Each SHLV project has a governance body such as an advisory or steering committee that has authority over key decision-making involving resources, strategic planning and review (Department of Communities and Justice, 2020). Advisory group meetings are held to guide the development of each SHLV local project and facilitate ongoing collaborative work between the partners (Breckenridge et al., 2014). In addition, Safety Action Meetings (SAMs) and the Local Coordination Point (LCP) for referrals are all part of the NSW government's integrated response plan to address DFV, and the SHLV services are involved in these activities and are considered to be part of the integrated service system.

SHLV is Oriented as a Homelessness Prevention Strategy

SAH responses may be oriented as homelessness prevention strategies, providing an alternative to Specialist Homelessness Services. The SHLV program is housing focused but it is not housing constrained (Breckenridge et al., 2014). SHLV is aimed at promoting housing stability for victim/survivors and contributes to preventing homelessness as a result of DFV by allowing women to remain in their home or a home of their choice (Department of Communities and Justice, 2020). In the Evaluation of the SHLV program, Breckenridge et al. (2014) reported that the program was successful in achieving housing stability for women and their children, and increasing feelings of safety for those who engaged in the program.

The SHLV program aims to address the barriers that prevent women from leaving and/or remaining separated from their violent partner including:

- facilitating access to and maintaining stable and affordable accommodation
- establishing or maintaining support networks
- maintaining security in employment/training for women
- maintaining security in education/childcare for their children (Breckenridge et al., 2014; Department of Communities and Justice, 2020).

SHLV Addresses Economic Insecurity

Enhancing women's economic security is increasingly recognised as an important component of any response to DFV (valentine & Breckenridge, 2016). Strategies to enhance women's economic security include referrals for financial counselling, advocacy with financial

institutions and assistance to facilitate women's retraining or further education or assisting women to return to the workforce (Breckenridge et al., 2016).

The SHLV program supports the economic security of clients. Under the SHLV program, women receive support and information regarding their options for maintaining their income and increasing the likelihood of financially maintaining their housing (Department of Communities and Justice, 2020).

To support the economic security of clients, many SHLV services offer referrals for clients to financial planning or financial counselling services, and advocacy to sustain income benefit levels from Centrelink. Support to build economic capacity is also provided by helping clients commence or remain in education or employment.

3. Evaluation Scope and Methodology

Methods and research design

The current Evaluation is a pre-post design which uses non-experimental data and a mixed-method inquiry, involving a synthesis of the quantitative service monitoring and outcomes data, and qualitative interviews with stakeholders, service providers (managers and staff) and service users (clients):

- across all 33 service locations,
- with a specific focus on the five newly funded services under the Homelessness Strategy, and
- a costing analysis has also been conducted to provide an average cost per client for the SHLV program over both 2019-20 and 2020-21 (provided as a separate document).

Ethics approval for the research was granted by UNSW Human Research Ethics Committee (HC210586) with data collected from August to November 2021.

Research Goals & Evaluation Questions

The overarching aims of the Evaluation are to:

Measure the effectiveness of the SHLV program.

Measure the effectiveness of the personal duress alarm response system.

Make recommendations to improve both the delivery of the SHLV program and the implementation of the personal duress alarm response system.

To address these aims, we examine the following research questions:

1. **Does the SHLV program enable women and children to remain free from DFV in a home of their choice, over time?**
    a) Does the SHLV program assist clients to maintain safe and stable accommodation of their choice?
    b) Does the SHLV program increase the wellbeing of women and their children who use the program?
    c) Does the SHLV program ensure open access to all families (including priority population groups)?
2. **What are the critical success factors in achieving positive client outcomes? What are the barriers to achieving positive outcomes?**
    a) Do women issued with a personal duress alarm (who are also in the SHLV program) report feeling safer after the issue of the device?
    b) Do police report the personal duress alarm system acts as a deterrent to repeat breaches and further incidents of serious harm to clients?
    c) Does the SHLV program assist clients to maintain control of their finances?

3. **What are the implications for the future design and delivery of DFV services?**
4. **What are the costs of delivering SHLV, and what proportion of funding is available for direct service delivery?**
5. **What were the service system outcomes, and what enabled them to occur?**
    a) Does the SHLV program facilitate an integrated and effective partnership response to intervention?
    b) Does the SHLV program utilise different components of service delivery, at what proportions and with what success?
    c) Does the SHLV program make referrals to other services and for what and how long?
6. **What strengths and challenges are shared between all SHLV services? What key differences are experienced by newer and older SHLV services?**

Data Collection

The Evaluation team analysed both quantitative data from a range of sources, and qualitative data and costings collected by the Evaluation team during fieldwork, including participants from across the SHLV project locations and key stakeholders from various sectors.

Collection of Quantitative Data

We received quantitative data from the following sources:

- Administrative data collected from service providers from the Client Information Management System (CIMS). This included data on client demographics at service entry, referral sources, brokerage data, client outcomes at service exit (safety and housing security) and client survey (goals at service exit)[3] data.[4]
- A formally validated and internationally accepted client outcome tool called the Outcome Rating Scale or ORS (Miller, Duncan, Brown, Sparks, & Claud, 2003) administered to SHLV clients to measure wellbeing at service entry and exit and at times of critical incident, if appropriate. Only case managed clients are required to fill out the ORS scale. There are three versions of the survey (Department of Communities and Justice, 2020):
    1. Adult ORS
    2. Child ORS
    3. Young child ORS.
- A copy of SHLV service program budgets and KPIs for 2019-20 and 2020-21.
- A summary of personal duress alarm monitoring data.

[3] The client surveys are hard copy surveys that service providers give to case managed clients to complete. They are an important part of the data collection process because they capture how clients feel about the support they have received and their outcomes.

[4] The CIMS data also includes: referral outcomes, education and training sessions, and case studies in the note section; however this could not be extracted from CIMS so it could not be used for the current Evaluation.

Analysis of Quantitative Data

Data Cleaning and Sampling

The SHLV Incoming Referral List contained data for 8887 referrals into the SHLV program which constituted 7383 clients[5] from 1 July 2019 to 30 June 2021.

Unless otherwise specified, data for analysis was limited to clients who:

- had not been referred to the SHLV program prior to 1 July 2019,
- had data recorded for at least one service goal, and
- were case managed.[6]

This resulted in 7079 unique individuals referred to SHLV for the first time from 1 July 2019 to 30 June 2021. Data was also limited to the first referral[7] during the data collection period that resulted in a case management plan. This ensured that only first-time clients were observed, resulting in a final sample of n = 2201 unique clients. This process is outlined in Figure 1.

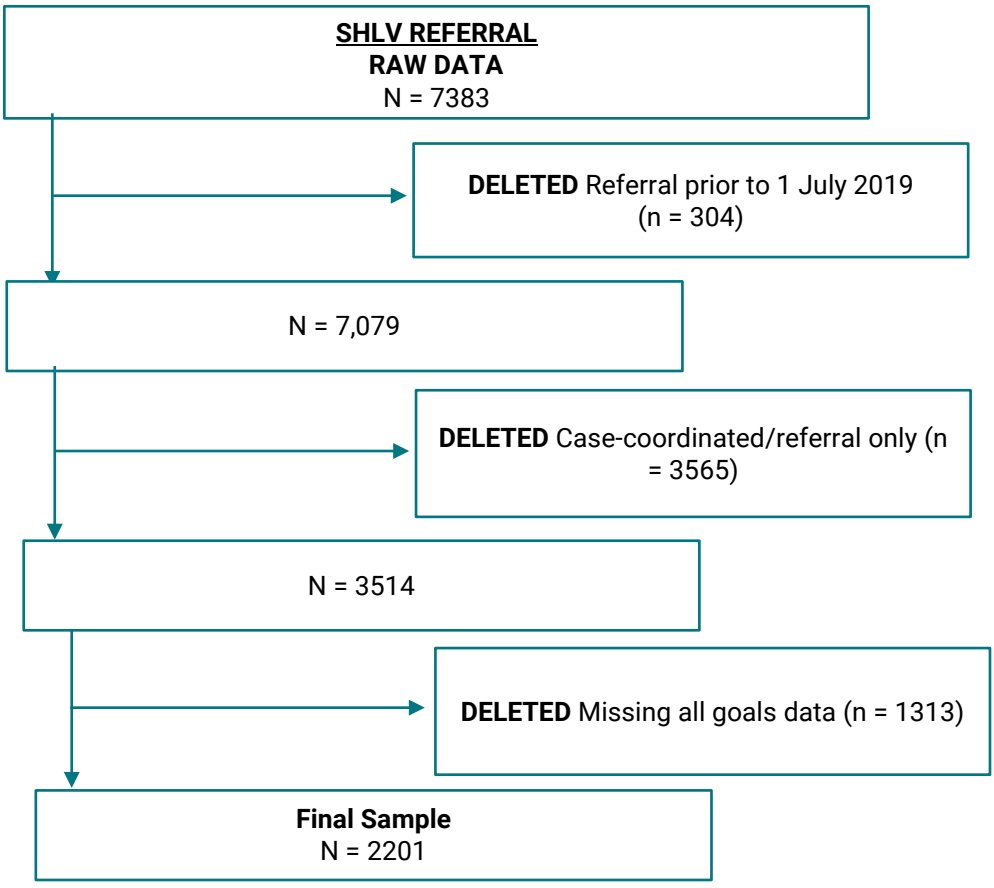

Figure 1. Reduction process for SHLV program incoming referral list data

[5] Some clients were referred to SHLV multiple times during the observation period. For example, someone could have been referred in early 2020 and again in early 2021.

[6] Case coordinated client data was excluded as there was a large amount of missing demographic and service data for case coordinated clients. It is our interpretation that there may be a process in the service delivery chain that limits the amount of data obtained from the case coordinated clients. However, case managed clients had the most complete data. Where data was missing, it was missing at random. In other words, data completeness for case managed clients was good.

[7] Focusing on first time clients precludes the potential impact of prior exposure to service.

The ORS dataset contained data for 2909 clients and 4881 corresponding ORS intake and exit surveys from 1 May 2019 to 21 October 2021. Data included in the analysis was limited to clients with surveys completed from 1 July 2019 to 30 June 2021. Child survey data was also removed because unique child IDs that differentiated them from their parents or siblings were not provided. In other words, children shared the same ID as their parent, making it impossible to differentiate between siblings, or to link the correct child to the SHLV Incoming Referral List data set.

Finally, only clients who completed the ORS at service intake *and* exit were retained. This ensured that within-individual improvements could be assessed over the time the client was case managed. The final sample consisted of n = 664 unique clients. The sample reduction process is outlined below in Figure 2.

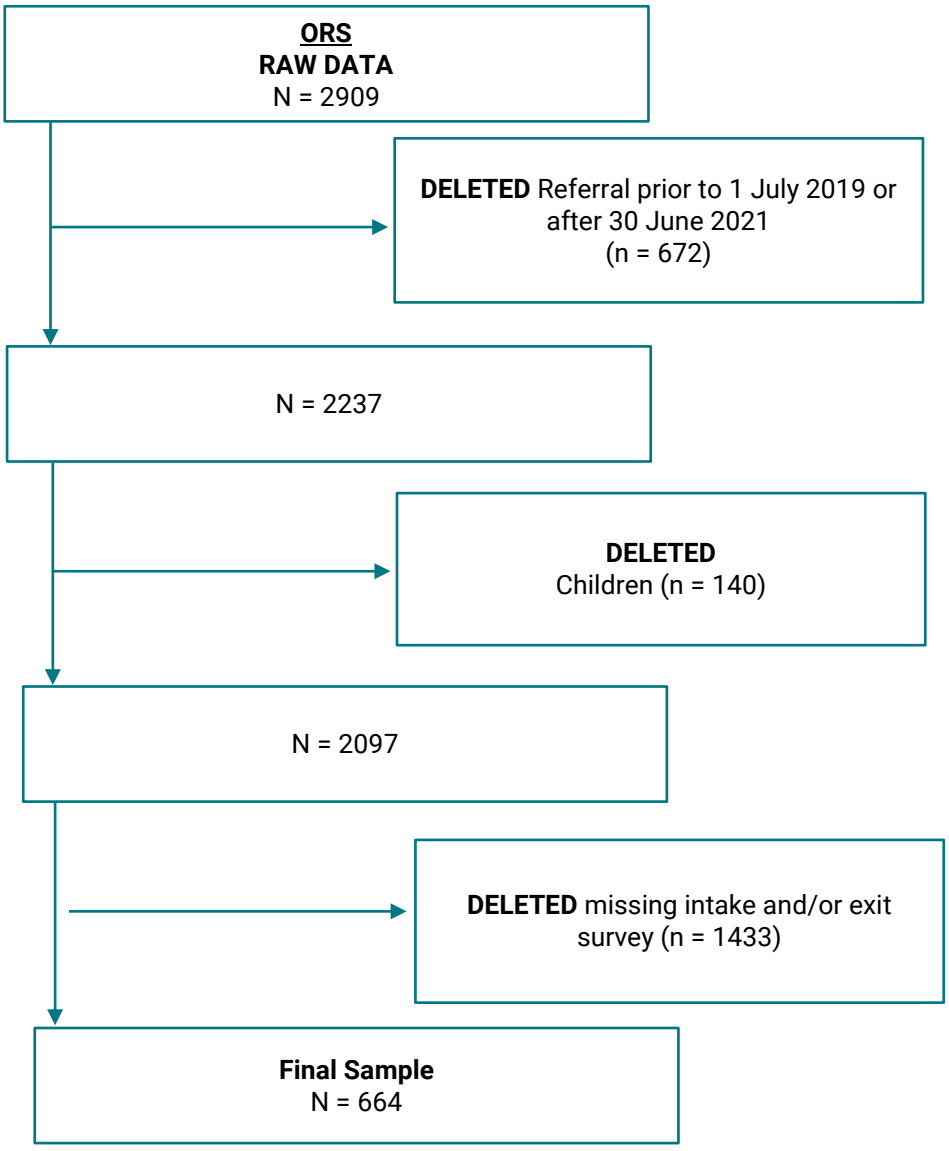

Figure 2. Sample reduction process for ORS data

Data Analysis

Descriptive statistics were generated from the data to analyse client demographic characteristics. Cross comparisons were conducted to identify significant differences between clients for key outcomes, and multivariate logistic regression analyses to test the effect of

different factors (such as client characteristics) on outcomes. More specifically, binary and multinomial logistic regression analyses were conducted to calculate Odds Ratios (OR) and corresponding 95% Confidence Intervals (CI).

All quantitative analyses report OR as the measure of the magnitude of the association between the independent and dependent variables. OR compare the relative odds or likelihood of the occurrence of an outcome after exposure to an intervention, and in this report odds ratios compare the occurrence of outcomes between client groups. An OR greater than 1 means that the outcome is more likely to occur in the focal group than in the comparison group, whereas an OR less than 1 means that the outcome is less likely to occur in the focal group. An OR of 1 means that both groups have an equal likelihood of the outcome.

Statistical significance was determined using 95% CI. An OR is statistically significant if the 95% CI does not overlap 1. This is generally interpreted to mean that the association between variables is unlikely to be due to chance alone. 95% CIs that overlap 1 are not considered to be statistically significant; there is unlikely to be a meaningful association between the variables, and any difference is likely due to chance. Statistical significance was also identified via *p values*, which represent the probability that differences between groups are due to chance. P values less than 0.05 are considered statistically significant. While p values indicate the probability of a meaningful significant difference, 95% CI provide more detailed information about the direction and range of the effect size.

Collection of Qualitative Data

The research team conducted interviews with a total of 58 individuals, including stakeholders (n = 6), service providers (n = 22) and clients (n = 30) who are currently or (in the case of clients) had previously been involved with the SHLV program. Interviews were undertaken in two tranches. In the first tranche, 27 interviews were conducted, face-to-face and over the phone, across five existing service sites (referred to as 'existing services'). These interviews were undertaken in late 2019 and early 2020 for the Safe at Home National Audit and Operational Framework (unpublished), and included stakeholders who held senior roles in relevant stakeholder organisations (n = 2), service providers (managers and staff) who had delivered the response (n = 8) and clients who had been engaged with the SHLV program (n = 17).

In late 2021, a second tranche of interviews was undertaken with the five new services funded in 2019, subsequent to the first round of interviews (referred to as 'new services'). The research team conducted semi-structured interviews over the phone with clients (n = 13) who had been engaged with the program, managers and staff (n = 14) who had delivered the response and stakeholders (n = 4) who held senior roles in relevant stakeholder organisations.

Client Interviews

Service providers (managers and staff) at each auspice agency recruited clients for interviews. Service providers were asked to select clients with a diversity of experience and from a range of population groups. Client availability and interest were strong factors. Clients were briefed by service providers and, with permission, their contact details were provided to the research team. For existing services, a researcher attended the service centre to conduct face-to-face interviews with clients. Some clients requested a telephone interview, in which case a researcher contacted the client and scheduled a time for the telephone interview. For new services, all interviews were conducted over the phone; some clients elected to have their case

worker present during the interview. All clients provided informed consent to be interviewed. Interview questions for clients focused on their:

- experiences of the SAH response(s), and whether it/they met their immediate and longer-term needs
- perceived safety and security following their engagement with the SAH response and specialised case management
- perceptions of the factors, contexts and SAH response elements which allow them to stay safely in their own homes or in the home of their choice (including devices, housing upgrades, safety planning and case management).

Of the 30 client interview participants, all clients identified as female, three women identified as Aboriginal and/or Torres Strait Islander and four women were from a CALD background. Twenty-four of the 30 clients, including those who had exited the program, were in secure long-term housing. The remaining six clients who were not in secure housing were planning to relocate and were continuing to receive case management support around housing and relocation.

Staff and Stakeholder Interviews

The research team conducted individual and group phone interviews with 22 managers and staff who deliver the SHLV program through a specialist domestic and family violence service agency and six stakeholders who hold senior roles in stakeholder organisations which deliver or fund SAH responses in NSW. Staff contact details were passed on to the research team with prior permission to be contacted. Interviews with service providers (managers and staff) focussed on program implementation, housing stability, safety and security, client outcomes, and the effectiveness of SHLV for clients from diverse backgrounds or with complex needs.

Analysis of Qualitative Data

All interviews were recorded and professionally transcribed. The transcripts were then imported into the qualitative data software NVivo to ensure effective management of data during the coding process. Thematic analysis was utilised to analyse data from the semi-structured interviews, because it allowed for results to emerge inductively, resulting in themes that were closely related to the raw data rather than preconceived theories or ideas (Patton, 2002). Thematic analysis is commonly used to analyse qualitative data by identifying and reporting key themes based exclusively on the information provided by participants, independent of any specific theoretical perspectives (Braun & Clarke, 2006). A coding framework was built through emerging themes and categories. Extracts from client and staff interviews are presented in this Report to illustrate participant experiences and knowledge of the SHLV program.

Research Limitations

There are a number of issues with the data collection system and data recorded by services that have affected the UNSW team's ability to provide a comprehensive response to the evaluation questions posed.

The integrity of the quantitative data may be affected because a significant amount of the quantitative monitoring data from CIMS were missing (not collected) for clients regarding characteristics/demographics, circumstances at program entry and achievement of client

service goals[8]. In addition, although data regarding date of entry into the SHLV program was recorded for all clients, client program end-date was inconsistently recorded for all clients. Missing data can lead to a loss of statistical power and can increase bias in the estimation of parameters. In other words, significant relationships may not be detected when they in fact exist.

Although the CIMS data provided an indication of whether clients had a risk assessment, the DVSAT scores were not available to the research team. This limits the analysis of client safety at program entry and exit.

Referrals provided to clients are recorded within CIMS in a format that meant this data was not able to be made available to the evaluation team, meaning that we were unable to use quantitative data to examine the research question 'does SHLV program makes referrals to other services and for what and how long?' This also means it is difficult to map the integrated service system.

The qualitative data collected from clients cannot be taken as representative of all women's experience of the SHLV program due to the small sample size and recruitment through convenience sampling.

It is also important to recognise that a substantial number of SHLV clients were case coordinated but not case managed. Case coordinated client data was excluded from the analysis because of missing demographic and service data (that is, there was an inconsistency in data recorded for case coordinated clients). Further, the SHLV program does not require case coordinated clients to complete the ORS wellbeing scale, nor do they administer client surveys (which capture how the client feels about the support they received and their goal outcomes) to case coordinated clients. This restricted our ability to examine case coordinated client outcomes. Findings are therefore not representative of the broader program.

The research team recognises that SHLV service providers have recently transitioned to using CIMS for recording client information and data. This may explain a portion of missing/inconsistent data. Should the Department be interested in comparing data from this evaluation with previous evaluations, this would not be possible as some data collected through CIMS is different to that collected through the previous portal.

In addition, only clients who completed the ORS at service intake and exit were retained for analysis. As described earlier, this ensured that within-individual improvements could be assessed over time. However, 1433 clients had missing ORS data (either at intake or exit) and were therefore excluded from analysis. There may be certain factors that contribute to a lack of ORS data for clients. For example, clients who have less successful program outcomes or who disengage from the program, may be less likely to complete an exit survey. This could bias the ORS findings and should be considered when reading this Report.

In addition, data was not provided or was incorrectly formatted for six existing services and one new service and could not be linked and analysed for this Evaluation.

Analysis of the effectiveness of personal duress alarms was very limited. From 2012 to 2019, an SOS alarm device (the AT Protector) and security monitoring service were provided to SHLV

[8] It is our assumption the case managed clients work with their case manager to identify case goals, from a list established by SHLV. We assume that each client/case manager identifies which of the goals the client aims to achieve during their time in the program.

clients under contract by Central Monitoring Services (CMS). However, during the evaluation period (in January 2020), iStaySafe (Iss) became the previous provider of personal duress alarms for the SHLV program, with security monitoring provided by Iss partner Security Monitoring Centres (SMC) (Designing Out Crime Research Centre & University of Technology Sydney, 2021). The current provider is mCare Digital. In the 2014 SHLV Evaluation (Breckenridge et al., 2014), clients were administered an SOS Response System questionnaire (using a hope and fear questionnaire) to establish clients' sense of safety before and after the use of an SOS device. The fear and hopefulness scale administered to women issued with a personal safety device was only available for the previous personal safety device provider. It is anticipated this data will continue to be collected with the new personal safety device provider. Given the recency of change of provider, no data for the fear and hopefulness scale were available for this Evaluation.

4. Findings

The results of the Evaluation present an analysis of outcome and monitoring data, followed by the themes that emerged in the analysis of qualitative interview data. The aggregate findings across all SHLV services are provided first and are followed by a separate examination of the five new services funded under the NSW Homelessness Strategy 2018–2023.

SHLV Client Characteristics

Number of clients serviced

There were 7079 unique individuals referred to SHLV for the first time from 1 July 2019 to 30 June 2021. A very small proportion of these individuals had multiple referral sources[9] and/or referral outcomes[10] at their first referral to SHLV (n = 277, 3.9%).

Figure 3 below presents the proportion of clients referred from each of the respective services. The greatest proportion of individuals were referred from Women's Domestic Violence Court Advocacy Service (n = 1794, 25.3%), followed by self-referral (n = 1106, 15.6%), other source of referral (n = 859, 12.1%), Family and Community Services (n =594, 8.4%), internal referral (n = 530, 7.5%), and local coordination point (n = 466, 6.6%).

[9] Clients who had multiple referral sources were referred to SHLV by more than one service/agency.

[10] Outcomes refers to the outcome at referral into the SHLV program. More specifically, whether a referral into the SHLV program resulted in a client being case managed, case coordinated, referral out/information, or no service provision.

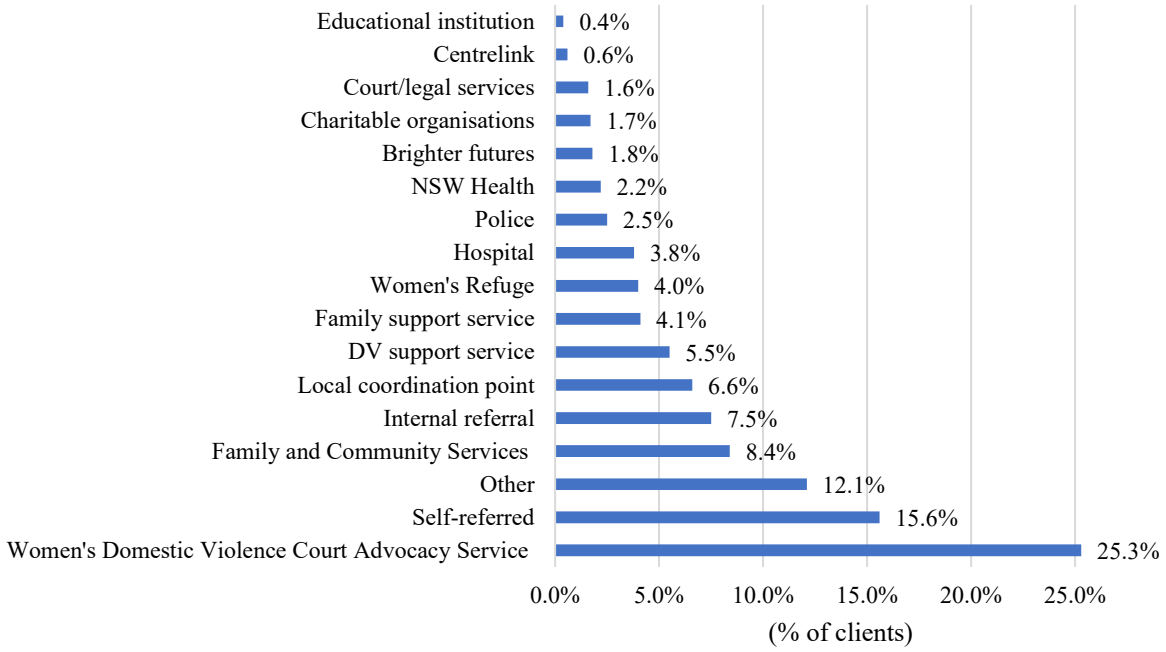

Figure 3. Proportion of individuals referred to SHLV from various sources[11]

The lowest proportion of individuals were referred from educational institutions (n = 30, 0.4%), followed by Centrelink (n = 45, 0.6%), court and/or legal services (n = 112, 1.6%), charitable organisations (n = 123, 1.7%), Brighter Futures (n = 127, 1.8%), and NSW Health (n = 153, 2.2%).

Figure 4 presents the service offered to each individual referred (referral outcome) to SHLV (n = 7079). The referral outcome for the majority of clients was a case management plan (n = 3549, 50.1%), while around a quarter of clients received a case coordinated plan (n = 1901, 26.9%). Almost one in six individuals referred to SHLV received information and/or referral only (n = 1190, 16.8%), and one in ten received no SHLV services (n = 663, 9.4%).

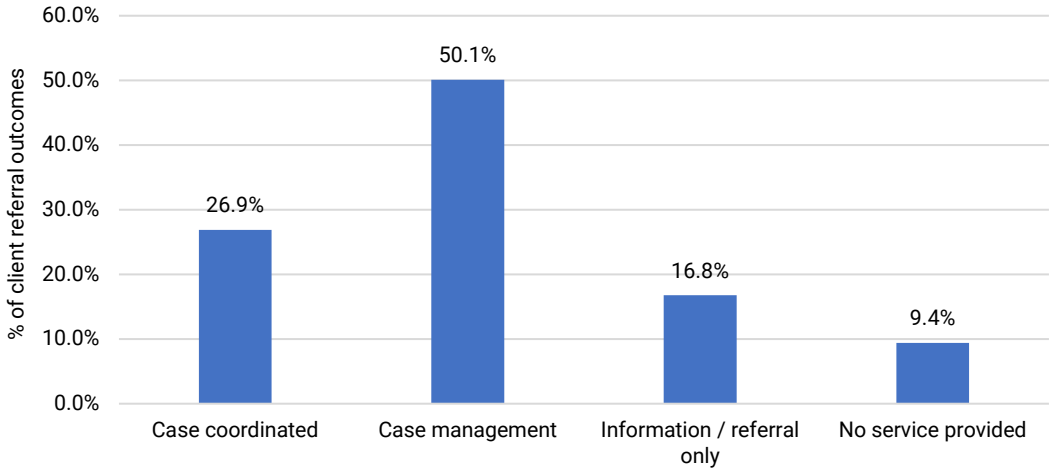

Figure 4. Proportion of referral outcomes[12]

[11] A small proportion of clients had multiple referral sources, which results in the total in Figure 3 being greater than 100%.

[12] A number of clients had more than one referral outcome (this results in the total Figure 4 percentages being greater than 100%).

Client demographic characteristics

There were 2201 unique clients (in the derived sample) who received a SHLV service between 1 July 2019 and 30 June 2021. The key demographic characteristics of these SHLV clients in this two-year period are presented below in Table 1.

- Most clients were women (89.2%);[13] there were 16 adult male clients included in the dataset. It is unclear from the data provided what the circumstances were that led to 16 adult males being included as clients. However, it is important to note that these are rare exceptions, as SHLV is a program specific to women and their children.
- The average age of clients was 30.1 years. Approximately 17 per cent of clients (16.8%) were aged 45 years or older. This is much lower than the proportion of people (41.2%) in the NSW population aged 45 years or older (ABS, 2017a).
- Almost one in four (24.0%) clients identified as Aboriginal and/or Torres Strait Islander. This is much higher than the proportion of Aboriginal and/or Torres Strait Islander people in NSW (2.9%; ABS, 2016b) and reflects the higher rates of DFV experienced within Indigenous communities.
- The majority of clients were born in Australia (81.5%).
- Most clients only spoke English at home (88.1%).
- The majority of clients were Australian citizens (82.4%).
- More than 50 per cent of clients had experienced socio-economic disadvantage[14] (57.0%). Data was missing for almost 20 per cent (17.9%) of clients. This should be considered when findings relating to socio-economic disadvantage are described in this Report.
- More than 50 percent of clients were affected by social exclusion (51.0%)[15]. Data was missing for approximately 20 per cent (19.5%) of clients. This should be considered when findings relating to social exclusion are described in this Report.
- Where clients provided data, the majority identified as heterosexual (97.9%). Data was missing for approximately 50 per cent of clients.
- For clients where data were recorded and available, 18.1 per cent indicated that they have a disability or impairment. This is similar to the proportion of the NSW population that have disability (16.9%; ABS, 2019). Data relating to disability was missing for 41.3 per cent of clients. This should be considered when interpreting all findings in this Report relating to clients with disability.

[13] The majority of male clients were children of SHLV clients, with 93.2 per cent of males (n = 218) in the sample under the age of 18 years (compared to 11.1% of females).

[14] The CIMS data set did not provide a definition of socio-economic disadvantage.

[15] The CIMS data set did not provide a definition of social exclusion.

Table 1. Descriptive statistics for SHLV clients with intake between 1 July 2019 and 30 June 2021 (n = 2201)[16]

		n (%) / m (sd)
Sex		
Female		1964 (89.2%)
Male[17]		234 (10.6%)
	missing	*3 (0.1%)*
Age		
Younger than 45 years of age		1819 (82.6%)
45 years of age or older		370 (16.8%)
Mean age		*30.12 (15.32)*
	missing	*12 (0.5%)*
Sexual identity		
Heterosexual		1081 (49.1%)
Non-Heterosexual		23 (1.0%)
	missing	*1097 (50.2%)*
Aboriginal and/or Torres Strait Islander		
Yes		529 (24.0%)[18]
No		1573 (71.5%)
	missing	*99 (4.5%)*
Continent of birth		
Australia		1793 (81.5%)
Asia		129 (5.9%)
Oceania (excluding Australia)		31 (1.4%)
Africa		21 (1.0%)
Europe		34 (1.5%)
North and South America		18 (0.8%)
	missing	*175 (8.0%)*
Language spoken at home		
English		1938 (88.1%)
Language other than English		263 (11.9%)
Migrant status		

[16] Due to rounding, percentages may not always appear to add up to 100%.

[17] The majority of male clients were the children of SHLV clients, with 93.2 per cent of males (n = 218) in the sample under the age of 18 years.

[18] Regarding adult clients, 16.7% (n = 2) of males and 22.6% (n = 379) of females identified as Aboriginal and/or Torres Strait Islander, respectively.

Australian citizen		1814 (82.4%)
Permanent resident		166 (7.5%)
Temporary resident		47 (2.1%)
	missing	*174 (7.9%)*
Client disability		
Yes		234 (10.6%)
No		1057 (48.0%)
	missing	*910 (41.3%)*
Client socio-economic disadvantage		
Yes		1255 (57.0%)
No		551 (25.0%)
	missing	*395 (17.9%)*
Client affected by social exclusion		
Yes		1122 (51.0%)
No		650 (29.5%)
	missing	*429 (19.5%)*

The SHLV program gives priority to women who may have a higher likelihood of experiencing ongoing DFV, or who are members of a particular client group who may find it more difficult to access support (Department of Communities and Justice, 2020). Therefore, cross comparisons based on demographic factors were conducted to identify significant differences and to better understand the characteristics of priority SHLV clients and client groups (see Appendix B for detailed description of findings).

Characteristics of Older clients (n = 370)

Figure 5 shows the results of comparing client demographic factors by client age. Of all clients aged 45 years or older with available data:

- 15.7 per cent identified as Aboriginal and/or Torres Strait Islander
- 13.4 per cent did not identify as Australian citizens
- 9.5 per cent spoke a language other than English at home
- 27.0 per cent had disability
- 57.3 per cent experienced socio-economic disadvantage
- 56.0 per cent experienced social exclusion.

Binary logistic regression analyses indicated that, compared to younger clients, clients who were aged 45 years or older were (only statistically significant [$p<.05$] findings are reported; see Appendix B for detailed analysis):

- two times (2.0) *less* likely to identify as Aboriginal and/or Torres Strait Islander
- almost one and a half (1.41) times *more* likely to not be an Australian citizen

- almost two (1.96) times *more* likely to have disability
- almost two (1.96) times *less* likely to experience socio-economic disadvantage and
- one and a half (1.45) times *less* likely to be affected by social exclusion.

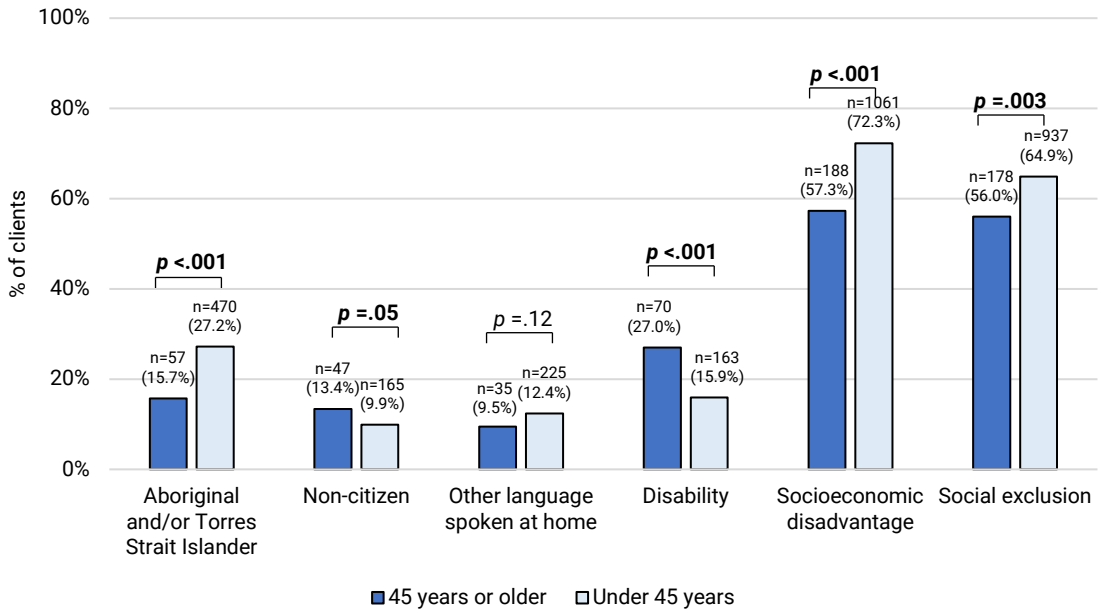

Figure 5. Differences in the proportion of client demographic factors by client age

Characteristics of Aboriginal and/or Torres Strait Islander clients (n = 529)

Figure 6 presents Aboriginal and/or Torres Strait Islander identity. Of all clients who identified as Aboriginal and/or Torres Strait Islander:

- 10.8 per cent were 45 years or older
- 1.2 per cent identified as not being Australian citizens
- 5.7 per cent spoke a language other than English at home
- 21.9 per cent lived with disability
- 86.3 per cent experienced socio-economic disadvantage
- 77.1 per cent experienced social exclusion.

A series of binary logistic regression analyses indicated that, compared to clients who did not identify as Aboriginal and/or Torres Strait Islander, clients who identified as Aboriginal and/or Torres Strait Islander were (only statistically significant [$p<.05$] findings are reported; see Appendix B for detailed description of findings):

- two (2.0) times *less* likely to be 45 years or older
- approximately thirteen and a half (13.33) times *less* likely to not be an Australian citizen
- two times (2.04) *less* likely to speak a language other than English at home
- more than three and a half (3.61) times *more* likely to experience socio-economic disadvantage

- more than twice (2.37) *more* likely to be affected by social exclusion.

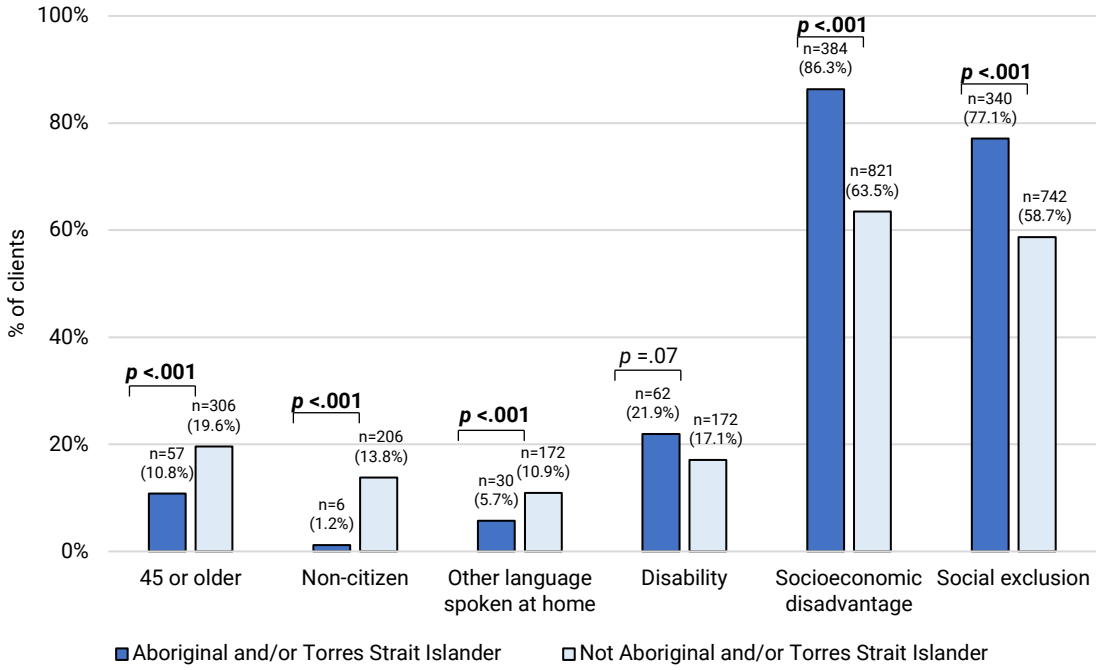

Figure 6. Differences in the proportion of client demographic characteristic by Aboriginal and/or Torres Strait Islander identity

Characteristics of clients with disability (n = 234)

Figure 7 presents the cross comparisons by client disability status. Of all clients with disability (where data was recorded and available):

- 26.5 per cent identified as Aboriginal and/or Torres Strait Islander
- 70 per cent were younger than 45 years
- more than 90 per cent were Australian citizens
- more than 90 per cent did not speak a language other than English at home
- 76.7 per cent experienced socio-economic disadvantage
- 74.9 per cent experienced social exclusion.

Compared to clients without disability, clients with disability were (only statistically significant [p<.05] findings are reported; see Appendix B for detailed description of findings):[19]

- approximately two (1.96) times *more* likely to be over the age of 45 years
- almost two (1.88) times *less* likely to not be an Australian-citizen
- two times (2.04) *more* likely to experience socio-economic disadvantage
- more than two (2.29) times *more* likely to be affected by social exclusion.

[19] Data was missing regarding disability for more than 40% of clients. It should be noted that missing data can lead to a loss of statistical power and can increase bias in the estimation of parameters. Significant associations may not be detected where they exist.

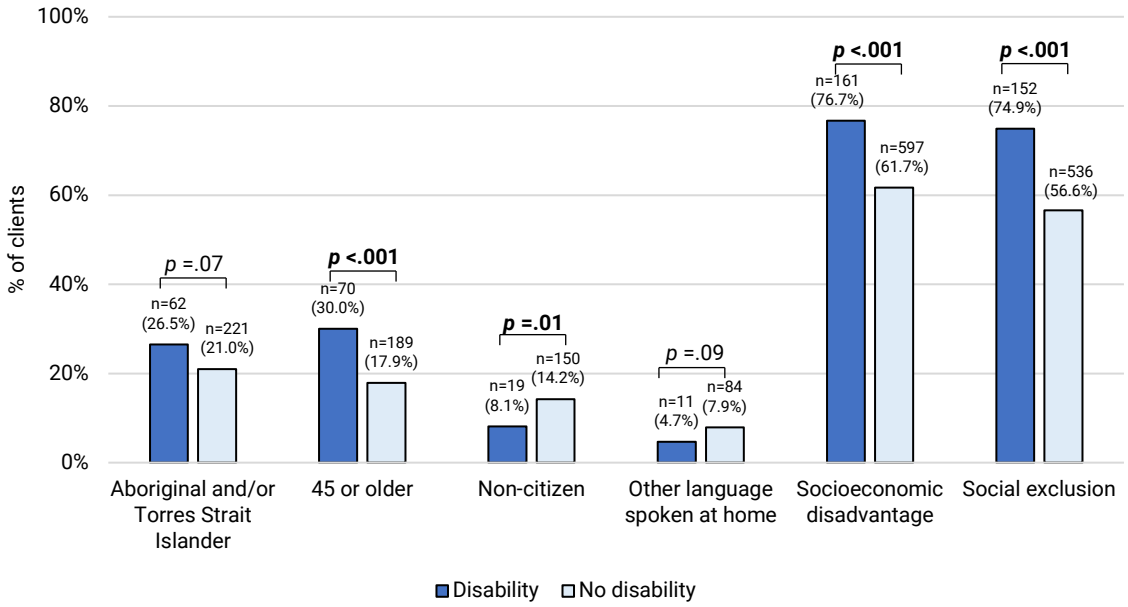

Figure 7. Differences in the proportion of client demographic characteristics by disability status

Characteristics of clients experiencing socio-economic disadvantage (n = 1255)

Figure 8 presents the cross comparisons by client socio-economic disadvantage status (see Appendix B for detailed description of findings). As shown in Figure 8, of all clients who experienced socio-economic disadvantage:

- 31.9 per cent identified as Aboriginal and/or Torres Strait Islander
- 15.1 per cent were 45 years or older
- 9.3 per cent were not Australian citizens
- 10 per cent spoke a language other than English at home
- 21.2 per cent had disability
- 83.5 per cent experienced social exclusion.

Binary logistic regression analysis revealed that younger clients, clients with disability, and/or clients who are impacted by social exclusion are significantly (statistically) more likely to be impacted by socio-economic disadvantage compared to other clients.

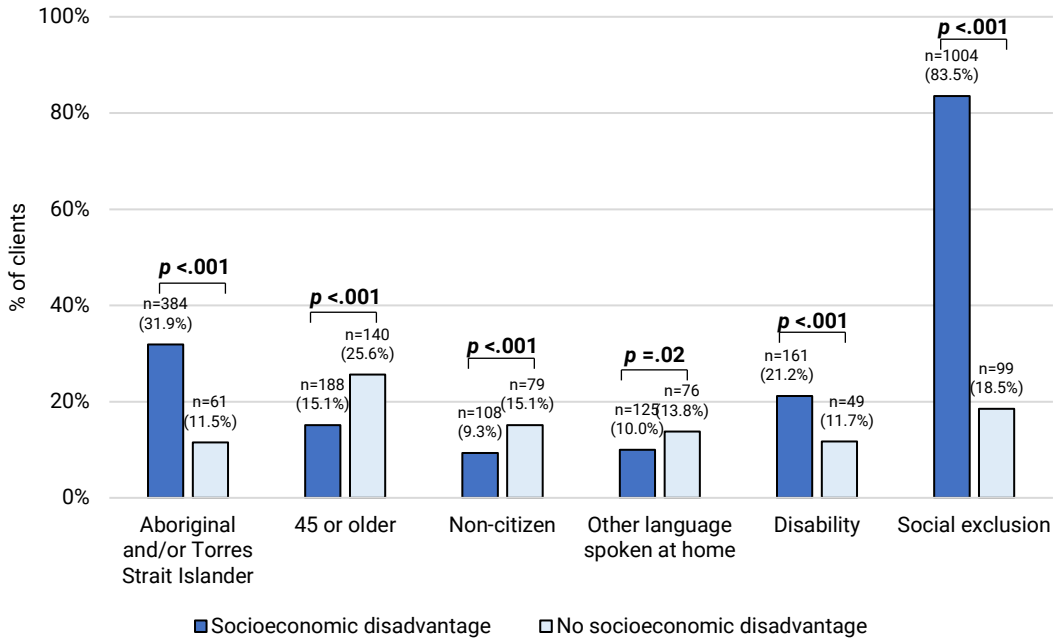

Figure 8. Differences in the proportion of client demographic characteristics by socio-economic disadvantage

Characteristics of clients affected by social exclusion (n = 1122)

Figure 9 presents the cross comparisons by client social exclusion (see Appendix B for detailed description of findings). As shown in Figure 9, of all clients impacted by social exclusion:

- 31.4 per cent identified as Aboriginal and/or Torres Strait Islander
- 16 per cent were 45-years or older
- 9.5 per cent were not Australian citizens
- 9.3 per cent spoke a language other than English at home
- 22.1 per cent had disability
- 91per cent experienced socio-economic disadvantage.

Further binary logistic regression analysis of the data indicated that clients who identify as Aboriginal and/or Torres Strait Islander, who have disability and/or who experience socio-economic disadvantage are significantly (statistically) more likely to experience social exclusion compared to other clients.

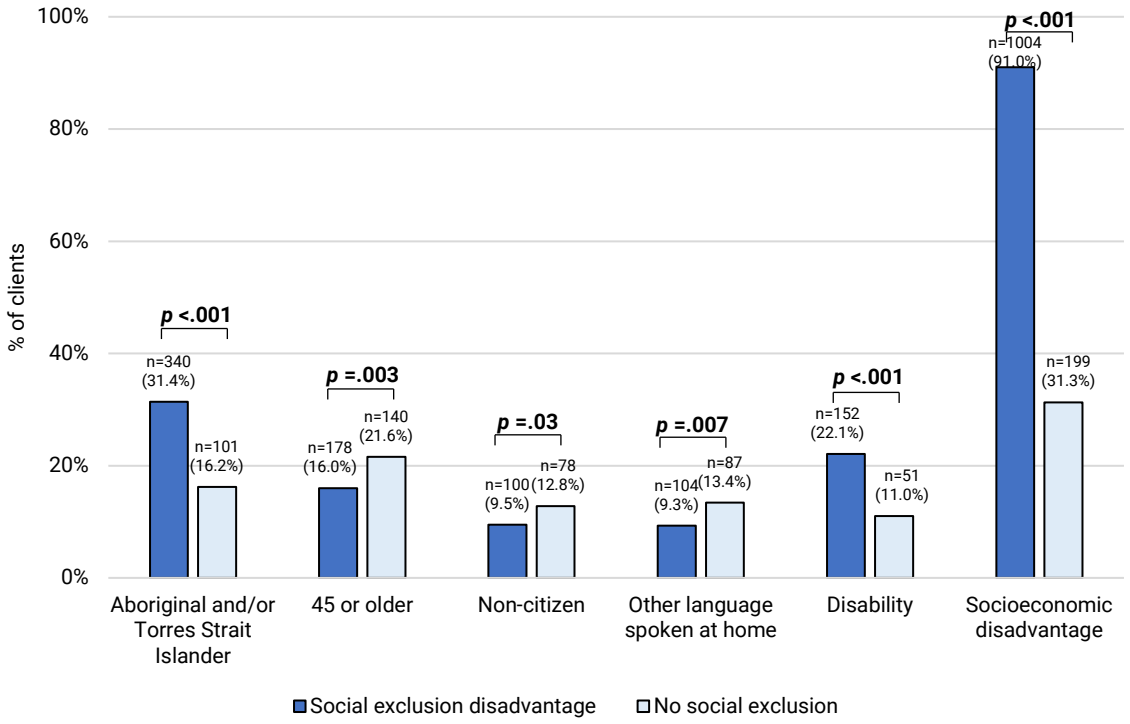

Figure 9. Differences in the proportion of client demographic characteristics by social exclusion

Summary of client demographic characteristics

Overall, these findings indicate that the SHLV program provides access to clients from different population groups, including clients who identify as Aboriginal and/or Torres Strait Islander (who make up 2.9% of the NSW population and 24% of SHLV clients) and individuals with disability (who make up 16.9% of the NSW population and 18.1% of SHLV clients).

However, 16.8 per cent of SHLV clients were aged 45 years or older, which is much lower than the proportion of people (41.2%) in the NSW population aged 45 years or older. This may be reflection of lower rates of DFV amongst Older women compared to younger women; however, it may also reflect reduced access to the SHLV program by older victims of DFV. More research is required to examine these possibilities.

Further, the ABS (2017b) indicated that 27.6 per cent of the NSW population is culturally and linguistically diverse. Most SHLV program clients were born in Australia (81.5%) and spoke only English at home (88.1%), which may indicate that culturally and linguistically diverse women and their families are not readily accessing the SHLV program.

These findings also suggest that there may be intersections of disadvantage among some clients. For example, clients who identify as Aboriginal and/or Torres Strait Islander and clients with disability may be likely to also experience socio-economic disadvantage and social exclusion. Further, older clients may be more likely to experience disability compared to younger clients. This suggests that SHLV services may need to consider different strategies to address the needs of these cohorts.

SHLV service delivery

The SHLV program has two overarching key goals:

- clients are free from DFV in their own home and remain so over time, and
- clients will experience long term stability in housing, income, education and healthy relationships.

Where possible, the following data are analysed in two sections addressing each of these two key goals separately.

Ensuring safety in client's own home or home of their choice

In the provision of SHLV services, safety is prioritised using a number of different strategies, specifically safety planning and security work, individual safety plan, risk/lethality assessment, safety audit in the home, safety equipment.

Table 2 presents the descriptive statistics for client services delivered by the SHLV program.[20] Most clients received an individual safety plan (67.5%) and safety audit in the home (57.4%). The lowest proportion of clients received safety equipment (36.1%). Clients received an average of 2.43 safety and security services.

Just under half (48.1%) of all clients accessed the police and/or court services. Of those with available data (data was missing for 37% of clients), most indicated that services helped them to access legal and court support (69.2%).

Table 2. Safety services delivered to SHLV clients between 1 July 2019 and 30 June 2021 – descriptive statistics (n = 2201)

	n (%) / m (sd)
Safety planning and security work	
Individual safety plan	1486 (67.5%)
Risk/lethality assessment	963 (43.8%)
Safety audit in the home	1263 (57.4%)
Safety equipment	794 (36.1%)
Security upgrade	850 (38.6%)
Number of safety/security work	2.43 (1.57)
Accessed police and/or court services	
Yes	1058 (48.1%)
No	1143 (51.9%)
Helped access legal and court support	
Helped	960 (43.6%)
Partially helped	344 (15.6%)
Did not help	83 (3.8%)

[20] Due to rounding, percentages in each category may not always appear to add up to 100%. Further, clients are not limited to one type of safety planning and security work.

	Missing	814 (37.0%)
Reason for leaving service		
Case goals met/no more assistance needed		1421 (64.6%)
Client disengaged with service		387 (17.6%)
Client moved out of area		136 (6.2%)
Not eligible		132 (6.0%)
Unable to contact client		115 (5.2%)
	Missing	*10 (0.5%)*

Finally, most clients exited the SHLV program because they met all their goals or no longer needed additional assistance (64.6%). However, as shown in Table 2 a considerable proportion of clients disengaged or were unable to be contacted (22.8%).

Service success status is defined as meeting case goals and/or assistance no longer being needed.[21] Figure 10 presents the proportion of clients who achieved service success according to the safety planning and security work received. Of all clients who achieved service success:

- 71.1 per cent had received individual safety plan. Further, the likelihood of service success was one and a half (1.57) times greater for clients who received an individual safety plan
- 46.3 per cent had received a risk/lethality assessment. Further, the likelihood of service success was almost one and a half (1.32) times greater for clients who received risk/lethality assessment
- 62.8 per cent had received a safety audit in the home. Further, the likelihood of service success was almost two (1.88) times greater for clients who had a safety audit in the home
- 41.3 per cent had received safety equipment. Further, the likelihood of service success was approximately two (1.94) times greater for clients who received safety equipment
- 45 per cent had received a security upgrade. Further, the likelihood of service success was *more* than two (2.23) times greater for clients who had a security upgrade.

These findings indicate that having an individual safety plan, receiving a risk/lethality assessment, having a safety audit in the home, receiving safety equipment, and/or having a security upgrade can increase the likelihood of clients achieving service success.

[21] No service success is defined as the client having left the service before they achieved their service goals or had all needs met.

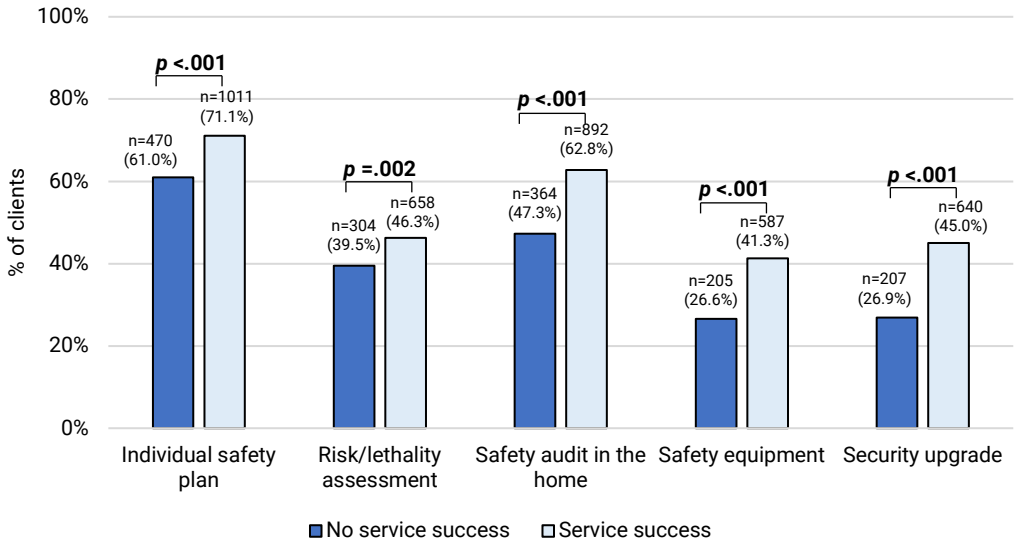

Figure 10. Differences in the proportion of clients who achieved service success by the safety planning and security work received

Figure 11 presents the proportion of clients who achieved service success by the number of safety planning and security work services received. Of all clients who achieved service success:

- 6.9 per cent received no safety planning and security work services
- 24 per cent received one safety planning and security work service
- 15.4 per cent received two safety planning and security work services
- 18.8 per cent received three safety planning and security work services
- 19.1 per cent received four safety planning and security work services
- 15.8 per cent received five safety planning and security work services.

Multinomial logistic regression was conducted to compare the impact of receiving one, two, three, four, or five services, on service success, compared to those who received no service (see Appendix B for detailed description of findings). Overall, receiving a greater number of safety planning and security work services resulted in a statistically significant [$p<0.05$] greater likelihood of service success. Compared to clients who did not receive any safety planning and security work, receiving one service increased the odds of service success by 2.06 times, two services by 1.55 times, three services by 3.22 times, four services by 3.70 times, and five services by 4.80 times.

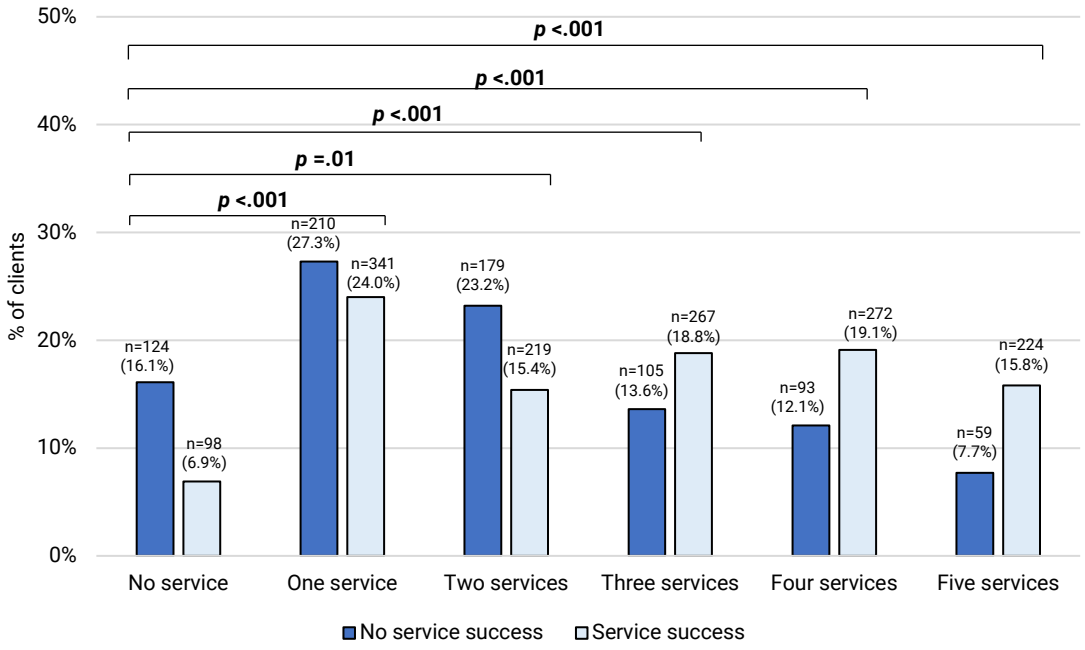

Figure 11. Differences in the proportion of clients who achieved service success by the number of safety planning and security work services received

Figure 12 presents the proportion of clients who accessed police and/or court services by demographic characteristics. Of all clients who accessed police and/or court services:

- 27 per cent identified as Aboriginal and/or Torres Strait Islander
- 16.7 per cent were 45-years or older
- 12.6 per cent were not Australian citizens
- 18.2 per cent had disability
- 70.9 per cent experienced socio-economic disadvantage.

Binary logistic regression analysis found that clients who were not Australian citizens were one and a half (1.55) times *more* likely to access police and/or court services, compared to clients who were Australian citizens. One explanation for this finding may be that women who are immigrants or were on spousal visas may be more likely than clients who are Australian citizens to require the assistance of providers such as SHLV to manage safety at home or in a home of their choice. However, more research is required to ascertain whether this is the case.

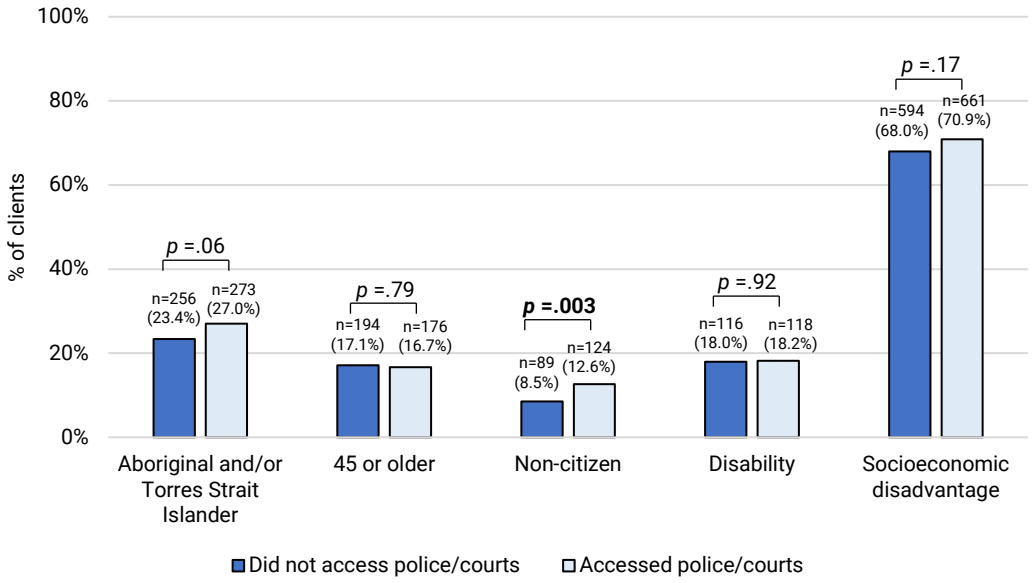

Figure 12. Differences in the proportion of clients who accessed police and/or court services by demographic factors

Figure 13 presents the proportion of clients who indicated that the SHLV program helped, partially helped, or did not help them to access to legal and court support by demographic characteristics (see Appendix B for detailed description of findings). As shown in Figure 13, of all clients[22] who indicated that the SHLV program 'did not help' them to access legal and court support:

- 38.7 per cent identified as Aboriginal and/or Torres Strait Islander
- 12.0 per cent were 45-years or older
- 7.2 per cent were not Australian citizens
- 21.9 per cent had disability
- 84.7 per cent experienced socio-economic disadvantage.

Further, multinomial logistic regression analysis of the data indicated that clients who identified as Aboriginal and/or Torres Strait Islander were around one and a half (1.64) and two (2.29) times *less* likely than non-Aboriginal and/or Torres Strait Islander clients to indicate that the SHLV program partially helped or helped them to access legal and court support, respectively.

Clients who experienced socio-economic disadvantage were almost three (2.82) times *less* likely than those who did not experience socio-economic disadvantage to indicate that the SHLV program helped them to access legal and court support.

[22] Data relating to the provision of court/legal support was missing or unavailable for 37% of clients, which is important to bear in mind when considering these findings.

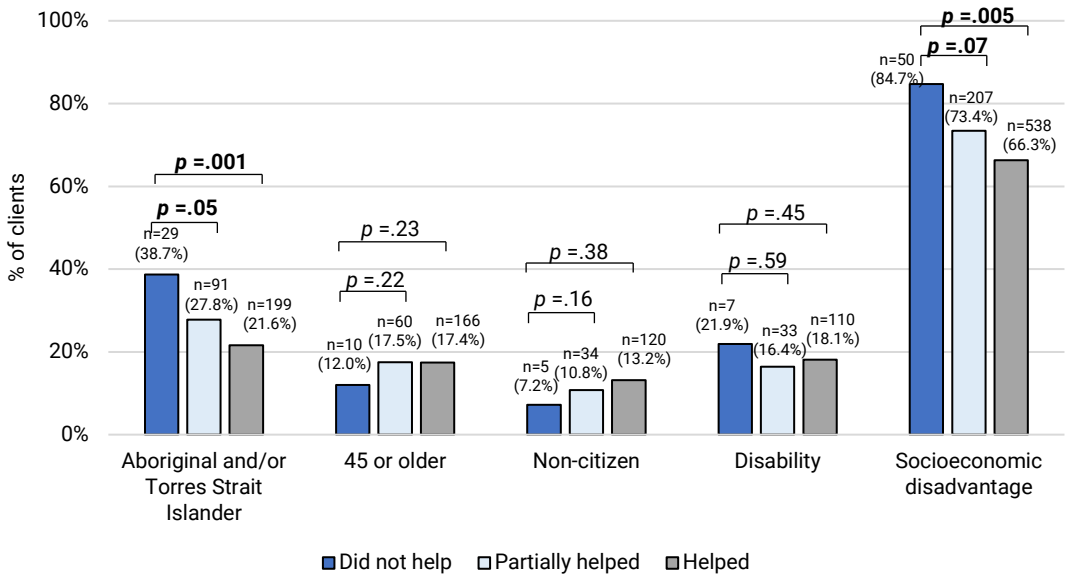

Figure 13. Differences in the proportion of clients who indicated that the SHLV program helped them access legal and court support by demographic characteristics

Examination of this data demonstrates that SHLV services that are provided to clients are oriented towards increasing the safety of women within their own home or a home of their choice. Further, the results indicate that safety and security provisions provided by SHLV (e.g., an individual safety plan, receiving a risk/lethality assessment, having a safety audit in the home, receiving safety equipment, and/or having a security upgrade) increase the likelihood of successful program outcomes.

The data also indicates that some clients may prefer to access different safety strategies and criminal justice responses. This should be considered by service providers when delivering the SHLV program.

Client housing and safety

Table 3 provides the descriptive statistics for client housing at service entry and exit. Importantly, the data indicated that at service exit, most SHLV program clients, where data were recorded and available, (n = 1576),[23] had achieved the goal of sustained stable housing or accommodation (75.8%). Just 7.4 per cent of clients who had data recorded and available did not achieve or partially achieve the goal of sustained stable housing or accommodation by exit from the program.

Further at service exit, the program had enhanced the safety of most clients and their children (71.7%).

At entry into the SHLV program, for clients where data were recorded and available (missing for 17.4%), the greatest proportion of clients resided in a private rental or their own home (53.7%), followed by public/community housing (22.8%), and no housing (6.1%).

[23] In addition, data is also unavailable or missing for 28.4% of clients. It is our assumption the case managed clients work with their case manager to identify case goals, from a list of goals established by SHLV. We assume that each client/case manager identifies which of the goals the client aims to achieve during their time in the program. Some of the missing data is therefore likely to be accounted for by clients not identifying housing stability as a case goal.

At program entry, one-third of clients resided where the DFV occurred (34.0%). Around one-quarter (27.9%) of clients were rehoused at service entry. Of these clients, half (50.5%) were rehoused due to safety concerns, and 49.5 per cent were rehoused for other reasons.

Sensitivity analysis was conducted examining the association between housing situation at service entry and housing goal achievement at exit (data recorded and available for n = 1311). Among clients with no housing at service entry (n = 120), around half (56.7%; n = 68) achieved their housing goal. Of those in public/community housing (n = 338), approximately three quarters (76.3%; n = 258) achieved their goal. By contrast, of the clients who had private or their own accommodation (n = 853), 83.4 per cent (n = 711) achieved their housing goal.

Overall, clients who were in public or community housing, or in a private or their own accommodation, were 2.47 (95% CI = 1.59 - 3.83) (p<.001) and 3.83 (95% CI = 2.56 - 5.73) (p<.001) times *more* likely to achieve their housing goals, respectively, than clients with no housing at service entry.

Table 3. Descriptive statistics for Housing and safety for SHLV clients with intake between 1 July 2019 and 30 June 2021 (n = 2201)

		n (%)
Type of housing at entry		
No housing (i.e., homeless, couch surfing)		134 (6.1%)
Public/community housing		501 (22.8%)
Private rental / Home owner		1183 (53.7%)
	missing	*383 (17.4%)*
Housing situation at entry		
Living where DFV occurred		749 (34.0%)
Not living where DFV occurred		1279 (58.1%)
	missing	*173 (7.9%)*
Rehoused at entry		
Yes		614 (27.9%)
No		1495 (67.9%)
	missing	*92 (4.2%)*
Reason for rehousing		
Safety concerns		310 (14.1%)
Other reason		304 (13.8%)
	missing	*1587 (72.1%)*
Goal at service exit: sustained stable housing/accommodation		
Achieved		1194 (54.2%)
Partially achieved		266 (12.1%)
Not achieved		116 (5.3%)
	missing	*625 (28.4%)*

Goal at service exit: enhanced safety of the victim and their children		
Achieved		1578 (71.7%)
Partially achieved		447 (20.3%)
Not achieved		111 (5.0%)
	missing	*65 (3.0%)*

Figure 14 presents the cross comparisons of clients who were rehoused at SHLV program entry by demographic characteristic. Of all clients who were rehoused at SHLV program entry (n = 614):

- 24.5 per cent identified as Aboriginal and/or Torres Strait Islander
- 14.1 per cent were 45 years or older
- 16.6 per cent were not Australian citizens
- 17.5 per cent had disability
- 67.7 per cent experienced socio-economic disadvantage.

The results of binary logistic regression analysis (see Appendix B for detailed description of findings) indicated that clients who were rehoused were significantly more likely to be younger than 45 years of age and/or were more likely to not be Australian citizens.

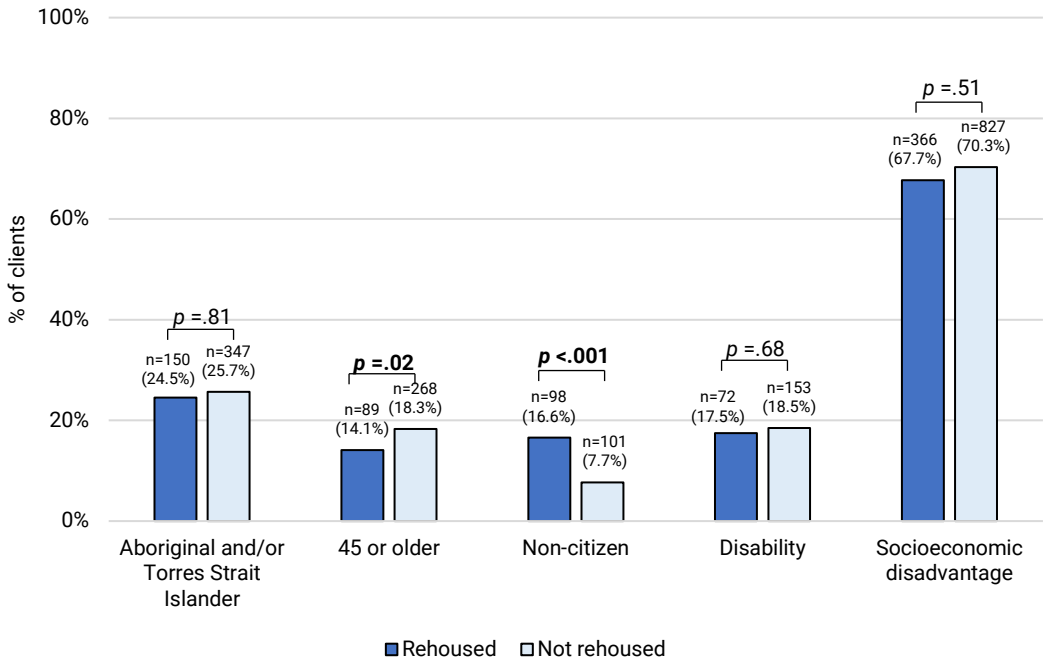

Figure 14. Differences in client demographic characteristics by whether clients were rehoused

Figure 15 presents the cross comparisons of the reason for rehousing by demographic characteristic. Of all clients who were rehoused for safety concerns (n = 310):

- 27.8 per cent identified as Aboriginal and/or Torres Strait Islander
- 10.7 per cent were 45 years or older
- 14.3 per cent were not Australian citizens

- 15.5 per cent had disability
- 70.7 per cent experienced socio-economic disadvantage.

Binary logistic regression analysis of the data (only statistically significant findings are reported; see Appendix B for detailed description of findings) found that clients who identified as Aboriginal and/or Torres Strait Islander or were younger than 45 years of age were 1.44 and 1.78 times, respectively, more likely to have been rehoused due to safety concerns.

These findings indicate that Aboriginal and/or Torres Strait Islander clients and younger clients may experience greater ongoing safety concerns in comparison to non-Aboriginal and/or Torres Strait Islander clients and compared to older clients, which may make it more difficult for them to remain safely in their own homes. It is likely this reflects ongoing perpetrator harassment and violence but could also reflect these groups are less likely to receive security upgrades.

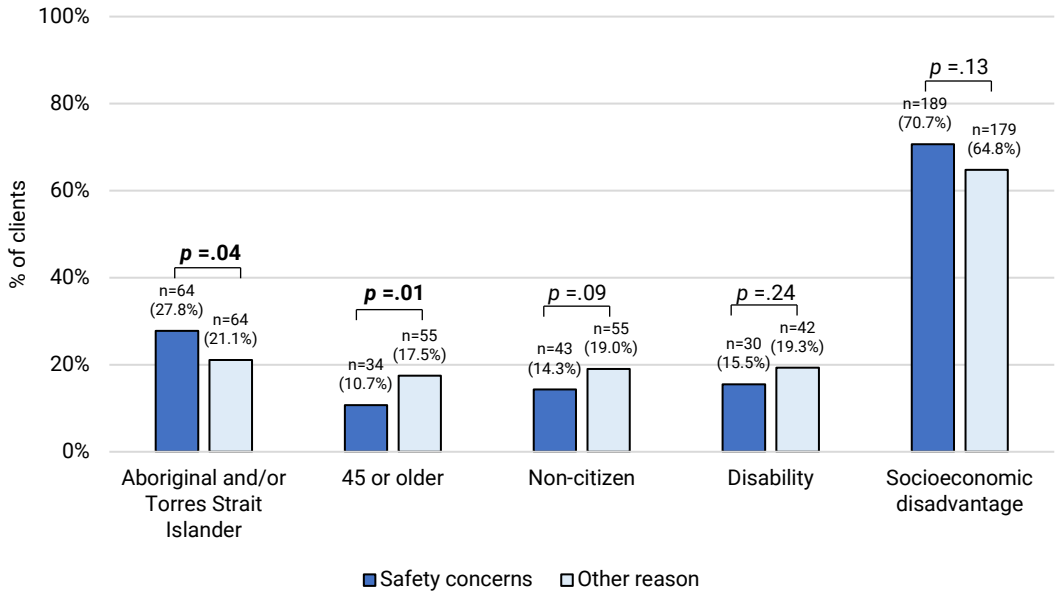

Figure 15. Differences in client demographic characteristics by reason for rehousing

A core goal of the SHLV program is to ensure housing stability at program exit.[24] Figure 16 presents the cross comparisons by whether clients achieved their goal of sustained housing/accommodation by program exit. Of all clients that 'did not achieve' the goal of sustained housing/accommodation by program exit (n = 116):

- 20.2 per cent identified as Aboriginal and/or Torres Strait Islander
- 11.2 per cent were 45 years or older
- 9.5 per cent were not Australian citizens
- 21.3 per cent had disability
- 79.5 per cent experienced socio-economic disadvantage.

Aboriginal and/or Torres Strait Islander identity was the only demographic factor to be significantly associated with achieving the goal of sustained housing/accommodation.

[24] Housing stability is living in one's own room, apartment, or house or with family for a longer-term period. Having housing stability means that a woman has the choice over when and under what circumstances she wants to move home.

Specifically, of all clients who 'partially achieved' the goal of sustained housing/accommodation by program exit (n = 266), 30.9 per cent identified as Aboriginal and/or Torres Strait Islander. This corresponds to clients who identified as Aboriginal and/or Torres Strait Islander being around one and a half (1.77) times *more* likely than non-Aboriginal and/or Torres Strait Islander clients to partially achieve their goal of housing stability at program exit, relative to clients who did not achieve their goal (see Appendix B for detailed description of findings).

This finding provides some indication of the effectiveness of the SHLV program in providing sustained housing/accommodation for Aboriginal and/or Torres Strait Islander clients. It is also salient to recognise that for many Aboriginal and Torres Strait Islander clients, 'home' may be defined differently, and a more appropriate service goal may be remaining in community or a community of their choice.

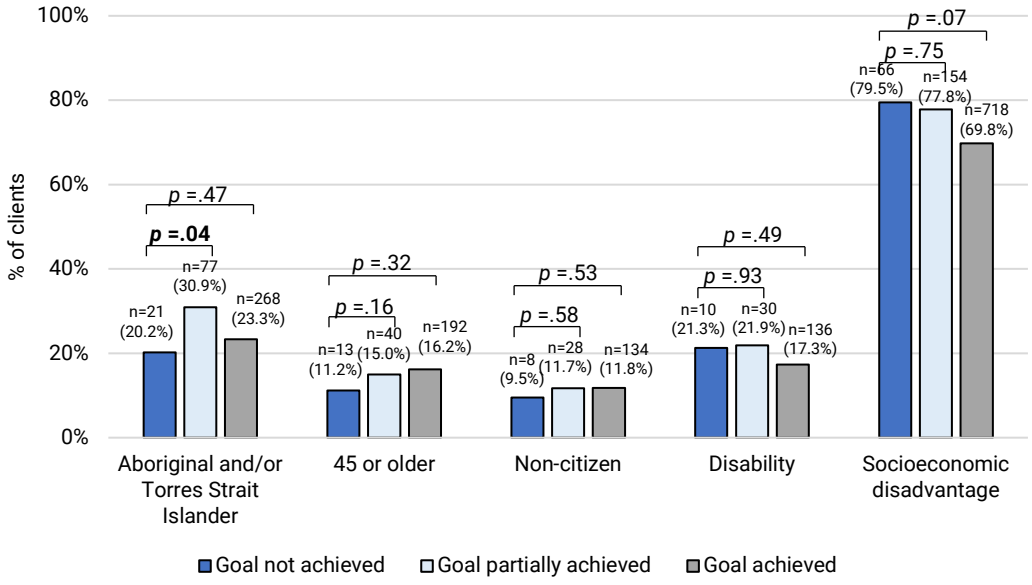

Figure 16. Differences in client demographic characteristics by whether clients achieved their goal of sustained housing/accommodation

One of the over-arching goals of the SHLV program is for clients to be safely housed[25] at service exit. Figure 17 presents the cross comparisons by whether clients achieved the goal of enhanced safety at program exit (see Appendix B for detailed description of findings). As shown in Figure 17, of all clients that 'did not achieve' the goal of enhanced safety at program exit (n = 111):

- 30.9 per cent identified as Aboriginal and/or Torres Strait Islander
- 13.6 per cent were 45 years or older
- 6 per cent were not Australian citizens
- 37.5 per cent had disability
- 82.5 per cent experienced socio-economic disadvantage.

[25] Being safely housed is a part of housing stability. In the SHLV program, being safely housed refers to increasing women's feelings of safety within their own home or a home of their choice.

Multinomial logistic regression analysis indicates that client disability and socio-economic disadvantage were significantly associated with lower likelihood of achieving the goal of enhanced safety at program exit. Specifically, clients with a disability were 3.57 and 2.72 times *less* likely than clients without disability to partially achieve or achieve the goal of enhanced safety at program exit, respectively. Likewise, clients who experienced socio-economic disadvantage were 2.31 and 2.07 times *less* likely than clients who did not experience socio-economic disadvantage to partially achieve or achieve their goal.

These findings indicate that clients with disability and clients who experience socio-economic disadvantage likely require tailored and/or additional support from service providers to be safe in their home or accommodation.

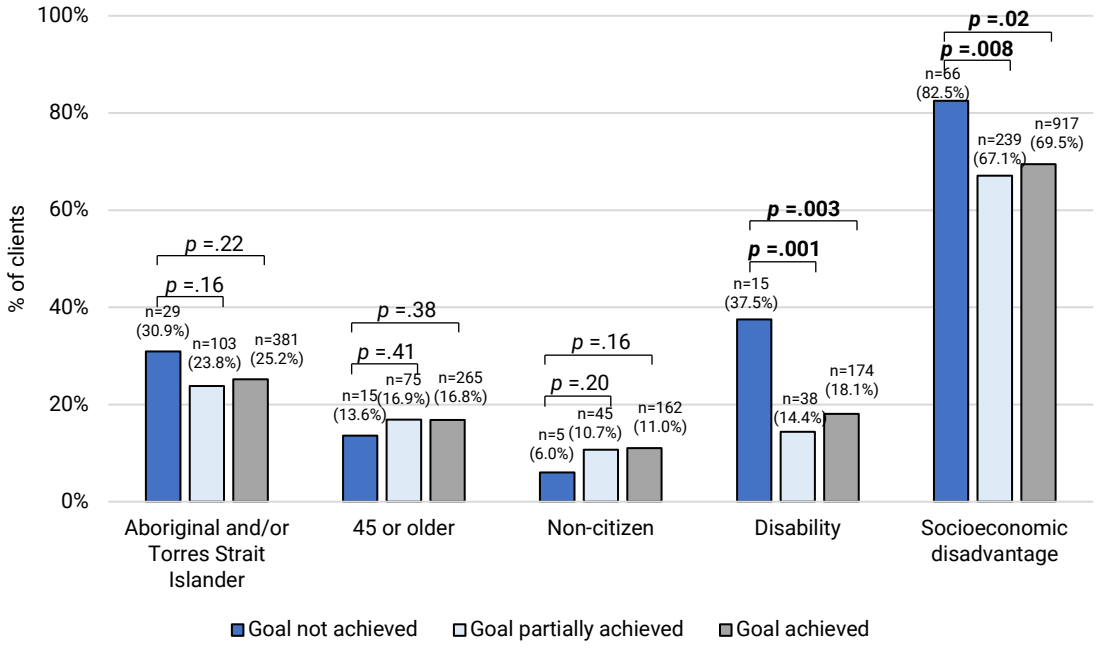

Figure 17. Differences in client demographic characteristics by whether clients achieved the goal of enhanced safety

Overall, the data indicates that some clients may experience greater ongoing safety concerns in comparison to other clients, which may make it more difficult for them to remain safely in their own homes or to maintain sustained housing. Further, some clients may require tailored and/or additional support from service providers to remain safe in their home/accommodation or community of their choice.

Personal duress alarms and safety

From 2012-19 an SOS alarm device (the AT Protector) and security monitoring service was provided to SHLV clients under contract by Central Monitoring Services (CMS). However, during the evaluation period (in January 2020), iStaySafe (Iss) became the new supplier of personal duress alarms for the SHLV program, with security monitoring provided by Iss partner Security Monitoring Centres (SMC).

Following a seven-month intensive trial by UTS Designing Out Crime Research Centre (UTS) that commenced in September 2020, mCare was selected as a new supplier for SHLV duress

devices. DCJ identified mCare as its preferred supplier and a procurement process was completed by June 2021.

The Iss monitoring data provided to the evaluation team indicated that, from January 2020 to July 2021, there were only 8 genuine instances where an alarm was activated, and 242 alarm activations were false alarms or tests. For each reporting quarter there were an average of 107 end users with a personal duress alarm.

Only 153 (7.0%) clients were issued with a personal duress alarm (SOS device) at their first admission to the SHLV program (only statistically significant [p<0.05] findings are described; see Appendix B for detailed description of findings). Figure 18 indicates that:

- 88.7 per cent of all clients who received an SOS device, achieved the goal of enhanced the safety. In comparison, 72.7 per cent of all clients who did not receive the device achieved the goal of enhanced safety[26]
- Importantly, clients who received a SOS device were almost three (2.95) times *more* likely to achieve the goal of enhanced safety compared to clients who did not receive a SOS device.

These findings suggest that having a SOS device enhances client safety.

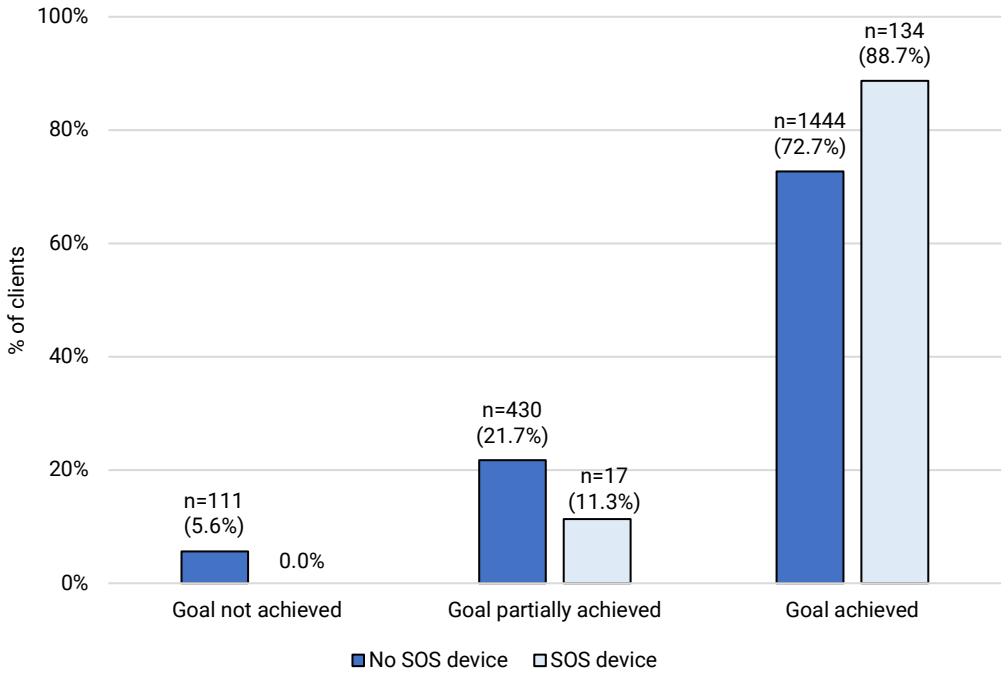

Figure 18. Differences in the proportion of clients who achieved the goal of enhanced safety by whether they received an SOS device

Next, it was examined whether client demographic characteristics were associated with greater odds of achieving the goal of enhanced safety for those who did and did not receive a SOS device (only statistically significant findings are described; see Appendix B for detailed

[26] It is important to note that matched comparisons were not conducted. Clients who received an SOS device are not necessarily directly comparable to clients who did not receive an SOS device. This should be kept in mind when interpreting these findings.

description of findings). Figure 19 presents the proportions of clients who achieved the goal of enhanced safety, comparing those who did and did not receive an SOS device.

- Among all clients who identified as Aboriginal and/or Torres Strait Islander (n = 529), 88.7 per cent of those who had an SOS device achieved the goal of enhanced safety compared to 72.6 of those who did not have an SOS device. Clients who identified as Aboriginal and/or Torres Strait Islander were almost three times (2.96) *more* likely to achieve the goal of enhanced safety if they had an SOS device.
- Among all clients who experienced socio-economic disadvantage (n = 1255), 89.7 per cent of those who had an SOS device achieved the goal of enhanced safety compared to 73.8 per cent of who did not have an SOS device. Clients who experienced socio-economic disadvantage were approximately three (3.09) times *more* likely to achieve the goal of enhanced safety if they had an SOS device.

The findings presented in Figure 19 provide an indication that a greater proportion of client groups who had an SOS device were more likely to experience enhanced safety by program exit compared to those without an SOS device. For example, in addition to the findings described above, 95 per cent of clients with a disability who had an SOS device achieved the goal of enhanced safety. In comparison, approximately 75 per cent of clients with a disability who did not have an SOS device achieved the goal of enhanced safety. However, there were no statistically significant associations found for clients with disability or for clients aged 45 years or older, or who were not Australian citizens. This is likely a result of small sample sizes.

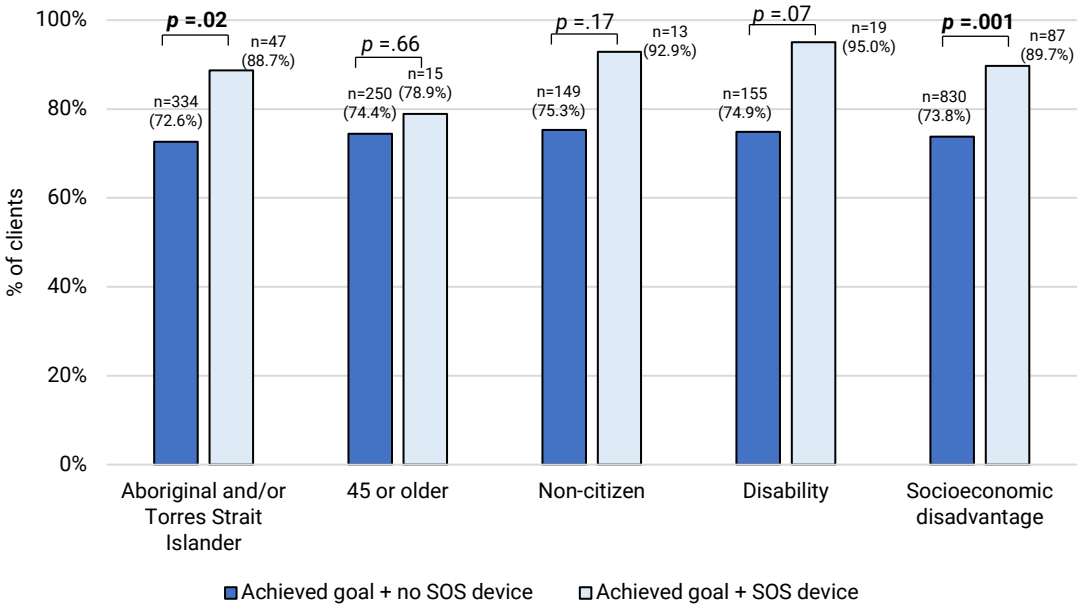

Figure 19. Differences in the proportion of clients who achieved the goal of enhanced safety by whether they received an SOS device across client demographic characteristics

Stability and wellbeing

Client wellbeing and achievement of goals

In the Outcome Rating Scale (ORS) survey, clients (n = 664) indicated their wellbeing at entry into the SHLV program and at program exit. Wellbeing was examined within the domains of individual (personal well-being), interpersonal (family and other close relationships), social (work, school, and friendships), and overall (general sense of well-being). Scores range on the ORS from 1 (not at all well) to 5 (extremely well), with higher scores indicating better wellbeing.

Paired samples t-test comparing the mean ORS score at service intake and exit indicated that there were statistically significant improvements (see Appendix C for detailed analysis) in client wellbeing scores over time (presented in Figure 20), with a:

- 49.6 percent improvement in overall wellbeing scores (with the average ORS score increasing from 2.40 at intake to 3.58 at exit)
- 56.8 percent improvement in individual wellbeing scores (with the average ORS score increasing from 2.30 at intake to 3.60 at exit)
- 40.4 percent improvement in for interpersonal wellbeing scores (with the average ORS score increasing from 2.55 at intake to 3.58 at exit)
- 40.5 percent improvement in social wellbeing (with the average ORS score increasing from 2.57 at intake to 3.61 at exit).

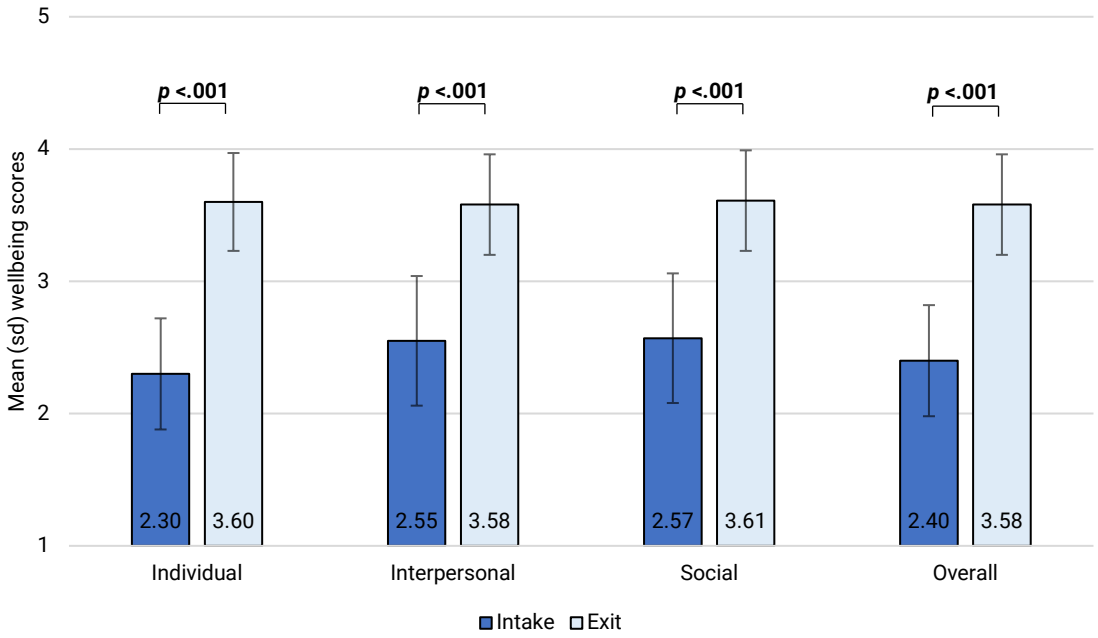

Figure 20. Mean (sd) wellbeing scores at service intake and exit

We also examined improvement in wellbeing score by client demographic factors and characteristics, (only statistically significant [<0.05] findings are described here; a full description of these findings is included in Appendix C). The significant results of the analyses indicated that:

- Clients who were not Australian citizens were almost one and a half times (1.32) times *more* likely to report greater improvements in overall wellbeing than those who were Australian citizens.

- Clients with disability were *more* likely (1.22 times) to report greater improvements in individual wellbeing, and *more* likely (1.25 times) to report greater improvements in interpersonal wellbeing, compared to clients without disability.
- Clients who did not experience socio-economic disadvantage were *more* likely (1.28 times) to report greater improvements in individual wellbeing and to report greater improvements in overall wellbeing (1.22 times), compared to clients who experienced socio-economic disadvantage.
- Clients who did not experience social exclusion were *more* likely (1.21 times) to report greater improvements in individual wellbeing, and to report greater improvements in overall wellbeing (1.23 times), compared to clients who experienced social exclusion.
- Clients who were not homeowners or resided in a private rental were *more* likely (1.2 times) to report greater improvements in interpersonal wellbeing, and to report greater improvements in social wellbeing (1.25 times), relative to clients who were homeowners or resided in a private rental. This could be because clients who did not own their own home or have accommodation in private rental were able to be assisted to achieve greater safety in *more* stable accommodation, contributing to an increase in interpersonal and social wellbeing.
- Clients who were living where the DFV occurred at entry into the SHLV program were *more* likely (1.29 times) to report greater improvements in individual wellbeing, to report greater improvements in interpersonal wellbeing (1.33 times), to report greater improvements in social wellbeing (1.29 times), and to report greater improvements in overall wellbeing (1.26 times), relative to clients who were not living where DFV occurred. These findings may reflect the additional stress of changing their housing circumstances even where it is a home of the client's choice.
- Clients who were employed at entry into the SHLV program were *more* likely (1.2 times) to report greater improvements in individual wellbeing, compared to those who were not employed at intake.
- Clients who were not provided with safety equipment were *more* likely to report greater improvements in interpersonal wellbeing, and to report greater improvements in overall wellbeing (1.17 times), compared to clients who were provided with safety equipment. The provision of safety equipment suggests that the client is subject to ongoing perpetrator harassment and abuse. This is a crucial factor affecting client wellbeing.

Table 4 presents the descriptive statistics for the wellbeing case goals[27] achieved by clients (n = 2201) at the end of their first SHLV intake (program exit)[28]. Most clients, where data were recorded and available,[29] indicated that they fully achieved the goal of improving knowledge about dealing with DFV (68.5%), followed by increasing stability for children (66.6%), increasing

[27] It is our assumption the case managed clients work with their case manager to identify case goals, from a list of goals established by SHLV. We assume that each client/case manager identifies which of the goals the client aims to achieve during their time in the program. Some of the missing data is therefore likely to be accounted for by clients not identifying certain case goals in their program plan.

[28] Due to rounding, percentages may not always appear to add up to 100%.

[29] Some of the missing data is likely to be accounted for by clients not identifying certain case goals in their program plan.

community engagement and access to support (65.9%), improved health for the victim and their children (61.2%), and improved parenting capacity/skills (54.3%).

In comparison, just under half the clients, where data were recorded and available, indicated that they fully achieved the goal of improving the management of finances (45.8%).[30] This finding is likely reflective of the more recent priority given to enhancing women's economic security as an area of service provision for SHLV and indicates that it is an area that may require further development for service providers, in order to help clients achieve their goals.

Table 4. Goal attainment at service exit of SHLV clients with intake between 1 July 2019 and 30 June 2021 (n =2201)

	n (%)
Goal at service exit: increased community engagement and access to support (n = 1864)	
Achieved	1228 (55.8%)
Partially achieved	507 (23.0%)
Not achieved	129 (5.9%)
missing	*337 (15.3%)*
Goal at service exit: increased parenting capacity/skills	
Achieved	546 (24.8%)
Partially achieved	342 (15.5%)
Not achieved	117 (5.3%)
missing	*1196 (54.3%)*
Goal at service exit: increased stability for the child(ren)	
Achieved	1020 (46.3%)
Partially achieved	390 (17.7%)
Not achieved	122 (5.5%)
missing	*669 (30.4%)*
Goal at service exit: improved health for the victim and child(ren)	
Achieved	840 (38.2%)
Partially achieved	420 (19.1%)
Not achieved	112 (5.1%)
missing	*829 (37.7%)*
Goal at service exit: improved knowledge about dealing with DFV	
Achieved	1416 (64.3%)
Partially achieved	551 (25.0%)
Not achieved	100 (4.5%)
missing	134 (6.1%)
Goal at service exit: improved management of finances	
Achieved	392 (17.8%)
Partially achieved	317 (14.4%)
Not achieved	146 (6.6%)
missing	*1346 (61.2%)*

An analysis was conducted of the proportion of clients who received brokerage services by case goals achieved (only statistically significant findings are described; see Appendix B). Clients who received brokerage services were *more* likely to achieve the goal of improving the victim's and child(ren)'s safety, improve their knowledge about domestic and family violence, to

[30] When interpreting this finding it is important to note that 61.2% of clients did not have data for this goal. It is likely that a large proportion of the 'missing' data is due to clients not identifying 'management of finances' as a case goal.

achieve the goal of sustainable housing, to effectively separate from the perpetrator, and to be able to access the courts and legal services.

Figure 21 presents the cross comparisons by whether clients achieved the goal of increasing their community engagement and access to support. Of all clients that did not achieve the goal of increasing their community engagement:

- 31.9 per cent identified as Aboriginal and/or Torres Strait Islander
- 10.1 per cent identified as 45 years or older
- 8.1 per cent were not Australian citizens
- 25.9 per cent had disability
- 84.4 per cent experienced socio-economic disadvantage.

Multinomial logistic regression analyses were conducted to identify the likelihood of clients partially achieving or achieving their goal of increased community engagement and access to support, relative to no goal achievement, by demographic characteristics (see Appendix B for detailed description of findings). Results indicate that:

- clients who identify as Aboriginal and/or Torres Strait Islander were 1.52 times *less* likely than clients who did not identify as Aboriginal and/or Torres Strait Islander to achieve this goal
- clients who experienced socio-economic disadvantage were 2.53 times *less* likely than clients who did not experience socio-economic disadvantage to achieve their goal.

In comparison:

- clients aged 45 years or older were 1.88 times *more* likely than younger clients to achieve the goal of increased community engagement and access to support.

This finding suggests that Aboriginal and/or Torres Strait Islander clients and clients who experience socio-economic disadvantage may be more isolated from community and may have more difficulty accessing required supports in comparison to other clients, and therefore may require additional support to increase their engagement in community and to provide access to support. However, more research is required to understand these factors and to ascertain whether this could be the case.

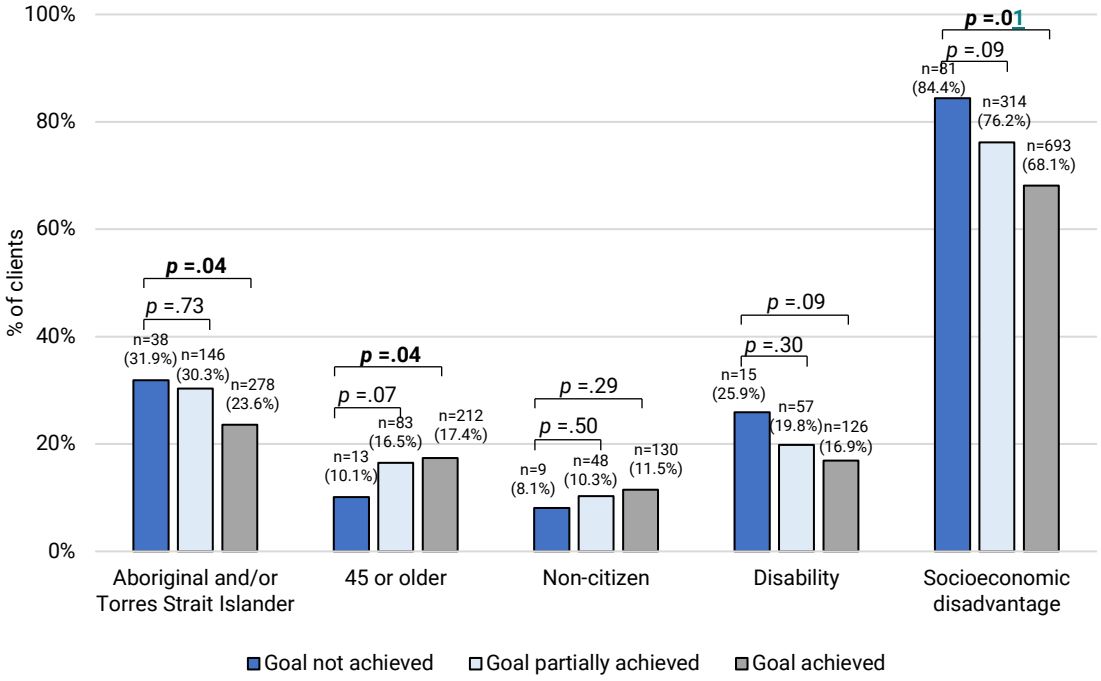

Figure 21. Differences in client demographic factors by whether clients achieved the goal of increasing their community engagement and access to support

Figure 22 presents the cross comparisons by whether clients achieved the goal of increasing their parenting capacity and skills. Of all clients who did not achieve the goal of increasing their parenting capacity and skills:

- 36.8 per cent identified as Aboriginal and/or Torres Strait Islander
- 3.4 per cent identified as 45 years or older
- 5.4 per cent were not Australian citizens
- 39.5 per cent had disability
- 88.4 per cent experienced socio-economic disadvantage.

Multinomial logistic regression analysis was conducted to identify the odds of partially achieving or achieving the goal of increasing parenting capacity and skills by demographic characteristics (only statistically significant [p<0.05] findings are described; see Appendix B for detailed description of findings). Relative to all clients who did not achieve the goal of increasing their parenting capacity and skills:

- clients who identified as Aboriginal and/or Torres Strait Islander were 1.64 times *less* likely to achieve their goal than non-Aboriginal and/or Torres Strait Islander clients
- clients with disability were almost five (4.98) times *less* likely to achieve the goal than clients who did not have a disability
- clients who experienced socio-economic disadvantage were almost three (2.93) times *less* likely than clients who did not experience socio-economic disadvantage to achieve the goal.

In comparison:

- clients aged 45 years or older were three and a half (3.56) times *more* likely than younger clients to partially achieve the goal
- clients who were not Australian citizens were 3.2 times *more* likely than Australian citizens to achieve the goal.

These findings indicate that clients who identify as Aboriginal and/or Torres Strait Islander, who experience disability and/or who experience socio-economic disadvantage may require additional support from service providers in order to improve their parenting capacity and skills. It may also be likely that they have greater concerns about engaging with child protection supports due to fear of the removal of children from their care.

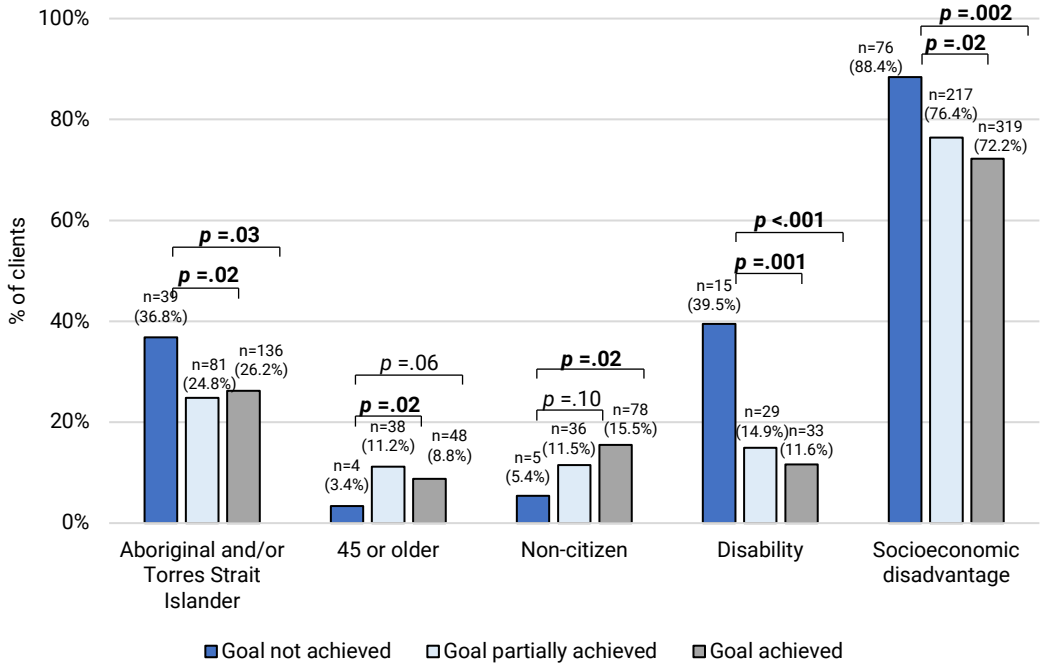

Figure 22. Differences in client demographic characteristics by whether clients achieved the goal of increasing their parenting capacity and skills

Figure 23 presents the cross comparisons by whether clients achieved the goal of increasing stability for their children. Of all clients who did not achieve the goal of increasing stability for their children:

- 17.9 per cent identified as Aboriginal and/or Torres Strait Islander
- 7.4 per cent were 45 years or older
- 8 per cent were not Australian citizens
- 14.9 per cent had disability
- 76.5 per cent experienced socio-economic disadvantage.

The results of multinomial logistic regression analyses indicate that clients who identified as Aboriginal and/or Torres Strait Islander were 2.26 times *more* likely than clients who did not identify as Aboriginal and/or Torres Strait Islander to partially achieve their goal of increasing stability for their children relative to clients who did not achieve this goal. This suggests that the

SHLV program may be effective in increasing stability for the children of Aboriginal and/or Torres Strait Islander clients.

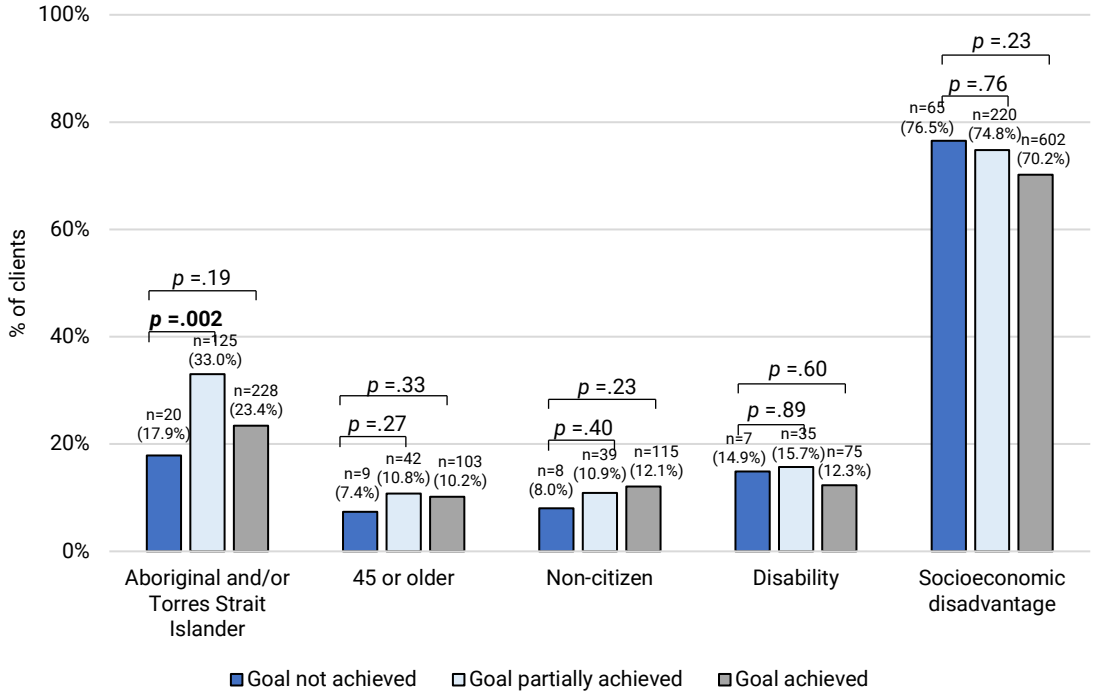

Figure 23. Differences in client demographic characteristics by whether clients achieved the goal of increasing stability for their children

Figure 24 presents the cross comparisons by whether clients achieved the goal of improving their health at program exit. Of all clients who did not achieve the goal of improving their health:

- 27.3 per cent identified as Aboriginal and/or Torres Strait Islander
- 10.7 per cent were 45 years or older
- 4.4 per cent were not Australian citizens
- 26.7 per cent had disability
- 78.6 per cent experienced socio-economic disadvantage.

Relative to all clients who did not achieve the goal of improving their health (only statistically significant [p<0.05] findings are described; see Appendix B for detailed findings):

- clients aged 45 years or older were almost two (1.95) times *more* likely than younger clients to partially achieve the goal of improving their health
- clients who were not Australian citizens were approximately three (2.95) times *more* likely than Australian citizens to achieve the goal of improving their health.

In comparison, however:

- clients with disability were two (1.99) times *less* likely than clients with no disability to achieve their goal of improving their health.

While the SHLV program appears to be particularly effective in improving the health of older clients and clients who were not Australian citizens (and therefore may not receive Medicare

benefits in some cases), clients with disability may require additional assistance to see improvements in their health.

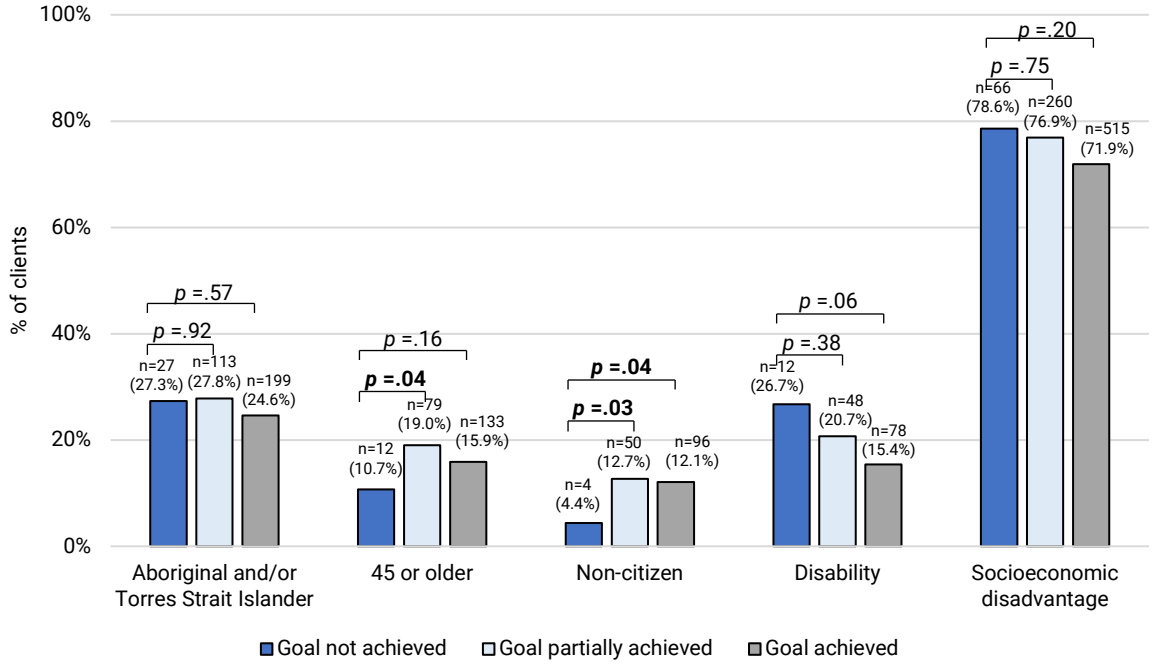

Figure 24. Differences in client demographic characteristics by whether clients achieved the goal of improving their health

Figure 25 presents the cross comparisons by whether clients achieved the goal of improving their knowledge about dealing with DFV. Of all clients that did not achieve the goal of improving their knowledge about dealing with DFV:

- 27.2 per cent identified as Aboriginal and/or Torres Strait Islander
- 10.2 per cent were 45 years or older
- 6.3 per cent were not Australian citizens
- 31.7 per cent had disability
- 82.9 per cent experienced socio-economic disadvantage.

Multinomial logistic regression analysis of the data found that (only statistically significant *[p<0.05]* findings are described; see Appendix B for detailed findings) relative to *all* clients who did not achieve the goal of improving their knowledge about dealing with DFV:

- clients with a disability were *more* than two (2.23) times *less* likely than clients without a disability to achieve the goal of improving their knowledge about dealing with DFV
- clients who experienced socio-economic disadvantage were approximately two (2.28) times *less* likely than those who did not experience socio-economic disadvantage to achieve the goal of improving their knowledge about dealing with DFV.

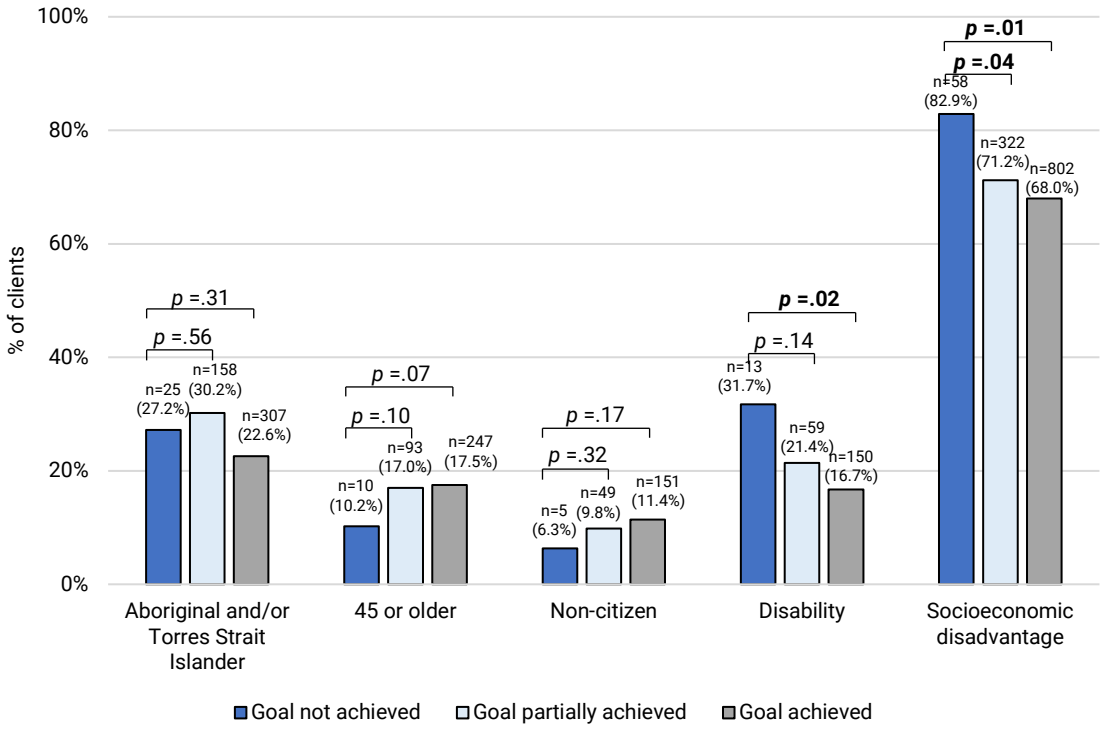

Figure 25. Differences in client demographic characteristics by whether clients achieved the goal of improving their knowledge about dealing with domestic and family violence

Brokerage (n = 1031)

Brokerage is available to all SHLV clients. This may specifically target client safety by upgrading home security provisions. Brokerage may also be provided for reasons including (but not limited to): security upgrades; assistance with pets; education items; groceries; bill payments, emergency transport; emergency household repairs; personal items; external therapies; housing (bond, rent, accommodation); legal expenses, removalists; and child-care expenses.

Of the 2201 clients in the derived sample, just under half (n = 1031, 46.8%) received brokerage at their first referral. The average amount of brokerage received by clients was $998.13 (sd = $1383.41). Half of those who received brokerage services (n = 515) received $490.00 or less, and 90 per cent (n = 930) received $2475.30 or less. Ten percent (n = 103) of clients received between $2485.30 and $8250.00.

Figure 26 presents the reasons clients received brokerage (n = 1031). The most common use of brokerage was for expenses relating to safety upgrades for the client's house (n = 665, 64.5%), followed by other expenses (n = 373, 36.2%), cash payments and/or vouchers (n = 236, 22.9%), groceries and/or clothing (n = 192, 18.6%), housing bills and household repairs (n = 97, 9.4%), educational items and support (n = 94, 9.1%), and external services (n = 44, 4.3%).

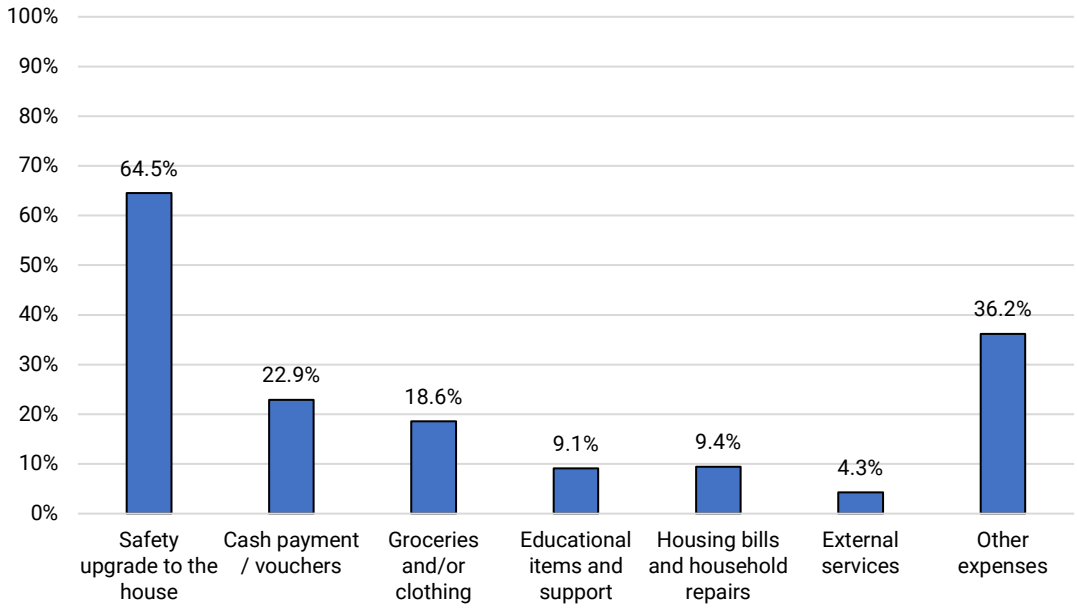

Figure 26. Reasons for provision of brokerage (n = 1031)

Finances and employment (n = 743)

Of the 743 clients with available data, 60.2 per cent (n = 447) indicated that the SHLV program helped them manage their own finances and maintain employment, while 26.5 per cent (n = 197) of clients indicated that the service partially helped, and 13.3 per cent (n = 99) of clients indicated the service did not help (see Appendix B for detailed description of findings).

As shown in Figure 27, of all clients who indicated that SHLV did not help with management of finances or to maintain employment:

- 33 per cent identified as Aboriginal and/or Torres Strait Islander
- 11.1 per cent were 45 years or older
- 9.9 per cent were not Australian citizens
- 19.6 per cent had disability
- 90.7 per cent experienced socio-economic disadvantage.

A series of multinomial logistic regression analyses indicate that, relative to clients who indicated that SHLV did not help with management of finances or to maintain employment:

- clients who identified as Aboriginal and/or Torres Strait Islander were two and a half (2.53) times *less* likely than those who did not identify as Aboriginal and/or Torres Strait Islander to indicate that the SHLV helped with finances and maintaining employment
- clients who experienced socio-economic disadvantage were more than two and a half (2.73) times *less* likely than those who did not experience socio-economic disadvantage to indicate that the SHLV helped with finances and maintaining employment.

In comparison:

- clients who were not Australian citizens were two (2.07) times *more* likely than Australian citizens to indicate that SHLV helped with their finances and maintaining employment.

A possible explanation for these findings is that Aboriginal and/or Torres Strait Islander clients and clients who experience socio-economic disadvantage may be more likely to enter the SHLV program with greater financial instability, compared to other clients. Therefore, they may require additional support from service providers to improve their finances and to secure employment. However, more research is required to determine whether this is the case.

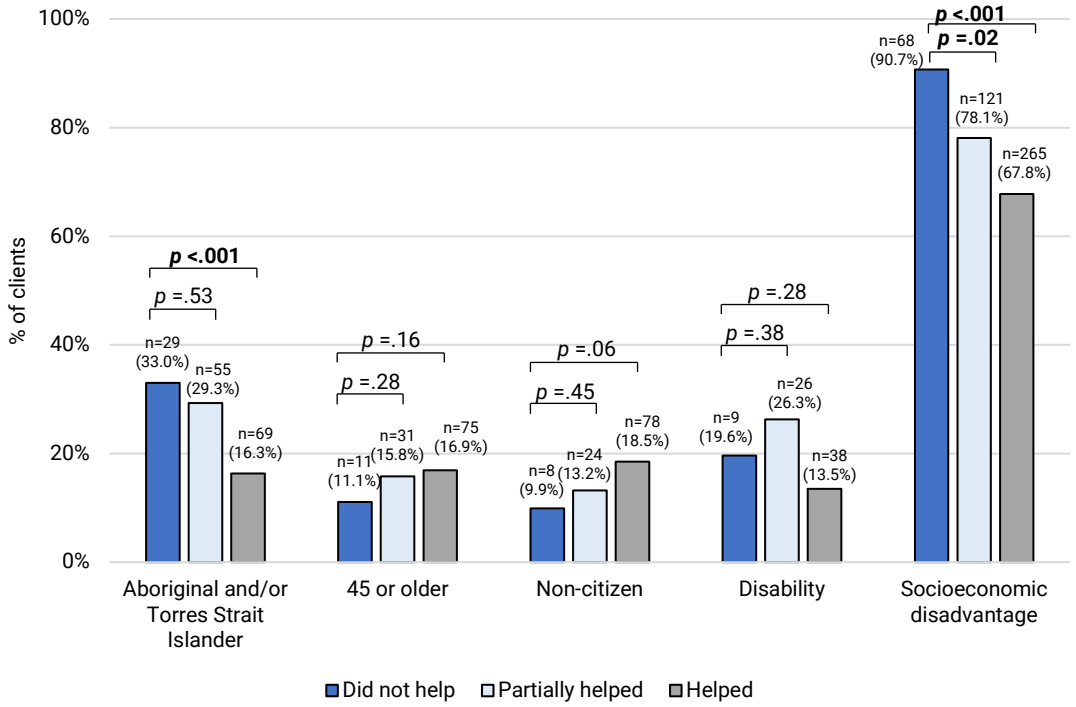

Figure 27. Differences in the proportion of clients who indicated that the SHLV program helped with finances and maintained employment by demographic characteristics

Analysis of the differences between existing and five new services

The following compares the service delivery and client outcomes between the five new and 22 existing[31] services. Data for one of the new services (Service 1) was not available in the CIMS data. The remaining four new services provided data for Service 2 SHLV (n = 149), Service 3 (n = 109), Service 4 (n = 335), and Service 5 (n = 48).

Collectively, 30.7 per cent (n = 675) of clients were admitted to these four new services at their first intake, compared to 69.3 per cent (n = 1526) of clients admitted to existing services.

[31] There are 33 SHLV sites. However, the remaining six sites did not provide data, or provided data that was incorrectly formatted and could not be linked/analysed for this Evaluation.

Figure 28 presents the proportion of clients admitted to the new and existing services by demographic factors (see Appendix B for detailed description of findings). Of all clients admitted to the new service (n = 675):

- 26 per cent identified as Aboriginal and/or Torres Strait Islander
- 11.9 per cent were 45 years or older
- 14.9 per cent were not Australian citizens
- 11.2 per cent had disability
- 73.9 per cent experienced socio-economic disadvantage.

Binary logistic regression analysis indicated that clients who were not Australian citizens, or who experienced socio-economic disadvantage, were significantly more likely to attend a new service than an existing service. In comparison, clients aged 45 years or older or with a with a disability were significantly more likely to attend an existing service than a new service.

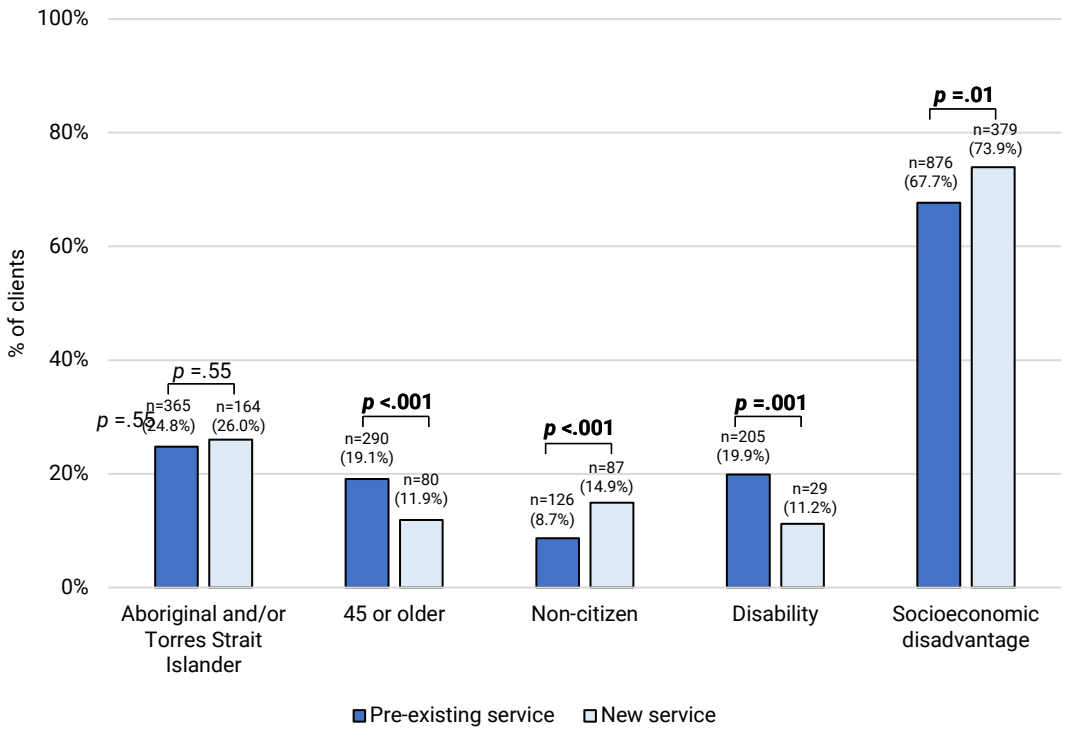

Figure 28. Differences in the proportion of clients admitted to the new and existing services by demographic characteristics

Figure 29 presents the proportion of clients in the four new and 22 existing services who were provided with safety planning and security work. Of all clients who attended a new service (n = 675):

- 68.6 per cent received an individual safety plan
- 42.5 per cent received a risk/lethality assessment
- 52.7 per cent received a safety audit in the home
- 30.5 per cent received safety equipment

- 24.7 per cent received a security upgrade
- 8.1 per cent received an SOS device.

The results of binary logistic regression analyses indicate that clients who attended one of the new services were:

- 1.31 times *less* likely to receive a safety audit in the home
- almost one and a half (1.43) times *less* likely to receive safety equipment
- approximately two and a half (2.47) times *less* likely to receive a security upgrade.

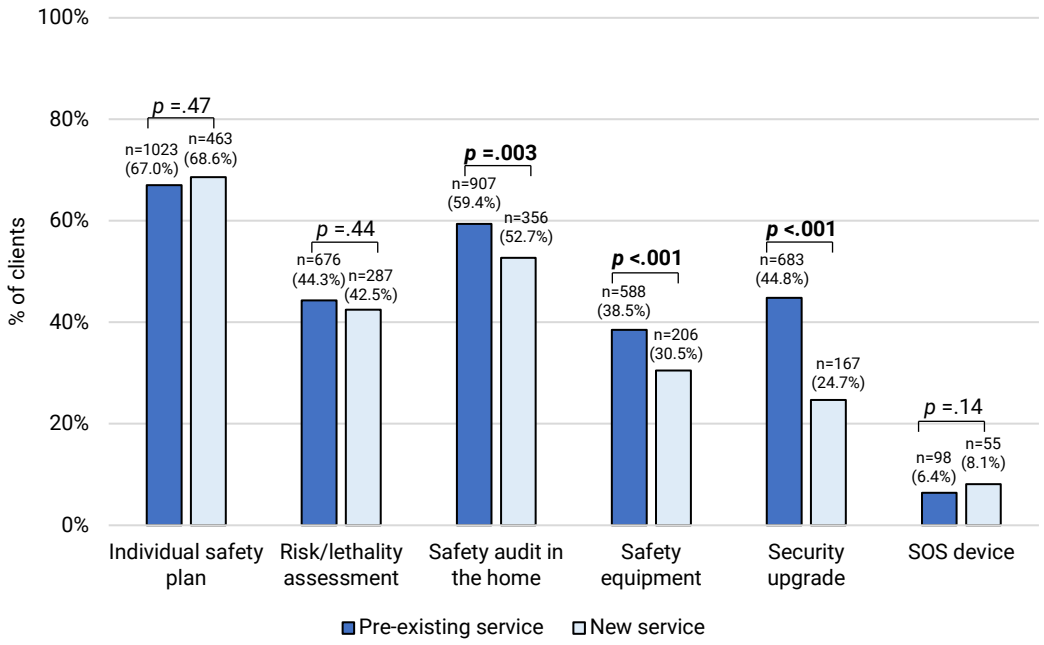

Figure 29. Differences in the proportion of clients admitted to the new and existing services who were provided with safety planning and security work

Further statistical analysis was conducted to assess the association between clients attending one of the new services and the likelihood of receiving safety planning and security work, and achieving case goals, separately, independent of client gender, Aboriginal and/or Torres Strait identity, age, citizenship, disability, and socio-economic disadvantage (see Appendix B for detailed description of analyses and findings).

Figure 30 presents the Odds Ratios (OR) and accompanying 95% confidence interval bars of clients in one of the new services receiving safety planning and security work, independent of demographic factors (only significant findings are described; see Appendix B for detailed description of findings). After controlling for demographic factors:

- clients attending one of the new services were almost one and a half (1.37) times *more* likely to receive a risk/lethality assessment, compared to clients who attended one of the existing services
- clients in any one of the new services were one and a half (1.50) times *more* likely to receive a safety audit in the home, compared to clients who attended one of the existing services.

In comparison:

- clients in the new services were more than two and a half (2.77) times *less* likely to receive security upgrades, compared to clients who attended one of the existing services.

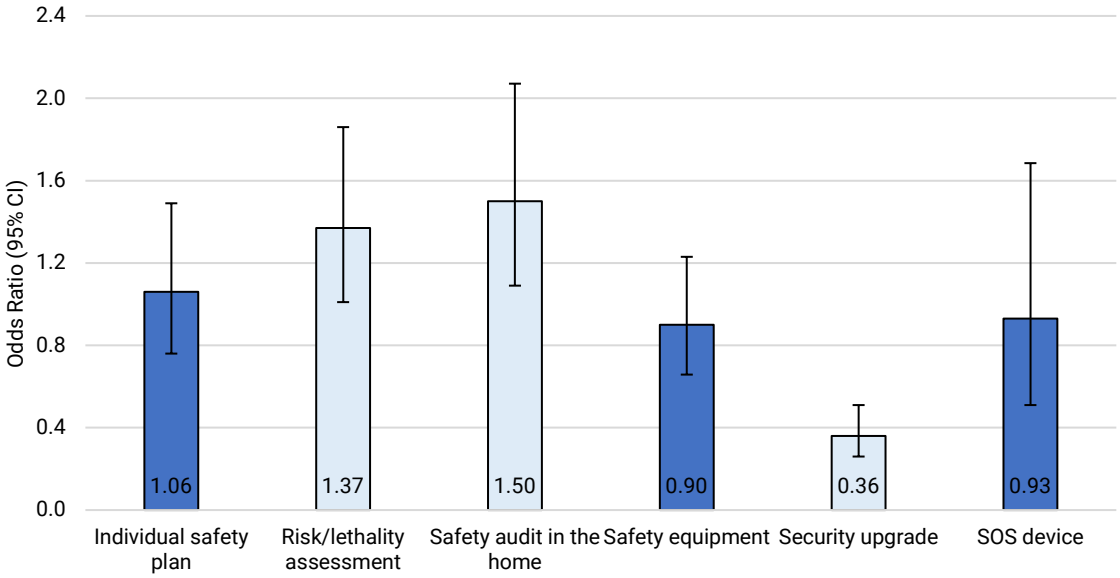

Figure 30. OR (95% CI) of clients in one of the new services receiving safety planning and security work (light blue significant at p<.05)

It is difficult to ascertain why these findings emerged in the comparison between existing and new services. Further research into the service provision between old and existing services is required. However, it is possible that workers in newly established services have less experience implementing the SHLV model and have prioritised different features of possible responses within the service provided.

Figure 31 presents the average difference in ORS wellbeing scores (n = 664) from entry into the SHLV to exit from the program for those who received assistance from an existing and a new service (see Appendix C for detailed findings). Scores greater than zero indicate that wellbeing at service exit was higher than at service intake, indicating an improvement in wellbeing. The size of the difference in wellbeing scores reflects the magnitude of the improvement in wellbeing.

There were no significant differences in the magnitude of improvement for individual, interpersonal, and overall wellbeing. However, clients who attended one of the new services were 1.22 times *more* likely to report greater improvements in social wellbeing compared to those who attended the existing services. In other words, the magnitude of improvement in social wellbeing scores was significantly greater for those who attended one of the new services.

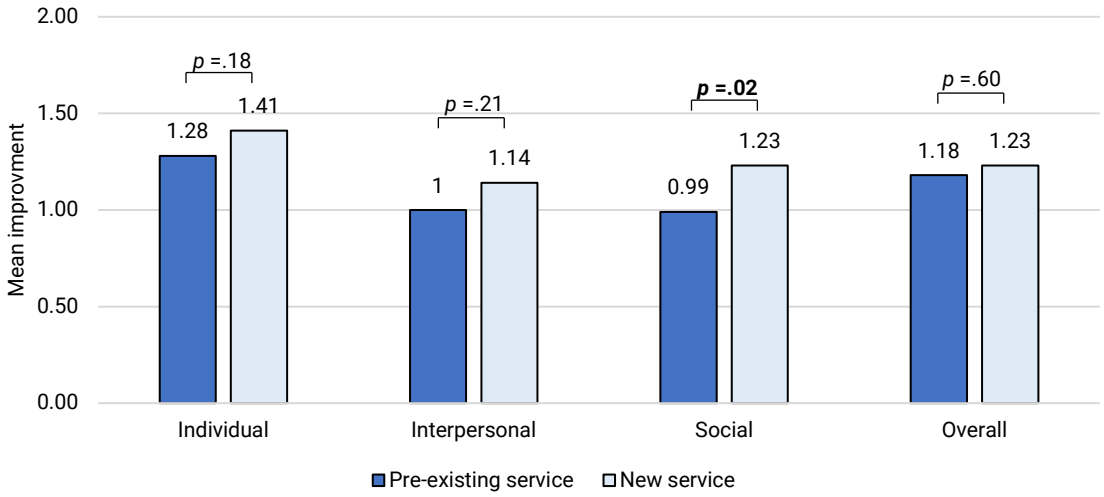

Figure 31. Average improvement in *ORS* wellbeing score by service type

Figure 32 presents the proportion of clients in the four new and 22 existing services who achieved each of the 12 service goals (see Appendix B for detailed description of findings). Of all clients who attended a new service:

- 71.9 per cent achieved their goal of enhanced safety at service exit
- 63.9 per cent achieved their goal of increased community engagement
- 56.1 per cent achieved their goal of increased parenting capacity/skills
- 63.8 per cent per cent achieved their goal of increased stability for their child(ren)
- 60.6 per cent achieved their goal of improved health
- 64 per cent achieved their goal of improved knowledge about DFV
- 48.9 per cent achieved their goal of improved management of finances
- 65.7 per cent achieved their goal of sustained housing
- 71.2 per cent reported that the service supported their separation from the perpetrator
- 64.6 per cent reported that the service supported them regaining parental responsibility
- 59.7 per cent reported that the service supported finances and employment
- 67.4 per cent reported that the service supported access to legal support and the courts.

Binary logistic regression analysis of the data demonstrated that, relative to clients who attended an existing service, those who attended a new service were:

- almost one and a half (1.34) times *less* likely to achieve the goal of improving knowledge about DFV
- two (2.08) times *less* likely to achieve the goal of sustained housing/accommodation.

Importantly, an equal proportion of clients in the new (63.4%) and existing (65.5%) services exited the program because they met their case goals or no longer needed further assistance.

A contributing factor to this finding may have been the higher proportions of clients who were not Australian citizens and who experienced socio-economic disadvantage attending a new

service. As noted earlier, clients who experienced socio-economic disadvantage were more than two times *less* likely achieve the goal of sustained housing/accommodation.

- Clients who attended one of the new services were two (2.02) times *more* likely to achieve the goal of regaining parental responsibilities, relative to clients in the existing services.

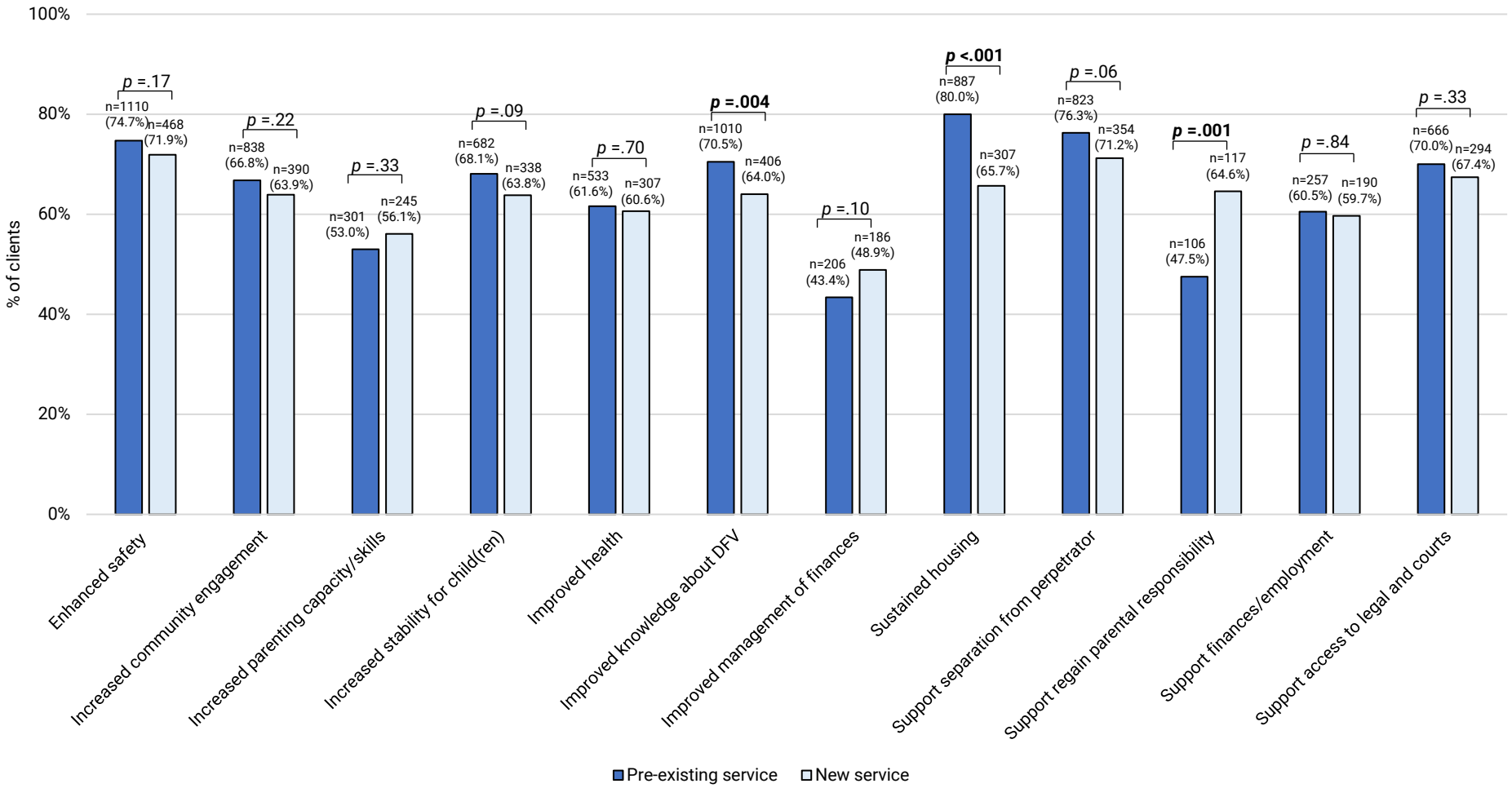

Figure 32. Differences in the proportion of clients admitted to the new and existing services by case goals achieve

Figure 33 presents the comparisons of clients in one of the new services achieving the respective case goals (only statistically significant findings are described; see Appendix B for detailed description of findings). The results of multivariate binary logistic regression analysis indicated that, after adjusting for demographic factors, the only significant finding was that clients in the new services were more than 1.58 times *more* likely to achieve the goal of improving the management of their finances, than clients in existing services.

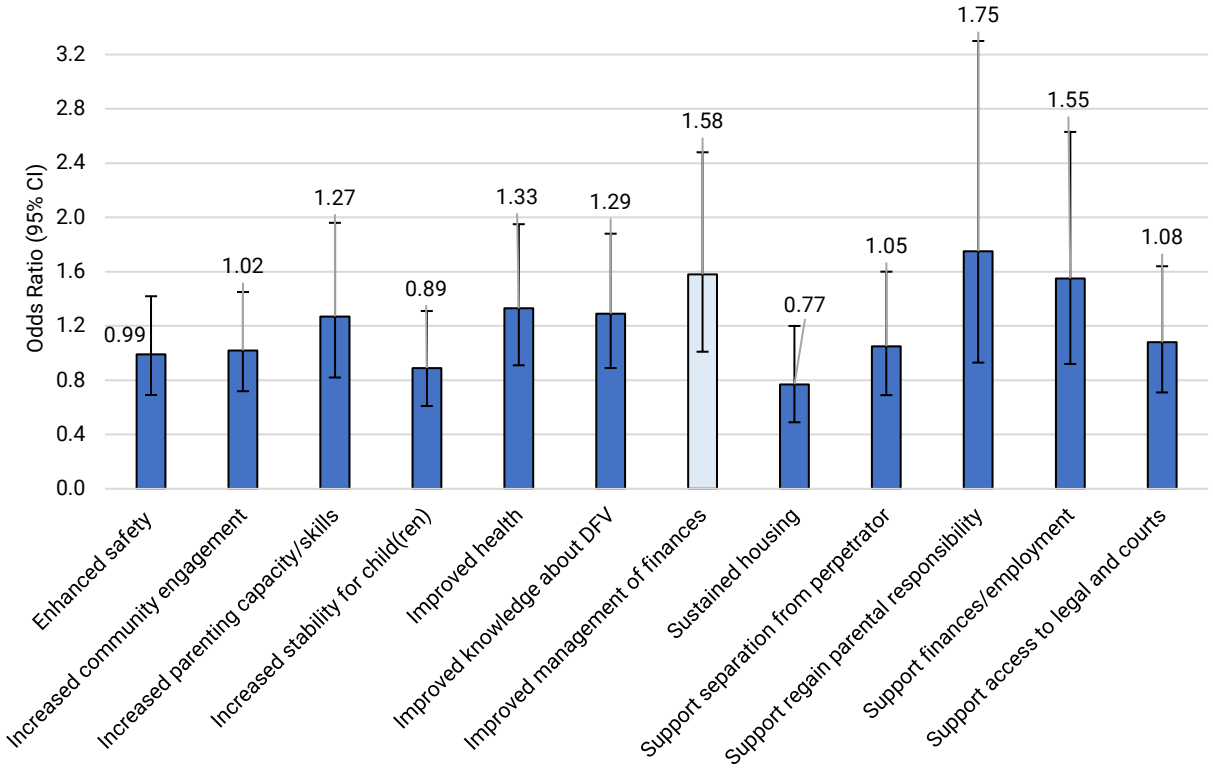

Figure 33. OR (95% CI) of clients in one of the new services achieving case goals (light blue significant at p<.05)

The quantitative data provides insight into services provided to particular client cohorts and the likely outcomes. The qualitative data which will be provided in the next section will allow a more nuanced understanding of the client and worker experience of the SHLV service.

Qualitative analysis of interviews

The research team conducted interviews with a total of 58 individuals, including stakeholders (n = 6), service providers (n = 22) and clients (n = 30) who are currently or (in the case of clients) had previously been involved with the SHLV program. Twenty-seven of these interviews were conducted in late 2019 and early 2020 for the Safe at Home National Audit and Operational Framework (unpublished), including with stakeholders (n = 2), service providers (managers and staff) (n = 8) and clients (n = 17).

In 2021, additional interviews were conducted specifically for this Evaluation with the five new services that received SHLV funding in 2019. The new service interviews include stakeholders (n = 4), service providers (managers and staff) (n = 14) and clients (n = 13). All names included with interview quotes below are pseudonyms; interview participant names are withheld.

For the existing service interviews, 24 of the 30 client participants were living in stable, long-term housing following their involvement with SHLV. The remaining six clients were planning to relocate and were receiving ongoing case management support. Fourteen client interview participants relocated during their involvement with SHLV.

Overall, the SHLV program was regarded very positively by the service providers (managers and staff) and clients interviewed. All clients interviewed described being very satisfied with the provision of SAH through the SHLV program. In particular, they spoke highly of the dedicated support they received from caseworkers.

Client Housing and Safety

All interview participants were overwhelmingly positive about the capacity of the SHLV program to enable women to live in stable housing and remain free from violence long-term.

Safe and stable accommodation

Clients interviewed reported living in safe and stable accommodation or an increased feeling of safety in the home as a result of the support provided.

> *The house [was the best part of the program]. They put me in a safe place. It's a huge difference because we feel safe. We have a roof over our heads.* – Client (new service)

> *It's nearly two years now and our lives have changed for the better, big time. I didn't know there was that kind of support out there.* – Client (new service)

It was clear from the interviews that remaining in the family home is not a viable option for some women. This may be due to ongoing fear and harassment, being unable to afford rent or mortgage costs, or associated trauma in the family home. The service supported clients to find appropriate housing and relocate.

> *I feel safe. At my nan's, I would get a lot of anxiety and that about different things and I would always be locking the front screen door and that. I always still lock the front screen door, but I feel more relaxed at my own place because not many – like, not many people know where I live.* – Client (existing service)

I didn't want to live in my home, and that's what I kept saying to them. And they could understand where I was coming from and what I was saying. I don't want to live in me home and feel like I'm a prisoner... I don't want to have to live like that. I still want to live normal and have me kids grow up… – Client (existing service)

Most of the clients interviewed felt that their safety and housing stability was long term, and they had no intention of relocating. Service providers said it was rare for SHLV clients to return to the relationship following their engagement with the program.

Community housing… It's made a big difference, I've got help to get in this house because I was actually living in a caravan at the back of my parents' house with my seven children… and pregnant with eight. Then I got this house... and, because [I was] having my tenth [child] they ended up putting a granny flat in my backyard for me... I've been here seven years and I'll never relocate now. – Client (new service)

I very, very rarely hear that an SLHV client has invited the perpetrator back into a home and continued a relationship, as opposed to the refuge model where I find women will generally return. –Service provider (new service)

Service providers emphasised that safe housing, including relocation or security upgrades, is dependent on each client's needs. For example, some women may only need a lock change whereas for others case management may be more involved.

It depends on the nature of the home, the risk that the woman may face from the perpetrator, the style of home and the tactics used by the perpetrator. Often, it's not safe at all for the woman to stay in that home and she may have already left, or she's made it quite clear she doesn't want to stay so we will support her… But generally, even once locks are changed, a woman feels a lot safer in staying in her own home. – Service provider (existing service)

That's right. I mean we may have a client that does not need to have any security upgrades done, but it's just walking beside her through her journey and letting her know she doesn't have to do it on her own. – Service provider (existing service)

Housing Support

Housing support is a significant component of SHLV case management, particularly in the early stages of a client's engagement. Clients felt that the housing support they received was beneficial, including case workers advocating with real estate agents and public housing, assisting with paperwork, and locating temporary or short-term accommodation.

[I asked] How do I get a rental when I've owned my own house and never rented in my life? So, she gave the real estate a ring to explain what was going on and I went to look at a house and when I got there the real estate agent said you're already pre-approved... And I'm like 'oh my god [suburb] is so hard to get a rental, yep I'll take it.' – Client (new service)

Service providers emphasised that housing is a significant component of SHLV. Housing support can alleviate some of the burden on women to find safe and affordable options. Developing positive relationships with local housing offices can be beneficial in this process.

That relationship with the local housing office makes a difference, too. We have really good communication with them. If the regular avenues for housing don't work out, that's

something that is the backup plan... The feedback's been good, and I think it has been pretty seamless because we try to hold a lot of that pressure. – Service provider (existing service)

In the new SHLV services, four clients that we spoke to told us that they were still living with the perpetrator when they first engaged with the SHLV program. Traditionally the SHLV model requires the woman to have left the relationship; however, these clients had positive experiences engaging prior to leaving the relationship. These women were able to develop a plan with their case manager to leave the relationship safely with financial and housing needs addressed in advance.

> *[In the first instance] we just worked out a plan to safely leave the relationship without him knowing… because I felt so stuck with the financial burden of leaving, when we had a plan in place, I felt like I could make the move.* – Client (new service)

Service providers at the new services told us that, while working with a woman while she is in the relationship is not always ideal, it can have positive outcomes. Services are limited in the supports they can offer in this scenario, but providing domestic violence education can be beneficial. Furthermore, this preliminary support can help to establish trust between the case worker and the client.

> *On occasion we get a referral through and there's a man still in the home and we know that we probably don't get the best outcomes there. However, we can deliver a little bit of education and some options at that point.* – Service provider (existing service)

> *The majority of our clients are Aboriginal clients so that makes a big difference for them. As [colleague] said if you're able to do a little bit of that pre work with the victim as such, even whilst the perpetrator is in the home, I think that it's doing that little bit of early intervention and pre-empting so that we can start to develop that little bit of a trust. [It works] a lot better.* – Service provider (new service)

Personal duress alarm response system

Staff and clients interviewed from the new services were asked specifically about their thoughts and opinions on the personal duress alarm response. Stakeholder interviews were also conducted with PoliceLink, who oversee the dedicated Police response line for the alarms, and mCareWatch, who manufacture and manage the devices.

The mCareWatch devices were introduced in mid-2021 following numerous issues with the previous provider and model. These devices were only provided to the new services in the last few months, and in one case the service only received them six weeks prior to the interview. Comments in relation to functionality and reliability are preliminary.

Overall, the feedback on the personal duress alarm response was positive, noting a significant improvement from the previous model. A few concerns were, however, raised in relation to eligibility requirements with AVOs, reception issues in regional areas, and information sharing between organisations.

Effects on safety

Of the clients who participated in interviews from the new services, four women had been provided with a personal duress alarm. All clients felt significant improvements to their

sense of safety and comfort in the home and in the community. The direct Police response line and the ability of the watch to record evidence once activated were highlighted as particularly promising features. Clients told us that their friends and family also felt greater comfort knowing that the watch provided an additional level of protection.

> *I can tell you they work immensely well. There's been a few incidents before I actually moved out of the marital home where I would just press it and the Police would turn up. I basically call it my lifeline. Without it I don't think I would be able to put myself out in society... [my friends] all worry about my ex-partner... and when I got the watch they said 'well that makes us feel better.'* – Client (new service)

> *With the watch, I was sort of scared like to get onto the Police, you've got to go through 000, all those steps you know… it makes you feel really safe that watch, knowing that they can hear everything what's going on.* – Client (new service)

Case workers similarly raved about the benefits of the watch for clients and their families. They emphasised that while there may not have been many incidents or activations, they have noticed drastic changes to women's felt and perceived safety.

> *When they work, they work wonderfully… It's like what better thing can you have in your toolbox than that?... We've probably had, I don't know how many incidents in total where they've used them and there's been a big response. Probably not as many actually. I found them to be the most helpful for sort of helping a woman feel that there is help there, should she need it.* – Case worker focus group (new service)

Case workers did provide an example of a recent occasion in which the alarm was used and successfully prevented an incident, highlighting just how effective the response can be for women.

> *One of our recent ones. Police had to respond, and it was just perfect, because he was released, and he went straight to her home and she pressed it and that was one of the magical ones where the Police came and it all worked as it should.* – Case worker focus group (new service)

A concern raised by stakeholders was the low rate of activation and whether women are instead opting to call triple zero directly. Case workers told us that some clients do feel more comfortable with a mobile phone than the device.

> *The question I would be interested to know is are they contacting police through another means outside of the device? Is the device just for that scenario when you can't talk*. – Stakeholders

> *Sometimes … [a client will] feel a little bit more comfortable with a mobile phone than they do with the device… It just depends on the client you know and they're used to carrying mobile phones with them everywhere.* – Service provider (new service)

Functionality and usability

The mCareWatch device presents like a smartwatch or fitness tracker and signals an activation to the user through vibration rather than sound. The discreet style of the watch enables women to trigger the alarm without alerting anyone. Clients reported greater comfort in knowing the device is inconspicuous.

> *It's a smartwatch. It is a GPS tracker and it works in complete silent mode or stealth mode. What that means is that…it looks like a Garmin smartwatch, which is discreet.* – Stakeholder

> *It's just a simple press a button and no one would know what I am doing because it looks just like a fitness watch…To be discreet is the most amazing thing because that's the last thing you need is to trigger the other person to know there's a watch beeping or there's something going on.* – Client (new service)

Service providers have access to an online dashboard from which they can monitor how often the client is using the device, including days it is charged, how often the device is switched on and SOS activations. Staff did not comment on this feature.

> *Our dashboard, so this is something that they can log into… they can see the quick snapshot to see, 'is the client using the device?'… They can actually see how many days during that one month was the client using the watch or was the device switched on and they can also so see was there any SOS activations.* – Stakeholder

Reception

Device reception, particularly in regional areas, has been an ongoing concern for services when issuing duress devices. This issue was particularly pronounced with the previous iteration of the devices which saw women unable to use the device in an incident. The watch providers told us the new iteration ensures longer battery life and greater connectivity. Service providers were hesitantly optimistic but felt it was too soon to definitively say whether the new devices had effective reception and connectivity.

> *Our watch meets all the Australian standards. What we have is a watch here that also uses Wi-Fi. So, over the number of years what we've learned is that you can't just rely on GPS. GPS is great if you're outside, but not everyone will be outside.* – Stakeholder

> *Look, we haven't had the best experience with the SOS devices in this area, just due to the telephone towers not connecting to the devices. But I know they've just given us those new ones and I haven't heard any feedback that they're not working yet.* – Service provider (new service)

Requirement of an AVO

PoliceLink have stipulated that an important eligibility requirement for the duress device is that the client has a current AVO against the perpetrator and thus has had prior contact with Police. Currently, not all clients with a duress device have an AVO and therefore PoliceLink are looking to work with DCJ and services to ensure that for clients without an AVO there is approval from PoliceLink for the device to be issued.

> *One of the stipulations for the issuing of a device previously was that the victim needed to have an AVO in place… The AVO told us that there had been some contact with police and that it had been deemed that they would be a suitable candidate… We haven't quite achieved what want to, in terms of understanding how many devices are out there to people that don't have an AVO in place… Going forward, if a device is issued to a client without an AVO, that will come to [us] and we'll do an assessment around whether or not that's suitable.* – Stakeholder

Case workers stated that there are numerous reasons that a client may not have a current AVO but that does not decrease their level of risk. An example provided was that, if a woman is waiting for AVO approval or for the AVO to be served to the perpetrator, this can be a critical time of heightened risk and instability. Having a mandatory AVO as a condition for receiving the duress devices can therefore create gaps and delays in immediate support and risk management. PoliceLink further noted feedback they had received about women who do not feel comfortable engaging or reporting to Police due to prior negative experience or general distrust of the Police, which then may leave them ineligible for the devices entirely.

> *It's been really important for a couple of the women that I've worked with to cover that time before the police are able to serve [the AVO], even serve the provisional AVO because he is hiding. And it's been incredibly helpful to have that for that time in case he just turns up and does whatever.* – Case worker focus group (new service)

> *Certainly, there was some feedback to say that some victims didn't particularly want to engage with police… Whether or not they had a bad experience previously or an outcome that they didn't expect or for whatever reasons, they didn't want to engage with police. So, it was very enlightening for us*. – Stakeholder

The eligibility requirement of a current AVO can also be a limitation for women if their case is historical. One client described having to go into hiding because she knew she was not safe in the community but did not have a recent AVO and was therefore ineligible for the SOS device.

> *We talked about the SOS device, but you need an AVO and I didn't have one at the time. I had AVOs on both [perpetrators] previously, but they had both expired… Again, going off gut feelings things had started to stir again. [Case worker] tried her best, but that was just part of the rules and that is something that was a big barrier for me to accept because that was something that I was holding onto that if I was right again and if they were in town, having the SOS device to use would have made me feel safer. I actually, I ended up going into hiding and hiding in my home and refusing to leave until I felt like they had gone.* – Client (existing service)

Technology and security upgrades

Brokerage for technology and security upgrades was another key success factor for positive client outcomes. Clients told us that security upgrades significantly improved their feelings of comfort and safety in the home. Clients were particularly appreciative when the upgrades were tailored specifically to the house and the behaviours of the perpetrator. One client, for example, told us about maintenance staff going out of their way to find a screw that could not be used with a standard screwdriver. The perpetrator subsequently tried to break into the home but was unable to due to these specific screws.

> *He searched high and low to get the screw that wouldn't go into the waterproofing, and something that [perpetrator] couldn't use a screwdriver with. And when I got home there was a screwdriver under me kitchen window. He's left, but kick in the guts, because you can't get in, because it's not a screw that you can use with a screwdriver… They'll go right out of their way.* – Client (existing service)

> *Checking that I had correct locks and fittings, peepholes, security lights, making sure my windows locked and I had proper winders so that I was safe, so they couldn't just bang open. So, I found that they really helped me feel a lot securer in my home. Yeah, so that was good.* – Client (existing service)

Service providers have found that being able to offer this practical solution to a client's safety needs can have a drastic effect on client outcomes.

> *It sounds like a petty thing, but that brokerage is a really, really big thing. For somebody to come in and say, I have this little barrier, I've got this screen door. It's making me feel unsafe. It's a huge thing to be able to go, yep, let's sort it out. I'll help you.* – Case worker focus group (new service)

> *You know to feel safe in your home, makes you sleep better, you're more productive. It is that added sense of security, and it's also knowing what you can do about it if he does breach or if he does show up… I think that just creates a sense of security with everyone.* – Service provider (new service)

Staff and clients further discussed technology upgrades improving their overall sense of wellbeing and safety in the home. Two clients told us about the security cameras successfully capturing AVO breaches and attempted break-ins by the perpetrator which was used as evidence in court.

> *The CCTV that was installed helped, on occasions, the family attended the property. They sent a personal investigator. All of these things are recorded and can then be passed on as evidence... It makes a massive difference in proof of the intimidation. A lot of the perpetrators will say, 'No, she's crazy, I'm not doing all of that,' so that cuts that into black and white. 'Yes, you did. You were there.'* – Client (existing service)

> *They put the security screens in, and they put the security cameras up, which was quite useful because he did turn up at the house and it was used in court as evidence. Without the security camera, I wouldn't have had any way of proving he was there because he'd already left before the police turned up.* – Client (existing service)

Clients further told us that their children feel safer in the home as a result of security and technology upgrades.

> *My 3-year-old has been diagnosed with autism and ADHD and he'll point to the cameras and goes 'mummy we're safe'. So for a 3-year-old to point that out, you know that means a lot. – Client (new service)*

> *I was able to make my kids feel safe.* – Client (new service)

Client Stability and Wellbeing

Client Wellbeing

The overall wellbeing of woman and children increased as a result of the support provided. Clients described feeling stronger and more independent which has had positive effects on their life and relationships.

> *I'm finally myself again. It's nice. It's a great feeling.* – Client (new service)

> *Well, now I feel like I'm feeling stronger than ever. I went through it for years and years, but now I'm just getting on my feet, and I feel safer with the device, and I feel good with the counselling. I feel good speaking to [case workers], with [service]; it's good. It's a good support network that we have.* – Client (existing service)

Interview participants were overwhelmingly positive about the success of the SHLV program in supporting women and families. Participants identified numerous critical success factors which predominantly related to emotional and educational support provided by a sole case worker.

Wrap around support

First, service providers and clients discussed the benefits of long-term and wrap-around support enabling the program to address a client's safety needs across every aspect of their life on an ongoing basis. Having a single case worker providing continuous support can relieve a lot of anxiety and fear for clients and help to ensure they are able to remain free from violence long-term. Service providers told us that the duration of engagement varies widely between clients depending on the nature of their case and the level of risk.

> *[The success of the SHLV program in] being able to support the client for a long period of time… With SHLV it can be two years or more and I actually have quite a few cases that are well and truly over the two years… Because their matters in the family court for example could go on for many years. They're still experiencing domestic violence but through a legal process.* – Service provider (existing service)

> *They can stay on for as long as I need them, they said. Even up to five years and everything so that's really good. Because the other services like they dropped me… That gave me real bad anxiety.* – Client (existing service)

Service providers found that it was important for clients to be able to reengage at any point should their level of risk change. This provides additional assurance and comfort to clients.

> *I think what I like about the service is women can keep revisiting because sometimes you're not going to get a woman on board the first time… we're always open* – Service provider (new service)

> *I had dropped off the books, but I've been re-referred due to another incident.* – Client (new service)

Access

Data gathered in relation to specific groups of women indicated that there is notable evidence that the kind of perpetration, significance of risk, and barriers to help-seeking can

be more difficult for specific population groups, including but not limited to Indigenous and CALD women, Older women, and women with physical disability. It is clear from interviews with staff that the SHLV program is effective in responding to specific needs based on population groups.

> *Absolutely [it's effective]. It's so multicultural. I've worked with clients from an Asian background, Indonesian, New Zealand, Australian. I've just recently engaged with two Aboriginal clients, which is absolutely brilliant. I've noticed that, since working with the program, working within the Indigenous communities, is a lot harder, but our program's definitely valid... We help all women… The [need] is definitely there.* – Service provider (existing service)

> *We've got a very diverse groups here in [region]. We do have same-sex couples. We do have women with disabilities, we have women with children with disabilities. It's really got to be person centred and looking at each case individually to come up with a plan and definitely for different groups of women, we may go down one path that we may not go with others.* – Service provider (new service)

Service providers did note that, depending on the circumstances of the client and whether they are already engaged with other services, clients from specific population groups may require more case coordination. Positive results can come through this approach by working with supports that the client knows and feels comfortable with.

> *Really strong inter-agency work. Particularly even for like young mums because that's probably one of the hardest ones. Working with their existing supports and who do they feel most comfortable with.* – Service provider (existing service)

> *We've got a really recent [client] who is a Congolese family who are currently engaging in intensive case management support through [other service]. So rather than us picking that client up and trying to integrate into that, we've just been able to do some secondary consultation with [service] case manager, which has worked really well.* – Service provider (new service)

Support for CALD women

Regarding the provision of support for CALD women, service providers told us that it often requires additional time and patience to ensure that language and cultural barriers do not negatively affect client outcomes. This may, for example, include discussing court documents in plain English or with a translator so that a client is clear about what is stipulated. Similarly, women from CALD backgrounds may not have a strong understanding of their rights under Australian law and therefore case managers work with the women to educate and inform them on these matters.

> *Sometimes I don't understand what they're talking about, and I have to ask [case worker] what that means, everything. For me it's wonderful.* – Client (existing service)

> *We've got a lot of women from CALD backgrounds coming through now, who've got limited understanding about the laws around domestic violence in Australia and their rights. Even a lot of women reluctant to report to police for whatever reason. It may be because they've had a very negative experience with police from the country that they've originated from.* – Service provider (existing service)

Service providers and clients from a CALD background reported increased isolation and limited friends and family in Australia. Clients told us that engaging with the service fostered a sense of belonging and community.

> *Because I have no one here, I am by myself in Australia, so I got lots of support from [service]. They have been amazing.* – Client (new service)

> *But like at that time I couldn't do. Making me feel like wanting to come home to the Philippines so I can get the comfort of my family but [I couldn't] because of lockdown as well.* – Client (new service)

The use of telephone-based interpreters was discussed by all services. This can be particularly useful when discussing specific information pertaining to a client's case, such as court documents.

> *I guess for us, then it's looking at delivering with an interpreter. Depending on her language skills, it's about doing that assessment and asking her about what's right for her. Learning about her cultural differences and how we need to respect that.* – Service provider (new service)

Finally, service providers noted that visas are incredibly restrictive for women experiencing domestic violence and that women often have limited options for long-term residency.

> *Women that [are] on Visas have very few options, very few options, and even under that Visa, DV doesn't really have any weight.* – Service provider (new service)

Support with women with disability

The provision of support for women with disability was discussed by service providers, noting this often involves case coordination with support workers, disability workers or NDIS workers. Here, SHLV may focus more on brokerage and security support because clients are receiving case management elsewhere.

Security upgrades must factor in the capacity and mobility of the client, for example an alarm would be ineffective for a deaf client so the service may opt for a light-based sensor alarm instead.

> *Someone with physical disabilities, I think it's really important they stay in their home 'cause generally the home is set up for them… it would be if we put, security locks on the door that the key stays in the door, so they're able to access it quickly if that's a restriction of their physical disability. Same with children in a wheelchair, we need to make sure that any safety precaution we put in the home is something that everyone can access in the property.* – Service provider (new service)

Support for First Nations women

Service providers at one service told us about the value of having Aboriginal and/or Torres Strait Islander staff in the service whom they could consult if they needed advice or guidance in how to proceed with a client. The option is also available to clients to either work with an Aboriginal caseworker or one of the dedicated SHLV workers who were not Aboriginal. This provided numerous options for both clients and staff to achieve best outcomes and a tailored response for First Nations women. Not all services interviewed

have dedicated Aboriginal and/or Torres Strait Islander staff; however, there are strong benefits for services that do.

> *If there's something that we're not sure how to handle when it comes to an Aboriginal family, we certainly get advice about if we're doing it right. And we can also get one of them to come with us if they really particularly want an Aboriginal caseworker. But in two and a half years we've not seen one Aboriginal client who has asked to have an Aboriginal caseworker, and I think that makes me feel really good.* – Service provider (existing service)

The new services funded in 2019 are all in regional areas and these providers told us they have a high volume of Aboriginal and Torres Strait Islander families engaging in the program. These service providers emphasised the importance of developing connections in the Aboriginal community and providing tailored support not only to an individual but to a wider family as well. Staff further highlighted the importance of working multi-generationally and ensuring that not only parents but also children are engaging with education and therapeutic programs.

> *I suppose we have a lot of connections in the Aboriginal community that really do support the work… I'll be restarting [a program] in the hope of educating, a lot of that therapeutic type work just to reach in where those gaps we have missed because mums have gone through it so now we're now working with the children of the mums and their children.* – Service manager (new service)

Furthermore, service providers in regional areas told us that often communities are small and close-knit, meaning case workers must be mindful of how they intervene in community relations when delivering the program.

> *We've had a couple [of cases] that have been from family based, from sisters to brothers to uncle and aunt. And that is a very difficult area to navigate. Because then you've got this one believes this family member and this one believes this family member and then you're creating that whole divide…. you then can split a town.* – Service provider (new service)

> *The Aboriginal community up here is very close-knit. Everyone knows each other's business. You actually can't get away from that situation. So, it really has been for us about one, making sure my staff are safe, going into those situations; two, making sure any upgrades or safety plans that we're putting in place with this family that there's someone else that knows about it as well.* – Service provider (new service)

One client interview participant who identified as First Nations discussed the value of referrals into programs for Aboriginal and/or Torres Strait Islander women and families. The client discussed an improved sense of wellbeing and connection with community as a result.

> *I think the best thing was the sense of community, women community. I thought that was the best. There were so many different programs. They showed me that I wasn't alone in that situation. The healing programs. I got to connect with my family again, being Koori. I didn't have a car at the time that I first started going. They picked me up*

and took me to transport to different events and took me out to the Mission, out to the... yarning group circle, which I love that. – Client (existing services)

Support for Older women experiencing family violence

Service providers (managers and staff) during interviews discussed an increase in reports of non-IPV family related violence in NSW which can challenge the ways services are delivered. Service providers feel that there is a gap in the service system for Older women and family violence, noting an absence of suitable tailored support options. They described difficulties for clients in ceasing contact with the perpetrator if the perpetrator is their primary carer, adult child, or adult grandchild.

In terms of case management, this may mean the case manager must develop a safety plan with the knowledge that the perpetrator will remain in the client's life or return to the home at some point in the future. The priorities and outcomes of the program change in this context and the emphasis is on providing clients with education and resources to maintain the familial relationship in a safe and sustainable way.

> *We're finding an increase in violence from adult children… I've just been speaking with a family, the grandmother, she's eighty and her adult daughter is in her sixties and then they live together with the grandson. He is an alcoholic and drug user and he's just been increasingly violent and over the years… recently they've taken out an AVO…. it is a real challenge for [staff] to be able to work with them knowing that he's going to return to the home at some point.* – Service provider (existing service)

> *There's that mother guilt, I suppose you could call it, with the client and her wanting to support her child, but also on the same hand, she's being perpetrated against. So, that can be quite difficult for us to navigate through.* – Service provider (existing service)

Service providers feel that there is a gap in the service system for Older women and in aged care, noting an absence of suitable tailored support options. One service provider discussed a case of a woman who left her husband in her 70s. In this case, risk of ongoing harassment was minimal; however, supporting the client through the separation, learning to live alone, and the trauma associated with decades of abuse was particularly intensive.

> *In aged care I reckon there's a – there's definitely a gap in aged care for our region I reckon.* – Service provider (new service)

> *One case we've had… a 70-year-old woman who decided to leave her husband after 50 years of abuse and DV… unfortunately, that woman's now living in a caravan cause there's no housing around… He had a lot of dementia… so a lot of the charges he didn't answer to, and he was ultimately put in a home. Her physical safety was okay. For her it was the psychological, the trauma, the nightmares, finding a new way of being without her husband in her life.* – Service provider (new service)

Sexuality and gender diverse clients

For sexuality and gender diverse clients, service providers highlighted that often women may not disclose their gender or sexuality during their engagement. There is no direct question on intake regarding client sexuality and services find it is best practice to let the client

disclose on their own terms. The data on engagement and outcomes for sexuality and gender diverse clients is likely distorted for this reason.

> *We've had a recent [sexuality diverse client]... We've known this particular client for many years and we've supported her over the years. However, she's not ever disclosed that she was gay, so that was something that's fairly recent… it took her a little while to feel safe to do that.* – Service provider (new service)

DFV education programs

Clients told us about the positive effects of domestic and family violence education, both in formalised classes and through one-on-one case management, which enabled them to recognise signs of abuse and unhealthy relationship dynamics. Furthermore, clients described feeling stronger and more independent as a result of the courses. One client told us that through the domestic and family violence course she was able to unpack and break free from generations of domestic violence in her family.

> *It's taken me all these years, you know 40 years old, to realise that my dad wasn't a very nice person. I'm third generation from family violence and only going through the service did I realise that that was the case and I was like 'oh my goodness'… it's freed me entirely not just from years that I was with him but the years since I was a kid. If I hadn't been lucky enough to be with [service] none of it would have happened.* – Client (new service)

> *Education program, number one. Very high up. I don't even know if this will help at all, but I really think that they need to do more educational programs in schooling, like from an earlier age. I probably not have been in this situation if I had of recognised flags a lot earlier.* – Client (existing service)

Service providers emphasised that education is central to breaking the cycle of violence and contextualising domestic violence away from the individual to a broader systemic issue.

> *One of our biggest strengths is our DV program… It's a good shift in thinking [for women]… a lot of programs individualise it whereas we put it in the broader political context which… gives [women] the space to see the bigger picture… When women see that, it shifts that space of, 'It's just me. It's my fault. It's my upbringing. It's my parents…' to 'Well, my mother did that because look at how her parents did it and what they thought.'* – Service manager (new service)

Service providers have found that clients are more open to considering counselling after receiving domestic violence education.

> *They might, after that consider counselling because a lot of women, 'I don't want that' so we really push it with the victim services or if we can access a DV counsellor for them. But they're more ready after they've done that DV education, because then they don't feel so stupid. They understand that it's a power-control thing.* – Service provider (new service)

Client-led response and positive relationship with case worker

The importance of a positive and supportive relationship between a client and their case worker was highlighted by all interview participants. Clients described feeling supported and

understood by their case worker. In particular clients discussed court support, emotional support and the value of having a skilled domestic violence case worker in your corner.

> *The best thing about the program [is] I never felt that I'm alone. I never felt that for a day that she left me behind… she would always call me almost every day and ask me 'Do you still feel safe?'* – Client (new service)

> *[At first], I was not looking for a safety plan, I just wanted someone to listen to me. She listened to me, and she guided me.* – Client (new service)

Service providers emphasised that their aim is to empower clients to live autonomously and independently. Here they addressed the value of client-led responses which respond to the specific needs and concerns of each woman.

> *We have quite a lot of autonomy as to the kind of support that we can offer. I think that there's a big focus, at least here anyway, is that the clients leading the client support that they want. They now have control over that over these things.* – Service provider (existing service)

Control of finances

The final critical success factor that was evident from interviews with service providers and clients was the control of finances through the SHLV program. This encompasses both clients having a voice in decision-making for brokerage and security needs, and the SHLV program providing clients with financial advice and guidance.

An important component to the brokerage success is the flexibility to tailor the spending to the specific needs of the client. For example, one client discussed receiving financial support to secure a bond and repair her car which she said could be the difference between returning to the relationship or continuing to live independently.

> *They did the bond on my house, when my car was pulled apart and not fixed, they did that. If I need... On the odd occasion I just can't make ends meet, I can come down here and get a petrol card or a Coles card... even though it doesn't seem to blink in, if you have no money, sometimes your only option is to go back to that person because you can't support yourself. But with this organisation you can.* – Client (existing service)

> *[The Victims Services Immediate Needs Support Package] really assists the client to get back to scratch because they're often left with debts from the partner, damaged furniture and it allows them to breathe… it really does aid our clients to offset that sting of all the financial things that can go wrong when you're in DV.* – Service provider (new service)

Clients were offered professional financial planning advice, particularly around debts inherited in the relationship and managing finances moving forward. One client told us that her financial advisor contacted each organisation on her behalf seeking a grace period in repayments which enabled her to slowly pay back debts and get back on her feet.

> *She offered me financial planning assistance, so they had [redacted] on the financial team whom if you struggled with any financial bills and things like that, [redacted] took care of those. For example, my husband wasn't very good at paying bills and got us*

behind on a few things so [redacted] sent off letters to each of those organisations explaining the situation. – Client (new service)

For me, coming from the DV, I'd never been in control of me own money. So, to budget was just shit. I didn't know how to pay me own bills. They linked me up with [another service], who gave me some financial advice on how to budget and helped me out with one of my bills. I found that helpful because it taught me to prioritise and do payment plans with things that I can't afford. – Client (existing service)

Referrals to other supports and service linking

Clients discussed the value of case workers facilitating referrals to other supports including counselling and legal support.

[Case manager] said 'I highly recommend you see someone' so I saw a DV counsellor, I also saw a psychologist independently for myself which has been ongoing for 18 months and... it made me heal. It made me see things a lot clearer, that it wasn't me who had the problem it was him. – Client (new service)

I was referred to a really good solicitor as well by [service]. And they did legal aid which is so good… and it was a really good family court solicitor as well. – Client (new service)

Court support was also addressed by most clients, noting this significantly reduced the stress and anxiety of attending court.

Having the support and having someone there to walk you through you know the court case and all of that sort of thing. Having the girls there on the day at court, that was absolutely amazing. Just having somebody there that you could talk to who didn't judge and was able to help you out. – Client (new service)

Service providers told us that, particularly in small regional towns, developing longstanding relationships with local services and the broader community is important.

The program is well known in the community. We receive referrals from all organisations and services within the [service area] and broader communities of service delivery. – Service provider (new service)

We have some really good long-standing relationships with the key people at other agencies that we really need… [For example] we have really good relationships with our local police. So our DVLOs, we generally know who is on the day. – Case worker focus group (new service)

Support for children

Clients were positive about supports and programs offered to children through the service. This included therapeutic programs and childcare support. For clients, the knowledge that their children are safe was central to the response.

When I was at my courses, they've got beautiful facilities and really nice staff that look after the kids. My teenager had been there and so had the young kids and they just had a ball like painting in the centre itself. They're really, really good. – Client (new service)

Knowing that me and my kids were safe, that was my main thing. And having concerns about a lot of things around here and I sort of got through them all. It's funny how things work out. – Client (new service)

Case workers told us that they endeavour to tailor the response to children and to understand what might help a child to feel safe and comfortable at home. This may also include doing an individualised case plan for the child along with the parent, depending on the child's age and circumstances. One service ensures that at the beginning of each client engagement a bag of artistic and therapeutic items is given to each child to acknowledge and bring them into the program. Services providers told us that they see positive outcomes for children when these additional steps are taken; however, more can be done to formalise this in the future (see discussion below in relation to future design options).

[We] have a real focus on how we're supporting children, particularly in our refuge based outreach as well… There are times when we can do really specialised responses for children… We are trying to really integrate that into our response, consider when we would do an individualised case plan for the child, as well as for the parent. – Service provider (new service)

We're passionate about acknowledging children's experience and providing everything to the child that we do to the Mum, but we can't always and enabling real space for the child's voice to be heard… When you meet a family, you take a trauma pack for each child … the idea behind the packs is that it's a way of deliberately meeting and acknowledging each child. – Service manager (new service)

Comments from the new services

Two of the five new services told us that, prior to taking on the SHLV program, there was no specialist domestic violence program in the region. Specifically, the ability to provide women with dedicated case management through SHLV has filled an important gap in the provision of domestic violence support. Service providers have noticed a boost in community trust in the service's response to domestic violence because they have the appropriate resourcing.

My knowledge was there was no DV-specific program within the area… and because we're able to deliver the program how we see it meets our community's needs and not one generic program to source everybody. I think that's what's been useful for us. – Service manager (new service)

While we were delivering a response for DV [prior to SHLV funding], it was actually an SHS service response. It was crisis accommodation and not necessarily DV accommodation. So that was really hard for the community to accept that actually we were able to respond to DV… I think the strength is that we're able to develop specialisation in the DV space. – Service provider (new service)

Service providers also found that the program was able to evolve over the last two years. Three of the five new services developed an integrated program model in their service wherein all case managers work across multiple programs, including for example SHS and SHLV. Staff said this has positive outcomes for clients who can keep the same case manager throughout their engagement.

We have basically tried to create an integrated spectrum of services… We've got six case managers who do SHS and SHLV. It's really great for a seamless experience for clients. Majority of the time they get to stay the same worker and kind of go through that process, which is really good. – Service provider (new service)

Initially we employed two case workers under the SHLV Program itself, and then we had workers [in another program], but we actually evolved along the way and we changed that to all case workers providing [both] services. – Service provider (new service)

Challenges to achieving positive client outcomes

Challenges to service provision were also reported by service providers. Some of these do not relate to the program itself but are external barriers over which case workers and services have no control.

High case loads

Staff in all participating services emphasised an overwhelming client demand which is only increasing. Service providers told us that the program resourcing does not sufficiently cover demand. Considering how involved long-term case management can be, it is not always possible to exit clients from the program quickly and keep up with new referrals. Service providers told us that there are times when they need to close the books because they do not have the staff or funding capacity to bring in any new clients.

While the funding agreement stipulates support for a certain number of clients per year, services found that this does not reflect actual demand or client need. For some women, particularly in regional areas, the SHLV program may be the only available specialist domestic and family violence support which offers case management, and therefore service providers feel a responsibility to work beyond capacity to ensure support is given.

Most services opt to have two case workers in the SHLV program and keep other funds for relief work and brokerage. There is flexibility in how services choose to assign their funding between staff and brokerage, and therefore the arrangement does vary. Services told us that they are under-resourced and that an additional staff member would improve the response and help to meet community need.

Our referrals have probably, they've probably tripled, haven't they, in the last two years. We were working at 40 clients and a hundred children, or something was around about what the program worked at. And I think we did, was it 130 last year, 130 clients? Not including children… We had, like, 600 children or something. – Service provider (existing service)

I think one of the things we identify with our team is the funding only allows us to have two staff members. I think to have a third staff member would be invaluable, because if one person's got a day off sick or goes on leave, it actually means the other case worker can't do any home visits … I think would give us a lot more room for movement and allow us to provide a better and bigger service. – Service provider (new service)

One of the new services told us they made the decision to limit case management to three months for all clients because they found that long-term case management is not

sustainable at their budget given the volume and demand in the area. While this is not the preferable option, they felt this was necessary in order to continue taking new referrals.

> *Right from the get-go it became very clear to us that even though the program guidelines say'"It can be long term…' that we just couldn't sustain that. Because of the volume of demand that comes towards us, we can't. If we did that, we'd have to say no and close our books, which we don't want to do because there is no other program locally that can do what SHLV does… Of course, the preference would be long term but we actually can't do that. It's not manageable at all. So it really is that short-term three months.* – Service manager (new service)

Limited housing availability

We know from the literature that domestic violence and homelessness are intertwined. Service providers emphasised the SHLV program is only effective if there are affordable housing options for women to either remain in the home or relocate. Housing subsidies such as Start Safely have a positive impact; however, in many areas, particularly in regional NSW, the housing is simply not available.

Service providers described working on cases in which the woman is in unstable housing, whether homeless or staying with friends, which complicates security measures and safety planning. The level of housing support provided varies between services. For some services, supporting a homeless client to find housing and relocate is beyond the scope of the program and capacity of providers. Interview participants felt this is a gap in support which can leave women in vulnerable and potentially dangerous situations.

> *How do you try to increase safety in a home when there's just no housing available? … Being in a rural area, there's just less housing available. You see a lot of people sleeping rough, and couch surfing. It's really hard for us to do what we do around security measures and things like that if there's no housing.* – Service provider (existing service)

> *It's tricky for us to work with women who are homeless, which we tried many, many times, and we sort of face the same sort of issue, is that it's more, I guess, a referral onto [service], that do that sort of work. Because you know, it takes up a lot of time, trying to support with finding housing, and that's not so much our area. It's hard to do safety planning and addressing those specific needs if they are homeless.* – Service provider (existing service)

The new SHLV services identified the housing crisis as the biggest barrier across regional NSW. The new services said this has worsened since the program was rolled out in 2019.

The rental market is a major obstacle due to high market rates and low housing availability. Furthermore, safe houses and transitional accommodation are often at capacity and women cannot move on from these properties into private rental or community housing because the availability is not there. Service providers at the new services told us that this leaves no obvious option for women and that in some cases women return to the perpetrator.

> *It's really difficult to keep people safe when we can't access safe housing for them… [it's] not only housing, but even emergency accommodation and transitional housing as well… one client in particular has returned to the perpetrator because she's just so*

sick of the homelessness and she hasn't had any good outcomes in the private rental market and through Housing. – Service provider (new service)

We have transitional properties. The issue is people aren't moving on from there because there's nowhere for them to go. Previously they could be there three months and find that private rental and move on… Two years ago you could get a three bedroom rental here for $350. Now you wouldn't get anything for under $600, which is just ridiculous, it's just not something our women can afford. – Service provider (new service)

There are emergency accommodation rooms and motels available in some regions; however, these may not be domestic violence-specific accommodation. Service providers told us that these spaces are often dangerous and traumatising for women and children.

There's a local motel and it is really traumatising to place women and children there because there's lots of drug use, there's lots of mental health and oftentimes if we take a woman and children in there, there will be police there, ambulance there because someone's going off… It's frightening, it's traumatising. It's horrible. – Service manager (new service)

Criminal justice and legal systems limit support and safety options

Service providers described ongoing frustration working with, and often against, legal and criminal systems which fail to protect clients. The systems were described as another means of abuse and perpetration. Interview participants provided examples of, amongst other things, perpetrators not being convicted or held accountable, women not being given information on custodial sentences or prison release dates for perpetrators, and women being forced to have contact with perpetrators through family court orders.

The criminal justice system. It fails clients all the time… Perpetrators not receiving custodial sentences for their crimes when they've already been issued with some type of bond or non-custodial sentence. And they're continually reoffending and being released into the community and perpetrating again. [They're] not being held accountable for their actions. – Service provider (existing service)

Police knowledge and response were identified as a key issue with clients describing instances in which police do not believe them or take their case seriously. Furthermore, clients found that Police were limited in their response options unless there was visible trauma or direct and identifiable threats.

Sometimes I felt the Police just couldn't be bothered... I just felt sometimes they didn't take me as serious… because at first I didn't have physical scars. I just thought are they really taking my issues to heart?... I don't think they have enough awareness or understanding when it comes to that coercive controlling behaviour – Client (new service)

My biggest barrier has been the Police. Not only do they not listen and not help, they write down very detrimental things in favour of the abuser… I think there needs to be more linking with Police and domestic violence services. – Client (new service)

> *They're very limited. I think they're very limited. And they have a limited understanding of domestic violence and how it actually affects people. And that is quite a bother… most of his last breach was on electronic devices and he would call me on a no called ID number and there was nothing the Police wanted to do about it.* – Client (new service)

One client, for example, told us that the perpetrator had relocated interstate but continued to harass and intimidate her via technology, including bugging the home and sending threatening messages anonymously. Despite this, she said the Police did not take these threats seriously and she was not eligible for an AVO. The woman wanted to relocate with her daughter so that the perpetrator did not have her address or contact information; however, she was told that this information would be available to him through family court documents, meaning there was nothing she or the service could do to stop the ongoing harassment until court proceedings ended.

> *Because most of our stuff was historical and my ex-partner had actually relocated interstate, the police wouldn't give me an AVO. They didn't see him as being a threat anymore… He's still interstate. I'm still terrified of him… while I don't have an AVO, my address will be in court documents… I can't really move anywhere until I have an AVO where they can screen my address. So, I'm excited for when Family Court does finish, because that's the first thing I'll be doing, is packing up and moving. There's lots of holes in the system still which don't protect you fully and that's one of them that I'm finding.* – Client (existing service)

Reporting and data management

Service providers and managers told us that the reporting across multiple data management systems is inefficient. Staff are needing to report through DEX and CIMS databases along with internal reporting processes for each client, which detracts from necessary client-facing work.

> *Only having enough funding for two workers, permanent part-time, it's challenging, trying to keep up with two databases, and you've got your case notes and everything else that's there, but then you've got your client support; so it kind of pulls away a little bit [from client support] … it's just very, very time consuming.* – Service provider (existing service)

Staff and managers found that the data being collected does not necessarily reflect the work being done. Service providers emphasised the high likelihood of inconsistencies in data particularly when staff are working across multiple programs and data systems.

> *It's super clunky... We've got people across four or five different programs, picking up SHLV clients and needing to then input the data. The data system's really different to SHS… so that's really tough for us to navigate. There's lots of potential for double-counting, missing or undercounting, or inconsistencies in the way we are capturing data.* – Service provider (new service)

Furthermore, staff have found that the questions relating to children in the CIMS database are the same as those for adults and are therefore not tailored, or representative of the work

being done with children. Service providers told us that there are minimal options available to report about children's outcomes, goals, safety needs and concerns within CIMS.

> *The client questions are fine, but then you enter the children into that system and it's asking you the same questions for the children as you do the adults, that really aren't relating to a child… I think it needs to be looked at a bit differently… That would be probably our one criticism, is the data really isn't reflective of the client base… And not helpful to the children*. – Service provider (new service)

Finally, providers at one of the new services told us that they have continually struggled to know what data is relevant and important to include. They told us that this information was missing in the initial training and additional guidance from funders would be beneficial.

> *The thing that I find really hard about CIMS [it is] unclear to everyone what data is important to grab, which data is less important because we want to be working with the clients primarily… two and a half years, we've sort of been waiting for someone to say, 'oh look you're doing this wrong, or can you work on this'* – Service provider (existing service)

Considerations in regional areas

All five new services are based in regional NSW. Service providers told us that there are additional limitations and considerations associated with regional areas which can complicate or delay service delivery.

A large barrier identified by all five new services and clients was a limited availability of appropriate domestic violence and family counsellors in regional areas. One client opted to have counselling over the phone which she said was helpful but not preferable.

> *I found the one thing that I struggled with was to get counselling. There was nobody here in our area who could help me… that took months until I got some sort of assistance... so now I get 22 free sessions and [case worker] has helped with that but she's actually [out of area] so I have to talk to her on the phone.* – Client (new service)

Service providers further told us that there is nothing available for children in terms of counselling and psychological support in regional NSW.

> *There are limitations within the community about what's available to children. You're looking at a vulnerable community and sometimes you're flat out getting a counsellor for an adult woman in these smaller outer-lying towns.* – Service provider (new service)

> *I've I haven't had any luck finding any [counsellors] that specialised in working with children either, which is really disappointing.* – Service provider (new service)

In terms of SHLV security upgrades, it can be expensive and difficult to find suitable contractors and trades. In some circumstances this may mean case workers are doing the upgrades themselves to ensure a quick turnaround. Service providers felt that the program needs a list of identified contractors who can prioritise SHLV upgrades.

> *I think one of the weaknesses [is] getting trades in there, to support safety upgrades and installation of cameras. I think a lot of our case workers are doing that*

> *themselves... It would be really good to have SHLV identified providers… we can go 'you've been identified as one of our preferred providers, we really need these cameras installed ASAP. Could we make it a priority?'* – Service provider (new service)

> *The screens. The costs where it might be locally done, we can't, it can be up about $4000. I feel like it costs us a lot more money than it would for a provider doing a program in a metro area.* – Service provider (new service)

Finally, many regional towns have a wide service area meaning case workers are travelling numerous hours to visit a client. Some of the services allocate staff according to town or region so that local connections can be established with services and community.

> *I mean because I'm based at [main town] – is three hours to [town 2]. One way. [Colleague]? She's based in [town 3] office you know it's 45 kms from [town 3] to [town 2].* – Service provider (new service)

> *Relationships are growing. And that's the beauty of it… we have workers allocated to different towns… It's a little bit easier. I don't know that's always the best way forward, but it's about knowing who those services are, getting to know those faces in that community, and building the relationships, to make it easier for client referrals and your client's pathways.* –Service provider (new service)

Information sharing

For the clients to receive the duress devices they must provide specific information on their case including details about themselves, their children, the perpetrator, and the nature of the risk. This information is shared between mCareWatch, the security monitoring company S1, and PoliceLink. Stakeholders told us that concerns have been raised by service providers in the past regarding sharing private information about a client between the Police, mCareWatch and the S1 security company. This includes personal information about the client, any children the client may have, and a description and threat level of any perpetrators. This was not addressed by service providers during interviews.

> *Both the police and DCJ have requested that we collect this information, [including] their date of birth, their mobile number, their physical description, their motor vehicle, registration, any children that the client has. Then what we also collect is the perpetrator information… name, address, date of birth if available. Is there an AVO? Threats of violence. All of this information is collected.* – Stakeholder

> *There was some issues there around information confidentiality. So in our SOPs, we require that the alarm monitoring company have access to specific details… And we got a lot of pushback saying, well, that's private information and we won't be handing that over. So, we had some concerns there.* – Stakeholder

Furthermore, PoliceLink interview participants noted that there is currently no formalised agreement between the alarm monitoring company and the Police regarding the exchange of information. This was not deemed necessary because the activation of the alarm is seen as a request for Police assistance akin to any emergency call from the public.

> *In terms of the monitoring company, providing police with information, I don't see that there would be any kind of agreements in place in terms of exchanging that*

information because it's New South Wales Police Force, and it's a request for assistance… we treat that pretty much as a call from the public. – Stakeholder

Considerations for future delivery of SHLV services

Service providers reported certain challenges in delivering the SHLV program which led to discussion of future design options for DFV support. These changes relate primarily to the SHLV program delivery and pertain to funding, training, and integrated partnerships which will bolster program delivery in the future.

Additional funding and management of financials

While service providers emphasised the success of the program for current clients, they did feel that there are limitations with the budget and service reach. Particularly in regional areas, service providers told us that there were women who live outside the service area who do not have access to DFV specialist case management services. It is difficult for providers to turn women away knowing that there are no alternative support options. Thus, expanding the geographical reach of existing services, which would also require additional staffing and funding, or establishing new specialist domestic violence services in regional areas, was recommended.

> *I think also just the fact that we only cover the [LGA[32]], so we get referrals at times for out of our area, and it's too much for us to be able to take on. There's no domestic violence specialist service that does case management in [that area]… So, you feel a bit helpless when you have to turn people away like that.* – Service provider (existing service)

Service providers felt that the funding model as it currently stands is ad hoc and could benefit from a streamlined approach across all funding pools. Services often have numerous funders and simultaneously apply for additional financial support on behalf of each client. Managing and distributing the funds according to program requirements and client needs is inefficient and can be a burden for staff. Service providers suggested a more integrated model enabling, for example, the service to access Victims Services Immediate Needs Support Package funding on behalf of the client without a time delay or an additional application form.

> *The funding, it's got a bit ridiculous with this state DV money and the [Immediate Needs Support Package] and how that all fits together is quite messy and it's still the situation that some women get heaps and some get none… not having to apply for [the Immediate Needs Support Package] or apply for Escaping Violence, if it's built into the program… in our brokerage section, then I think that would be a lot easier. Then you can provide women with what will assist them to be able to navigate life after DV in a way that's respectful.* – Service manager (new service)

> *[Funding is] really ad hoc. We've got three different funding pools. I think we've got health, we've got legal aid, and we've got the DCJ funding that we hold. None of them have spoken to each other. They're not connected in any way. It's all kind of just goodwill and trying to make that happen*. – Case worker focus group (new service)

[32] LGA refers to Local Government Area.

Training and specialised staff

Training and SHLV-specific support can be difficult to access and finance for services, particularly those in regional areas. Service providers reported a need for greater access and flexibility for training days to ensure current best practice support is delivered. Furthermore, participants raised the possibility of having dedicated mental health support staff attached to domestic violence and homelessness services to support staff and clients in mental health needs.

> *It's actually really hard to access training… It's a lot of just trying to go to what is free, and in the area, which is really hard... There is, obviously, a small budget for that. That can run out really quickly if you're having to pay for the flight, and accommodation, as well as the training.* – Service provider (existing service)

> *Everyone presenting for any of our program's domestic violence or homelessness, comes with a degree of mental wellness issue. Whether that's anxiety, depression or severe mental health diagnosis, so for us we would like to be able to have speciality staff, or attachments that can focus on DV and mental health responses.* – Service provider (existing service)

Prior to the commencement of the SHLV program, staff in each of the five services attended a two-day training course which provided a grounding in the program and domestic violence response measures. Service providers felt that a follow-up training session once the program had been rolled out would have benefitted their learning and response.

> *I remember [co-worker] and I did a two-day training in Sydney, which was good, but we hadn't even started the program yet. We were going, oh, we hadn't learned all the things we needed to learn. I don't think there's been anything since then.* – Service provider (new service)

Furthermore, some of the new services did not have prior experience as a specialised domestic violence response. Staff felt that they needed to learn on the job once they acquired SHLV funding and noted that new staff often felt overwhelmed and underconfident in providing professional domestic violence support to clients. While staff have been able to locate training programs and resources independently, they felt that a domestic violence training program supported by DCJ was missing from the SHLV rollout.

> *There's been no training. We've sought our own DV training from a few different sources. And the experience of new staff coming in has been, actually, I feel really overwhelmed. I don't feel confident… because people are learning on the job and we're just trying to use what's available to us to fill in those gaps… I'm curious about the SHLV training and what that might look like because I think that's something that would be really helpful.* – Service provider (new service)

Technology brings a whole slew of challenges to ensure installation and maintenance of devices. There is a high level of technical knowledge required of service providers to stay abreast of updates in technology and support clients in the operation of devices. There are relatively few resources available to case managers around technology purchasing and maintenance, meaning service providers must learn on the job without formal guidance.

Services reported seeing an increasing rate of technology-facilitated abuse, including hidden apps on devices, and perpetrators tracking clients through cloud-based services. Basic guidance is provided to clients through the service around password management and cyber-security; however, as methods of surveillance become increasingly sophisticated it is impossible for services to keep up. Services do not have resources or guidance about managing technology facilitated abuse, and no specific funding or tools are provided to support clients. A bug sweeping tool for the home and vehicle to detect hidden cameras, trackers or listening devices would be an effective investment for the program.

> *There's no way myself, I could learn how to use all of them. Often the client knows how to use it more than me. The hidden apps the perpetrator may have installed on the client's device. That's always a concern just knowing how to identify those and be aware of them. Very difficult... And then there's other things like perpetrators creating cameras, or trackers, or listening devices in homes and cars. It happens and sometimes it's not unless the client herself has got some inclination that that's occurred… We do have a device to help look for hidden cameras, but I'm not sure how successful it is. So, that's something we're actually looking at. We're researching new devices for ourselves to use.* – Service provider (existing service)

Integrated partnerships and service linking

Staff and managers recognised the importance of integrated partnerships and service linking in the delivery of the SHLV program. Providers felt that the onus is on the service and staff to establish and maintain relationships with local services. A formalised relationship facilitated by funders to enable structured collaboration could be beneficial to client outcomes.

> *I think formal mechanisms to be connected to other systems, there's no collaboration in the New South Wales network. There's nothing that's kind of formal and connected to us. It's all really goodwill because we communicate with WDVCAS and we have such a good relationship that we're on the SAMS… It's because we are making such a big effort.* – Service provider (new service)

One primary example discussed by staff and managers was a formalised relationship with the Police. Staff told us that they often feel that they must fight with Police to get the appropriate information or response for their client. In one focus group, case workers suggested having a dedicated space in the local Police station one day a week for SHLV staff to do call backs and work directly with Police. They suggested this could be a reciprocal relationship benefitting both parties.

> *SHLV's a great program, but we're not only battling the perpetrator, we're battling police believing the client, and assisting the client going to do a statement. And then the barriers that the police might have with their attitudes themselves.* – Service provider (new service)

> *I have always thought more formalised relationship with Police. Because that's something we can do at our level… In [another SHLV service] I used to go to the Police Station once a fortnight… Go in before the LCP started, before DVCAS, so we would go*

and we would do those call backs. But we were also available for [Police]. – Service provider (new service)

Infrastructure to facilitate information sharing between services and Police was also raised, in particular AVO details, prison release dates, and perpetrator history. Having access to this information could drastically affect how the program supports a client.

> *We recently had a catch up with somebody working at Orange Door [in Victoria] and it was interesting to hear the access to information that they had. They had a lot of court information, they could access AVO information. They had all of these resources that we have to get from a third source… [we'd like to] get to that point where we have a database.* – Service provider (new service)

Finally, case workers and managers at one service raised the possibility of networking between SHLV providers to exchange best practice and share experiences of operating the program. This may be a networking opportunity facilitated by funders which engages stakeholder voices in the conversation.

> *I feel an opportunity is some networking amongst different SHLV providers. There's no real conversations or networks or relationships between other providers and how they do work. We just hit the ground and did it the way we thought.* – Service provider (new service)

Perpetrator programs and housing

Investment in programs and housing options for perpetrators, men and boys who are violent or at risk of homelessness was identified as a key preventative measure that may reduce harassment and abuse for women and families. Service providers are interested in integrating men's behaviour change programs and safe relationship education into service support to cater to men who are seeking to change their behaviours and women who may not wish to leave the relationship. This was identified as a gap in the service system.

> *How do we do some more preventative work? I don't know whether that's ever in the scope of this program but having men's behaviour change programs and safe relationships really integrated would be amazing for women who want to stay in the relationship or young men that are displaying some behaviours that are a little bit concerning.* – Service provider (new service)

> *The lack in the community, unfortunately, like what [client] touched base with before, is the support for the men. We need more support for the men, and the young boys as well. We find a lot of services for women and young women, but when it comes to the men's side of things it's very limited.* – Service provider (existing service)

Service providers told us that there are some women who wish to remain in the relationship and would benefit from case management during this process. This is currently outside the scope of SHLV which requires women to have left the relationship prior to engaging with the program. Supporting women through SHLV to remain in the relationship could link in with perpetrator responses wherein services work with the couple together and independently to establish a healthier and safer way to stay in the relationship.

> *With our criteria, it doesn't necessarily mean that only we would be the ones to fill that gap but there is definitely a gap. With women who are still in the relationship, which is*

hard, but women that need that support that are still living with the violence and unable to receive case management support that is focused on domestic violence. That is definitely a gap. – Service provider (existing service)

One of the new services that participated told us that they have Men's Behaviour Change programs and crisis accommodation in their service. They discussed positive early intervention outcomes for the men who do engage.

We have a men's 24/7 crisis accommodation service as part of our SHS services… we're very lucky that if we had to we can offer that to the male. That does get us out of a little bit of that 'Oh my God what are we going to do? Where can we send him so that she's safe?'… We're an accredited provider of Men's Behaviour Change. So we're able to do a complete wraparound package where we do Men's Behaviour Change with him, we're supporting women, we're doing that really good intensive early interventiony type stuff. – Service provider (new service)

Investment in housing

In response to the lack of housing across New South Wales, service providers at the new services emphasised that housing should be a priority investment moving forward. This may mean investing in social housing or, as suggested in one focus group, investing in modular or portable housing options for clients such as caravans and cabins. While this may not be suitable for all clients it does provide additional options for housing away from the refuge and transitional housing models.

There's such a lack of housing options for our region, I've been talking in other spaces around the need to maybe look at modular housing options for our region. Say if you have three lots of family members in the one house and their children… having a little transportable unit out in the back yard … because we know they're not going to buy or build more houses in our region but that option to be able to do something a little bit alternate would be awesome. – Service provider (new service)

I think we should really strongly just believe we need investments in longer term housing because we know that when people go from refuge, to transition to housing, that that's not a good experience. – Service provider (new service)

Furthermore, two of the new services do not have a local refuge for women who need immediate crisis housing. According to service providers, women are forced to go to a refuge out of town which moves them away from their community and supports. The services without a local refuge all felt that investing in a refuge in the region would complement the program and give women a safe option for crisis housing.

Unfortunately, in the LGA, we don't have a refuge women can access. The closest refuge… is about a half hour out of the LGA. But what we have found during my time here is women will always return back to the area because it's where their supports are. – Service provider (new service)

I think [region] needs a refuge. We have, of our own accord, organised two safe houses. But there is no safe accommodation here that women can go to… there is no safe option for women here… they end up in TA, which is like a motel where there's

drugs about. It's a terrible option. Or they go to one of the refuges out of area. – Case worker focus group (new service)

A greater focus on supports for children

Numerous service providers and managers emphasised that the SHLV program would benefit from formalised supports for children. There is a sense that priority is placed on the safety of the mother and, in that process, children may miss out on focussed individual support.

> *It's very important to us that we provide service to the children that goes beyond tokenism… In the funding guidelines it says you provide all this stuff to the woman or parent, carer, whatever and then it will tack on at the end, 'and each child' and then what generally happens is you're so flooded with the demand that you can't get to the children.* – Service manager (new service)

> *Because we're looking at our future there. And if we want to stop that cycle of violence, [working with children] would be the next layer of that program.* – Service provider (new service)

The supports provided to children vary between services and may not be formalised. In some cases, the service may have minimal or no contact with the child and therefore they cannot glean how the child is coping and what supports may be effective.

Case studies from SHLV services

Case Study * Mary

Mary had been receiving SHLV assistance since the beginning of 2020.

Mary was referred by another service for a case management support. Client didn't have a permanent residence or any income and all her savings were spent to pay ex partner's gambling debts. Mary is the primary carer of her three young children and an AVO was applied for her protection.

Since the relationship ended, Mary managed to keep her part time job; however, she unfortunately lost her job due to COVID-19. Therefore, she didn't have money to pay for her main expenses and this situation made things worse for the family.

Our service approach was client focused and trauma informed practice which made a difference in the way our service was delivered as the client felt that her efforts and actions were validated and her commitment to protect her own children from her abusive ex-partner was acknowledged. Client expressed on multiple occasions that working closely with our service made her feel heard, empathised, trustworthy and comfortable to share her story and ask for assistance whenever she needs. Our service approach enabled us to develop a good connection with the client and have a clear understanding of each other's roles and responsibilities.

During engagement, our service assisted client with financial assistance (groceries and rent) and referrals and advocacy to a women's refuge for a medium-term accommodation as client was no longer able to afford the rent and it was challenging to find another accommodation without a permanent residency. Luckily, one of the many refuges accepted the referral and the client with her children moved into a safe, affordable and suitable property.

The moment that sticks in my mind is when the client rang to let me know that they have arrived safely at the refuge and she was very thankful for the support provided as at last they had a safe and secure place to stay during this winter time and do not have to worry of being homeless and dying of starving. Client is now waiting to hear from her immigration application which is one of her many goals to achieve.

Case Study * Terrie

Terrie and her children (aged 10 and 13 years) were referred to SHLV from the Domestic Violence Liaison Officer for [redacted] LGA.

Terrie had been a victim of Domestic & Family Violence for 12 years with her ex-partner ,which involved physical, verbal, emotional abuse, coercive control, stalking and harassment and gaslighting.

In March 2021 the ex-partner threatened to kill Terrie and himself. On the day of the incident he drove his car through the front gate and brick fence of Terrie's rental property, the car was aimed directly at Terrie. Whilst this caused extensive damages at the property, Terrie did not sustain any physical injuries; however, her mental and emotional state was greatly affected, resulting in undue trauma for Terrie.

The SHLV Case Worker initially engaged with the local Police DVLO and commenced engaging with Terrie. They then conducted the initial assessment with Terrie, this consisting of completing a Needs and Risk Assessment, DVSAT, and also a home audit for the rental property.

The completion of the DVSAT resulted in an outcome of Serious Threat and Terrie and her children were referred by SHLV to the Women's Domestic Violence Court Advocacy Service for additional support. At this point the perpetrator was unable to be located, which escalated the response for Terrie and her Children.

SHLV Case Worker negotiated with Terrie's landlord once the front fences had been repaired, for permission to do security upgrades at her rental property which was approved. The Case Worker purchased the security equipment and liaised with a provider to complete the install. This was further complicated as Terrie lives in a Rural and Regional Aboriginal Community, where getting contractors in for any type of security installation can be challenging. In addition, the case worker had to navigate the strict COVID restrictions for the contractors who were required to travel into this community. However, the security upgrades were completed in a timely manner ensuring that Terrie and her children's immediate safety were a priority.

The SHLV Case Worker commenced an intensive case plan with Terrie which included advocating and referring Terrie and children to access counselling through a local provider. She also ensured Terrie was provided with court support during this process.

SHLV program continued to work with Terrie throughout her case plan and supported her to access Relationships Australia for mediation, as the ex-partner was requesting contact with the children; this resulted in telephone contact being granted.

Terrie had continued to gain support from SHLV throughout the Court proceedings, she felt safe within her rental property as a result of the upgrades that the program had provided and the children were able to maintain school attendance (online).

Terrie has now commenced work again and the Program has continued to maintain contact in preparation for her exit from the program.

5. Conclusion & Recommendations

This conclusion focusses on our analysis of data collected, which measures the effectiveness of both the SHLV program and the personal duress alarm system. We also provide qualitative comments from workers, managers, key stakeholders and clients, which provide insight into their perceptions of the effectiveness of both as well as barriers to effectiveness and issues that require further consideration.

The overarching aims of the Evaluation were to:

- measure the effectiveness of the SHLV program
- measure the effectiveness of the personal duress alarm response system
- make recommendations to improve both the delivery of the SHLV program and the implementation of the personal duress alarm response system.

To address these aims, six evaluation questions and related sub-questions were developed to respond to first the two evaluation goals. This section concludes with evidence-based recommendations to improve service delivery.

Evaluation Question 1: Does the SHLV program enable women and children to remain free from DFV in a home of their choice, over time?

a. Does the SHLV program assist clients to maintain safe and stable accommodation of their choice?

Together, the quantitative and qualitative data indicate that the SHLV program assists clients to maintain safe and stable accommodation of their choice. For example:

- Most clients indicated that the program helped them obtain sustained stable housing/accommodation (54.2%).
- Just one-quarter (27.9%) of clients were rehoused at service entry. Of these clients, half (50.5%) were rehoused due to safety concerns. In a meta-evaluation of SAH Responses, Breckenridge et al. (2016) found that clients also seek to be rehoused because their current housing is no longer affordable, or they wish to pursue a fresh start away from where the violence occurred.
- Most clients left the SHLV program because they met all their goals or no longer needed additional assistance (64.6%), indicating that they were maintaining safe and stable accommodation.
- Just under three quarters of clients indicated that the SHLV program appropriately focusses on the safety of clients and their children (71.7%).
- Most clients received an individual safety plan (67.5%) and safety audit in the home (57.4%). A significant proportion of clients also received safety equipment (36.1%).
- SHLV has continued to emphasise safety through financial security. Almost half of the clients (46.8%) received brokerage.

Qualitative data support these findings. All clients interviewed reported feeling safe or safer in the home as a result of support provided. It was clear from the interviews that remaining in the family home is not a viable option for some women. This may be due to ongoing fear and harassment, being unable to afford rent or mortgage costs, or associated trauma in the family home. The service supported these clients to find appropriate housing and relocate. Clients told us that without the housing and financial support, they may not have been able to leave the relationship and live independently long-term. Most of the clients interviewed felt that their safety and housing stability was long term, and they had no intentions of relocating.

b. Does the SHLV program increase the wellbeing of women and their children who use the program?

The quantitative and qualitative data indicate that the SHLV program enhances the wellbeing of clients. For example:

- There were significant improvements in client wellbeing scores from intake into the SHLV program to exit from the program, with improvements in overall wellbeing (49.6%), individual wellbeing (56.8%), interpersonal wellbeing (40.4%) and social wellbeing.
- Most clients indicated that they had improved knowledge about dealing with DFV (68.5%), increased stability for children (66.6%), increased community engagement and access to support (65.9%), improved health (61.2%), and improved parenting capacity/skills (54.3%).

All clients interviewed reported increased wellbeing for both themselves and their children. Clients told us that since leaving the relationship and receiving support they feel stronger and happier within themselves. Furthermore, staff and clients further discussed technology upgrades improving their overall sense of wellbeing and safety in the home.

It is important to recognise that these findings relate to case managed clients only as wellbeing data were not collected for case coordinated clients.

c. Does the SHLV program ensure open access to all families (including priority population groups)?

Service providers during interviews emphasised that the program is effective in supporting clients from specific population groups. The person-centred philosophy which underpins the provision of SHLV enables services to respond to the specific needs of each client. Service providers found that case management is often more intensive, noting clients from specific population groups face higher risk levels and more barriers to help-seeking. Case coordination and interagency work were identified as effective, for example working closely with a client with disability's NDIS case manager.

The quantitative data indicates that the SHLV program provides access to most families. For example:

- Approximately one in four clients identified as Aboriginal and/or Torres Strait Islander. This is much higher than the proportion of Aboriginal and/or Torres Strait

Islander people in NSW (2.9%) and reflects the higher rates of DFV experienced and/or reported within Indigenous communities.

- Almost one in five (18.1%) clients reported that they live with disability, which is consistent with the proportion of the NSW population with disability (16.9%).

However, some women and their children from certain populations may not be readily accessing the SHLV program:

- Approximately 17 per cent of clients were aged 45 years or older. This is much lower than the proportion of people (41.2%) in the NSW population aged 45 years or older. This is consistent with the failure observed amongst health and social care professionals to recognise DFV as occurring in older women (Carthy & Taylor, 2018) resulting in these women not being referred to DFV services. This may also reflect the SHLV service priority being women with children.
- The ABS (2017b) indicates that 27.6 per cent of the NSW population is culturally and linguistically diverse. However, most SHLV program clients were born in Australia (81.5%) and spoke only English at home (88.1%), which indicates that culturally and linguistically diverse women and their families may not be readily accessing the SHLV program. This may again reflect service priorities which focus on intimate partner violence rather than violence occurring in a broader family system.

Analysis of the quantitative data also demonstrated that pre-existing client demographic factors may influence the extent to which some population group/s access supports. For example:

- Clients who experienced socio-economic disadvantage were:
    - *less* likely to indicate that the SHLV program helped them to access legal and court services
    - *less* likely to indicate that the SHLV program helped them with finances and maintaining and employment
    - *less* likely to achieve the goal of increasing their community engagement and access to support.
- Clients who identified as Aboriginal and/or Torres Strait Islander were:
    - *less* likely to indicate that the SHLV helped with finances and maintaining employment
    - *less* likely to achieve the goal of increasing their community engagement and access to support
    - *less* likely to indicate that the SHLV program helped them to access legal and court services.

Evaluation Question 2: What are the critical success factors in achieving positive client outcomes? What are the barriers to achieving positive outcomes?

Within the two-year observation period, only 153 (7.0%) clients were issued with a personal duress alarm (SOS device). In addition, the SOS device and provider were replaced prior to the commencement of this evaluation by mCareWatch; therefore our analysis specifies the device and provider for each finding presented.

a. Do women issued with a personal duress alarm (who are also in the SHLV program) report feeling safer after the issue of the device?

The quantitative and qualitive data indicate that having an SOS device increases feelings of safety. For example:

- Clients who received an SOS device were almost three times *more* likely to achieve the goal of enhanced safety compared to clients who did not receive an SOS device.
- All client groups who had an SOS device experienced enhanced safety by program exit, indicating that the SOS device is beneficial across population groups.

Clients who received the personal duress alarm reported significant improvements to their feelings and perceptions of safety and comfort in the home and in the community. The direct Police response and the ability of the watch to record evidence once activated were highlighted as key success factors. The eligibility requirement of a current AVO was identified as barrier to women accessing a duress device.

b. Do police report the personal duress alarm system acts as a deterrent to repeat breaches and further incidents of serious harm to clients?

During the interviews, PoliceLink did not comment on whether the personal duress alarm acts as a deterrent. PoliceLink representatives told us that there are relatively few activations of the alarms across the state per month and therefore there is no comprehensive data on deterrence. Service providers and clients did discuss events in which the device was successfully activated, and the perpetrator was apprehended by Police.

c. Does the SHLV program assist clients to maintain control of their finances?

- Of the 743 clients with available data, 60.2 per cent (n = 447) indicated that the SHLV program helped them manage their own finances and maintain employment.
- Just under half the clients indicated that they achieved the goal of improving the management of finances (45.8%). This finding is likely reflective of the enhancement of women's economic security being a growing area of service provision for SHLV and indicates that it is an area that requires further development for service providers.

Financial support was discussed by clients and service providers in interviews, including flexible brokerage, applications to the Victims Services INSP, and professional financial planning advice for clients who may have inherited debt or difficulty managing money. A

critical success factor that was evident from interviews with service providers and clients was the control of finances through the SHLV program. This encompasses both clients having a voice in decision-making for brokerage and security needs, and the SHLV program providing clients with financial advice and guidance.

While clients spoke positively of financial management strategies, there was potentially more work that could be undertaken by SHLV service to support current employment, return to employment and retraining of SHLV clients.

In addition to the success factors discussed above, the following success factors were also identified:

- Brokerage for technology and security upgrades was another key success factor for positive client outcomes. Clients told us that security upgrades significantly improved their feelings of comfort and safety in the home. Service providers have found that being able to offer this practical solution to a client's safety needs can have a drastic effect on client outcomes.

- Service providers and clients discussed the benefits of long-term and wrap-around support enabling the program to address a client's safety needs across every aspect of their life on an ongoing basis.

- Having a single case worker providing continuous support can relieve a lot of anxiety and fear for clients and help to ensure they are able to remain free from violence long-term.

The following barriers to achieving positive outcomes were also identified:

- Staff in all participating services emphasised an overwhelming client demand and high case load and it is not always possible to exit clients from the program quickly and keep up with new referrals.

- Service providers emphasised the SHLV program is only effective if there are affordable housing options for women to either remain in the home or relocate. The new SHLV services identified the housing crisis as the biggest barrier across regional NSW. The new services said this has worsened since the program was rolled out in 2019.

- Service providers described the criminal justice and legal systems' limited support and safety options as a key barrier.

- Service providers and managers highlighted that reporting across multiple data management systems is inefficient.

- A large barrier identified by all five new services and clients in regional areas was a limited availability of appropriate domestic violence and family counsellors in regional areas.

Evaluation Question 3: What are the implications for the future design and delivery of DFV services?

During interviews services providers, including managers and staff, identified a series of potential changes to the SHLV program and DFV service system more broadly.

Some service providers described the current funding strategy as inefficient and lacking in transparency.

Service providers consistently reported finding it difficult to access affordable training programs. They expressed the need for greater access and a specific budget for training encompassing both specialised DFV training (including on technology-facilitated abuse) and SHLV-specific training.

Service providers felt responsible for establishing and maintaining relationships with other services to support the local integrated service system and at times felt this competed with direct client service delivery. Recognition of the importance of relationship building and local networks is critical, as well as a formalised strategy for service integration facilitated by government.

Service providers described clients being unable to move on from crisis or transitional accommodation because there are no rental or government housing properties available due to the ongoing housing crisis in NSW. Investment in housing, including long term government housing properties, along with short term modular or mobile housing, would provide more options to SHLV clients.

Investment in programs and housing options for perpetrators, men and boys who are violent or at risk of homelessness was identified as a key preventative measure that may reduce harassment and abuse for women and families. Service providers are interested in integrating men's behaviour change programs and safe relationship education into service support.

Finally, service providers found that it can be difficult to have the time and resourcing to support children. The SHLV program would benefit from more formalised supports and funding options for children to receive individual support.

There was also some inconsistency in the data about whether an SHLV service was recording children as clients or not.

Evaluation Question 4: What are the costs of delivering SHLV, and what proportion of funding is available for direct service delivery?

It is difficult to compare the proportion of funding available for direct service delivery. In interviews it was apparent that services could make different decisions about how to allocate their funds; for example, dividing SHLV funding between staffing and brokerage is at the discretion of the service. A majority of services have two dedicated SHLV case workers on a permanent part time or full-time basis with the remainder of funds for brokerage. Other services opted to have fewer case workers and a larger amount for brokerage.

An analysis of unit costs is provided in a separate report on request of the Department of Communities and Justice.

Evaluation Question 5: What were the service system outcomes, and what enabled them to occur?

Integrated services are an important underpinning of SHLV. These local partnerships require considerable work and effort to ensure effectiveness of referrals and joint work. Not all local areas have the same number and range of partner agencies which means the integrated response can be variable.

a. Does the SHLV program facilitate an integrated and effective partnership response to intervention?

SHLV relies on referrals from a variety of other services, and it is not uncommon for clients to be referred by more than one local service. Case managed and case coordinated clients are also provided with referrals to external organisations; however, only 16.8% of SHLV clients received information and/or referral from SHLV. The effectiveness of referral in and out of SHLV is predicated on the centrality of local, integrated and effective partnerships.

Service providers discussed the importance of developing longstanding relationships with local services. Clients discussed the value of case workers facilitating referrals to other supports including counselling and legal support. When the SHLV program is well known to other services, referrals come through numerous organisations and women are more readily able to access the response. Furthermore, strong relationships with Police were identified as key. Some service providers and clients did, however, discuss difficulties with poor knowledge and response from Police. Clients similarly found poor Police response was a primary barrier to safety.

b. Does the SHLV program utilise different components of service delivery, at what proportions and with what success?

Of all individuals referred to SHLV program in the observation period, most received a case management plan (n = 3549, 50.1%), while around a quarter received a case coordinated plan (n = 1901, 26.9%). Of the remaining referred clients, 16.8% received information and/or referral only and 9.4% did not receive a service.

- Most clients who entered the SHLV program received an individual safety plan (67.5%) and safety audit in the home (57.4%). The lowest proportion of clients received safety equipment (36.1%). Clients received an average of 2.43 safety and security services. Analysis of the data indicated that an individual safety plan, receiving a risk/lethality assessment, having a safety audit in the home, receiving safety equipment, and/or having a security upgrade increased the likelihood of clients achieving service success.
- For just under half (48.1%) of all clients, SHLV provided access to the police and/or court services. Of those with available data, most clients indicated that SHLV helped them access legal and court support (69.2%).

The quantitative data demonstrated that most women in the SHLV program achieved their service goals across the three key areas of SHLV program delivery:

1. Empowering women with knowledge about domestic violence, its impacts, and the recovery process.

2. Helping women to understand and navigate legal and court processes.
3. Supporting and encouraging women to make empowered personal choices as they move away from violence over a longer period of time.

This finding demonstrated evidence of the effectiveness of the SHLV program response, particularly highlighting the strength of a wraparound service provision.

c. Does the SHLV program make referrals to other services and for what and how long?

Monitoring data was not provided regarding referrals made for clients to external services as it was not easily extractable from the CIMS database. This meant we were unable to examine whether the program made referrals to other services and for what and how long. It is recommended that this data be extracted and examined in future evaluations.

Referrals to other supports and service linking were highly regarded by clients during interviews. Clients discussed referrals to counselling, legal aid and court support. The length of these engagements varied between clients depending on their case and level of need. For counselling, clients are typically provided with 22 free sessions through the Victims Services supports.

Evaluation Question 6: What strengths and challenges are shared between all SHLV services? What key differences are experienced by newer and older SHLV services?

It is important to provide the caveat that new services may not have the depth of experience or data to provide a comparison of strengths and challenges with pre-existing services.

However, shared strengths, evident from interviews conducted with service providers and clients at existing and new services, included developing a positive relationship between client and case worker, ongoing case management and specialised support, the provision of domestic and family violence education, and flexible brokerage designed to meet the specific safety needs of each client.

The shared challenges identified from interviews with service providers and clients at existing and new services included high caseloads and demand which exceeds resourcing and funding capacity, the ongoing housing crisis in NSW, particularly affecting regional areas, criminal justice and legal systems limiting safety options for women and families, and the SHLV reporting and data management systems, which are inefficient and detract from client-facing work.

When comparing the five new SHLV services to the pre-existing services, the quantitative data demonstrated that clients who received support from both new and pre-existing services left the program because they met their case goals or no longer required assistance. This indicated effectiveness across all services in helping clients to remain safe in their home or in accommodation of their choice.

However, the quantitative data also indicated that clients who attended one of the new services were two (2.08) times *less* likely to achieve the goal of sustained housing or accommodation, relative to clients in the pre-existing services. The five services funded in 2019 emphasised that the housing crisis in regional NSW has worsened. Service providers

reported finding it progressively more challenging to locate suitable and affordable housing options for clients.

During interviews with the new services, service providers were able to reflect on the benefits the newly established SHLV program had brought, not only to the auspice agency but also to the community. New service providers perceived the SHLV program as well-designed and demonstrating strong aims and values which are clearly evident in the provision of SHLV support.

There were a few key points of difference between new and existing services which emerged during the interviews. A key point of difference between new and existing services was in the structure of staffing and support within the service. This, again, varied between the services; however, three of the five new services developed an integrated program model across all case managers. Some services reported have dedicated SHLV case workers who work solely with SHLV clients; however, the new services found it more effective to have all case workers providing support across multiple programs.

It is unclear whether this practice will dilute the SHLV specialist service provision or mean that workers not trained in DFV will be asked to undertake SHLV work. This is a particularly relevant consideration given two of the five new services did not have prior experience as a specialist DFV service. Providers at these services told us that SHLV filled an important gap in service provision with dedicated case management and brokerage; however, staff did have limited specialist DFV training and knowledge during the program rollout. Service providers from one new service reported that there was no training made available, which resulted in staff feeling unconfident in their role and forced to learn on the job.

Furthermore, new services have had difficulty finding appropriate trauma-based counsellors in regional areas for clients and children. Some clients have waited numerous months for a counsellor to become available, while other clients have opted for over-the-phone counselling with professionals out of area. Children are often unable to receive counselling support for this reason.

The following recommendations reflect our analysis of the qualitative and quantitative data and the conclusions just drawn.

Recommendations for the Department of Communities and Justice

Data and Reporting

Recommendation 1: Consider improving data collection for the following data:

- the identity of the perpetrator/s via the addition of relationship tab (identifying the relationship between perpetrator and victim) to CIMS
- wellbeing outcome data from all case coordinated clients regardless of length of engagement
- wellbeing outcome data following an incident of harassment and abuse for both case coordinated and case managed clients
- the fear and hopefulness scale for clients issued with a safety device
- referrals out including referral type or purpose and length of engagement with other agencies in a manner that is easily extractable from CIMS

- exit date for case coordinated clients
- promotion, community education and establishment and maintenance of interagency partnerships
- children and families including supports provided and outcomes achieved.

Report reference: Research Limitations, pages 33–34

Rationale: It is difficult to know whether a new data system (CIMS) has resulted in large amounts of missing data because workers were unfamiliar with the new system. However, some data is no longer collected that had previously been collected in the previous data portal. The new data collection platform means that it is difficult to compare current findings to previous evaluations where different data were recorded.

We have noted that SHLV workers did not collect wellbeing outcome data from case coordinated clients or at times of harassment and abuse from either case coordinated or case managed clients, as was the case in the 2014 SHLV Evaluation. This limits our understanding of wellbeing in a substantial proportion of clients and our understanding of how an instance of violence and abuse may affect client wellbeing.

Referrals to other supports and services were highly regarded by clients during interviews. Clients discussed referrals to counselling, legal aid, and court support. The length of these engagements were reported to vary between clients depending on their case and level of need. Monitoring data was not provided regarding referrals made for clients to external services, which meant we were unable to examine the ways in which the program made referrals to other services in their local service system, and for what purpose and how long.

SHLV service providers are often time poor, and the onus is on service staff to enter information as it is collected. Staff knowledge and system usability could be investigated further as part of continuous quality improvement.

Recommendation 2: Consider how to streamline reporting requirements for SHLV workers, given additional separate reporting required by the Commonwealth Department of Social Services and some SHLV auspice agencies.

Report reference: Challenges to achieving positive client outcomes, pages 91–92

Rationale: Collecting monitoring and evaluation data is important, but SHLV staff are required to enter data into a minimum of two monitoring portals and may have to separately report to an auspice agency. These responsibilities are reported by service providers to be onerous and detract from the time available for client work. Service providers and managers told us that the reporting across multiple data management systems is inefficient. Staff are needing to report through DEX and CIMS databases along with internal reporting processes for each client which detracts from necessary client-facing work. Furthermore, staff feel that the data collected does not accurately reflect the work that is being done and the data requirements are different depending on the system.

Recommendation 3: Consider providing further training in use of CIMS for service providers including the benefits of robust data collection for service planning.

Report reference: Challenges to achieving position client outcomes, pages 91–92

Rationale: As noted in a previous recommendation, the research team recognises that SHLV service providers have recently transitioned to using CIMS for recording client information and data. This may explain a portion of missing/inconsistent data. Training has two purposes: first, to increase service provider's capacity to enter data correctly, and second, to ensure service providers understand the ways in which the data collected may assist service planning and requests for further resourcing.

Further training may be considered for DCJ Commissioning and Planning contract managers in monitoring data collection and advising on appropriate collection methods for service providers. In light of the transition to CIMS, DCJ may review past and existing data capture strategies to determine what data is beneficial to SHLV providers and future evaluations.

Program level requirements

Recommendation 4: Consider revision of SHLV entry criteria to ensure it is clear that SHLV services are provided to women and children affected by DFV, not only those experiencing IPV.

Report reference: Client Stability and Wellbeing, page 83

Rationale: Monitoring data and interviews suggest an increase in reports of non-IPV family related violence in NSW which can challenge the ways services (including SHLV) are delivered. Service providers (managers and staff) described difficulties for older clients in ceasing contact with the perpetrator if the perpetrator is their primary carer or adult child. Current entry criteria for SHLV require the client to have left the relationship prior to receiving support; however, for people experiencing non-IPV family related violence, leaving the relationship may not be possible or ideal for the client. Service providers during interviews emphasised that the program is effective in supporting clients from specific population groups where violence from other family members is likely; however, this does require a different approach to risk assessment and case management.

Recommendation 5: Increase resourcing to ensure that staffing and brokerage requirements are both met, rather than one prioritised over the other.

Report reference: Challenges to achieving positive client outcomes, pages 88–90

Rationale: Under-resourcing and high client demand has resulted in SHLV service providers needing to choose to allocate funding differently to either staffing or brokerage; for example, reducing staff numbers to increase the amount of brokerage available.

There are a number of reasons to maintain staffing ratios:

- Staffing ratios maintain the centrality of the worker-client relationship.
- Staffing ratios were reported as critical to SHLV effectiveness and achieving service goals including the increased wellbeing of clients.
- Service providers found that case management is often more intensive, noting clients from specific population groups face higher risk levels and more barriers to help-seeking, requiring additional staff time. Staff in all participating services emphasised an overwhelming client demand which is only increasing.

- Long-term case management can be very involved, and it is not always possible to exit clients from the program quickly and keep up with new referrals.
- Service providers told us that there are times when they need to close the books because they do not have the capacity to bring in any new clients.

Recommendation 6: Brokerage should be strengthened by continuing to encourage flexible use of funds. This enables tailored and targeted practical support for victims. An increase in brokerage funds would similarly increase the potential effectiveness of brokerage.

Report reference: Client stability and wellbeing, pages 85–86

Rationale: Brokerage is consistently reported to be important for achieving service goals and for clients to be able to leave and remain separate from their partner.

Recommendation 7: Consider greater access and budget for staff training which encompasses both specialised DFV training and SHLV-specific training.

Report reference: Considerations for future delivery of SHLV services, pages 94–96

Rationale: Staff reported finding it difficult to access affordable training programs. Two of the five new services did not have prior experience as a specialist DFV service. Providers at these services told us that SHLV filled an important gap in service provision with dedicated case management and brokerage; however, staff reported limited specialist DFV training and knowledge during the program rollout. Whilst there was induction training provided, staff were concerned that there was no training made available to service providers which resulted in them feeling underconfident in their role and forced to learn on the job.

Partnering with other agencies in training programs may provide tailored skills for SHLV case management; for example, partnered training with Police in regard to ADVOs, DFV criminal charges, and establishing effective working relationships with local Police departments.

Recommendation 8: Decisions about resourcing of the SHLV program should take into account the intensive work that is required in managing clients across numerous programs, and case coordinated clients. A streamlined strategy for resourcing and funding across programs would reduce the burden on staff and allow more time for client-facing work.

Report reference: Considerations for future delivery of SHLV services, page 94

Rationale: During interviews, services providers, including managers and staff, identified a series of potential changes to the SHLV program and DFV services more broadly. Service providers indicated the need for a more streamlined strategy for funding which integrates existing funding across the multiple programs that services run, and the additional funding that services apply for on behalf of each client (for example Victims Services INSP). Service providers described the current strategy as ad hoc and inefficient.

Recommendation 9: Recognise children as clients in their own right and ensure all SHLV programs provide more formalised supports and program funding options for children.

Report reference: Stability and wellbeing, pages 59–60; Challenges to achieving positive client outcomes, page 92 and Considerations for future delivery of SHLV services, pages 98–99

Rationale: Currently, SHLV providers only record children as clients in their own right if significant services are provided to individual children; therefore children were inconsistently recorded as clients of the services. Service providers reported finding it difficult to have the time and resourcing to support children. Interviews with service providers highlighted that supports provided to children vary considerably between services and are at the discretion of case workers and managers. The SHLV program is typically adult-centred. Age-appropriate supports for children need to be developed to best meet their needs which may include counselling and psychological support.

Recommendation 10: Invest in further research to determine the effectiveness of SHLV for different populations and identify and appreciate the factors which facilitate or hinder achieving service goals and the extent to which the service is effective for different cohorts.

Report reference: Client demographic characteristics, page 42 and Client stability and wellbeing, pages 80–84

Rationale: Service providers emphasised that the program is effective in supporting clients from specific population groups. In particular, the person-centred philosophy which underpins the provision of SHLV enables services to respond to the specific needs of each client. Service providers found that case management is often more intensive, noting clients from specific population groups face higher risk levels and more barriers to help-seeking. Case coordination and interagency work were identified as effective, for example working closely with a client with disability's NDIS case manager.

Service providers (managers and staff) and stakeholders also described receiving significantly fewer referrals for clients with complex needs or clients from diverse backgrounds. Depending on the region in which the service was based, some service providers (managers and staff) described minimal referrals for CALD women, gender and sexuality diverse people, and women with disability. Funding community education in the local context and reviewing program elements to ensure they are fit for purpose with different population groups may address this issue.

Service integration and partnerships

Recommendation 11: Develop a formalised strategy for service integration to enable greater collaboration between services in NSW and between different SHLV auspice services.

Report reference: Considerations for future delivery of SHLV services, pages 96–97

Rationale: Service providers felt that they bear the responsibility to establish and maintain relationships with other services as integrated services are an important underpinning of SHLV and other SAH responses. These local partnerships require considerable work and effort to ensure effectiveness of referrals and joint work. Not all local areas have the same number and range of partner agencies which means the integrated response can be variable. While established interagency mechanisms such as the fortnightly SAMs meeting provide essential collaboration between agencies for high-risk clients, there is room for greater collaboration to ensure effective referrals and case coordination for all clients.

Service providers felt that formalised networking opportunities between SHLV auspice services would benefit the program. This may include meetings to trade best practice advice and discuss program challenges or improvements.

Recommendation 12: Invest in local affordable housing and build opportunities for housing partnerships with SHLV providers, state government, real estate agents, Specialist Homelessness Services, and the private sector.

Report reference: Considerations for future delivery of SHLV services, page 98

Rationale: Service providers have found that clients are unable to move on from crisis or transitional accommodation because there are no rentals or government housing properties available due to the ongoing housing crisis in NSW. While housing partnerships are strong in some locations the issue of low housing stock remains and continues to affect SHLV clients and families. Investment in housing including long-term government housing properties, along with short-term modular or mobile housing would provide more options to clients.

Technology and security upgrades

Recommendation 13: Consider specific training for staff and clients to enhance their knowledge of and ability to use technology.

Report reference: Considerations for future delivery of SHLV services, pages 95–96

Rationale: Safety can be enhanced by technology which provides evidence of a breach of a protection order, but must be supported by proactive policing. Yet the usefulness of technology may be compromised by the capacity of some workers to advise on, and clients to use, different technologies. Investment in both staff and client training is important.

Client training should consider learning needs and capacities including education level, English language skills and people with cognitive disability who might require additional support. Staff training should include specialised technology options that can be targeted to the needs of specific population groups, for example light sensors and alarms for clients who are hearing impaired.

Recommendation 14: Consider SHLV specific contractors for safety upgrades.

Report reference: Considerations in regional areas, page 92

Rationale: SHLV security upgrades can be expensive and service providers reported that it was difficult to find suitable contractors and trades, particularly in rural and regional areas. In some circumstances this may mean case workers are doing the upgrades themselves to ensure a quick turnaround. Service providers felt that the program needs an agreement with identified local contractors who can prioritise SHLV upgrades. The difficulty with this is creating contractor availability; however, an established relationship facilitated by funders may incentivise contractors and reduce the burden on service providers to find available contractors and trades.

Recommendation 15: Consider removing the requirement for a protection order for a safety alarm to be issued.

Report reference: Client safety and housing, pages 76–77

Rationale: An issue raised in qualitative interviews was that the Police require safety alarms to be issued only to clients with a protection order to ensure that the client has had prior contact with Police and that their case is classed as high risk. This requirement has been in place since SHLV was first set up; however, interview data shows that women are not always

successful in obtaining an order for reasons other than risk and some population groups (such as Aboriginal and Torres Strait Islander women) have little trust in the criminal justice system and would be concerned about seeking a formal order. The professional opinion and documentation from service providers should be considered sufficient.

Recommendation 16: Ensure security upgrades factor in the capacity and mobility of the client.

Report reference: Client stability and wellbeing, pages 80–81

Rationale: Clients were particularly appreciative when the upgrades were tailored specifically to the house and the behaviours of the perpetrator, for example an alarm would be ineffective for a deaf client so the service may opt for a light-based sensor alarm instead. One client reported that maintenance staff went out of their way to find a screw that could not be used with a standard screwdriver; the perpetrator subsequently tried to break into the home but was unable to do so because of use of these specific screws.

Privacy and Information sharing

Recommendation 17: Create a formal agreement between the security monitoring company and the Police regarding the exchange of information.

Report reference: Challenges to achieving positive client outcomes, page 93

Rationale: For the clients to receive the duress devices they must provide specific information on their case including details about themselves, their children, the perpetrator, and the nature of the risk. This information is shared between mCareWatch, the security monitoring company S1, and PoliceLink.The Police told us that concerns have been raised by services regarding the information sharing and management through the response.

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Appendix A: Australian Safe at Home Responses

Australian Capital Territory: The Australian Capital Territory (ACT) Staying@Home program is delivered by Domestic Violence Crisis Service (DVCS). DVCS and Housing ACT have an existing partnership that provides risk assessments and security upgrades for public housing clients.

The Staying@Home program provides long-term, ongoing support to women and their families so that they can stay safe in their home after they have left an abusive relationship. The program works with women to help them identify and access the support and services they need for their situation.

New South Wales: The Staying Home Leaving Violence (SHLV) program is a specialised DFV program delivered in NSW and designed to assist women and their children to stay safely in their own home or a home of their choice after leaving a violent relationship. SHLV is delivered state-wide in NSW, and uses an evidence-based, case management model that involves referral services prior to and during client engagement with the service, case coordination for clients who enter the SHLV program with an existing case manager, and more intense, longer term case management.

Northern Territory: The SAH response in the Northern Territory is the 'Keeping Women Safe in their Homes' (KWSITH) program, delivered by YWCA Darwin, serving Darwin and Palmerston. The program commenced on 1 July 2017. The KWSITH program is aimed at performing risk assessment, safety planning and security upgrades for all women and children experiencing DFV so they can stay in their own homes, or a home of their choice.

Queensland: The Keeping Women Safe in their Homes Technology Initiative offered in Queensland helps women and their children escaping DFV by providing technology-driven solutions as part of a comprehensive risk assessment and safety plan to support women to remain safer in their own homes. The initiative is delivered at four sites in Queensland.

The Queensland Government has also developed the Private Rental Initiative (PRI), which is part of the Keeping Women Safe in their Homes initiatives, funded through the Commonwealth Women's Safety Package. The aim of the PRI is to reduce barriers for women affected by DFV that prevent them from accessing or sustaining accommodation in the private rental market.

South Australia: The South Australian Staying Home Staying Safe (SHSS) program is a state-wide SAH response, delivered by Victims Support Service SA, and has been funded since 2009. The SHSS program provides safety audits, home security packages, safety planning assistance and referrals to other support services to assist women at a high risk of

homelessness or violence as a result of DFV. The goal of SHSS is to reduce homelessness for women and children who have been subject to DFV by assisting them to remain in their home and in turn giving them the choice to remain in contact with their communities, schools and support systems.

Tasmania: The Tasmanian Safe at Home service system is a state-wide SAH response, delivered as an integrated whole-of-government criminal justice response and intervention to DFV. This SAH response has been funded in Tasmania since 2004. Women, children and perpetrators enter the Safe at Home service system when a family violence or family argument report is made to Tasmanian Police. They may also be referred by other services including DFV services and may also self-refer. The goal of the Safe at Home service system is to reduce homelessness for women and children who have been subject to DFV by assisting them to remain in their home and in turn giving them the choice to remain in contact with their communities, schools, and support systems.

Victoria: Victoria's Personal Safety Initiative (PSI) is a state-wide SAH response, run by Family Safety Victoria (FSV). The PSI supports victim survivors to access appropriate and effective technology and security responses that allow them to remain safely in their own homes and communities, as part of a case management response that addresses safety and security goals and helps manage family violence-related risk. PSI is a non-crisis response that aims to utilise safety and security responses, including property modifications and technology, to enable victim survivors of family violence to remain safely in, or return safely to, their own homes and communities, or relocate to a new home, and to increase safety and feelings of safety for victim survivors.

Western Australia: Since 2010, SAH services have been funded in Western Australia under various National Partnership on Homelessness Agreements. These services offer risk assessment, safety planning and practical and emotional support to women experiencing DFV. SAH responses in Western Australia assess the safety and support needs of all women and children through risk assessments, safety planning, home security audits and upgrades, and case management. Taking a multi-agency approach, staff at each service work closely with the Western Australian Police, the criminal justice system, the Department of Child Protection and Family Support, and other service providers to reduce or manage the risk posed by the perpetrator and to ensure women receive a coordinated response.

Appendix B: Detailed CIMS Data Analysis

The SHLV Incoming Referral List contains data for 7383 clients and 8887 corresponding referrals from 1 July 2019 to 30 June 2021. Data was limited to clients who had no referrals to SHLV prior to 1 July 2019 and had non-missing data for at least one service goal. Data was also limited to the first referral during the observation period that resulted in a case management plan. This ensured that only first-time clients were observed, resulting in a final sample of n = 2201 unique clients,

Table B.1 provides the descriptive statistics for client demographic factors. Overall, most clients were female (89.2%), not Aboriginal (71.5%), born in Australia (81.5%), only spoke English at home (88.1%), were Australian citizens (82.4%), experienced socio-economic disadvantage (57.0%), and were affected by social exclusion (51.0%). Almost half of all clients had missing data for sexual identity (50.2%) and disability (41.3%). The average age was 30.1 years.

Table B.1. Demographic descriptive statistics (n = 2201)

		n (%) / m (sd)
SEX		
Female		1964 (89.2%)
Male		234 (10.6%)
	missing	*3 (0.1%)*
AGE		
Young than 45 years of age		1819 (82.6%)
45 years of age or older		370 (16.8%)
Mean age		*30.12 (15.32)*
	missing	*12 (0.5%)*
SEXUAL IDENTITY		
Heterosexual		1081 (49.1%)
Non-Heterosexual		23 (1.0%)
	missing	*1097 (50.2%)*
ABORIGINAL / TORRES STRAIT ISLANDER		
Yes		529 (24.0%)
No		1573 (71.5%)
	missing	*99 (4.5%)*
CONTINENT OF BIRTH		
Australia		1793 (81.5%)
Asia		129 (5.9%)
Oceania (excluding Australia)		31 (1.4%)
Africa		21 (1.0%)
Europe		34 (1.5%)
North and South America		18 (0.8%)
	missing	*175 (8.0%)*
LANGUAGE SPOKEN AT HOME		
English		1938 (88.1%)
Language other than English		263 (11.9%)
MIGRANT STATUS		
Australian citizen		1814 (82.4%)
Permanent resident		166 (7.5%)

Temporary resident		47 (2.1%)
	missing	*174 (7.9%)*
CLIENT DISABILITY		
Yes		234 (10.6%)
No		1057 (48.0%)
	missing	*910 (41.3%)*
CLIENT SOCIO-ECONOMIC DISADVANTAGE		
Yes		1255 (57.0%)
No		551 (25.0%)
	missing	*395 (17.9%)*
CLIENT AFFECTED BY SOCIAL EXCLUSION		
Yes		1122 (51.0%)
No		650 (29.5%)
	missing	*429 (19.5%)*

Cross comparisons were conducted to identify significant differences in the proportion of clients based on demographic characteristics These differences are expressed as Odds Ratios (OR) and 95% Confidence Intervals. Only significant ORs are reported. Cross comparisons were conducted for Aboriginal identity, age, migrant status, language spoken at home, client disability, socio-economic disadvantage, and social exclusion.

Clients who were aged 45 years or older were 2.00 (95% CI = 1.48 – 2.70) times *less* likely to identify as Aboriginal and/or Torres Strait Islander, 1.41 (95% CI = 1.00 – 2.00) times *more* likely to not be an Australia citizen, 1.96 (95% CI = 1.42 – 2.71) times *more* likely to have a disability, 1.94 (95% CI = 1.52 – 2.49) times *less* likely to experience socio-economic disadvantage, and 1.45 (95% CI = 1.14 – 1.86) times *less* likely to be affected by social exclusion.

Results indicate that Aboriginal and/or Torres Strait Islander clients were 3.61 (95% CI = 2.69 – 4.84) times *more* likely to experience socio-economic disadvantage, and 2.37 (95% CI = 1.85 – 3.04) times *more* likely to be affected by social exclusion. No other significant differences in the proportion of clients by Aboriginal and/or Torres Strait Islander identity were observed.

Clients who were not Australian citizens were 13.33 (95% CI = 5.88 – 30.30) times *less* likely to not identify as Aboriginal and/or Torres Strait Islander, 24.91 (95% CI = 16.76 – 37.03) times *more* likely to speak a language other than English at home, 11.88 (95% CI = 1.14 – 3.10) times *less* likely to have a disability, 1.75 (95% CI = 1.28 – 2.39) times *less* likely to experience socio-economic disadvantage, and 1.40 (95% CI = 1.02 – 1.92) times *less* likely to be affected by social exclusion.

Results indicate that clients who spoke a language other than English at home were 2.04 (95% CI = 1.37 – 3.05) times *less* likely to identify as Aboriginal and/or Torres Strait Islander, 1.45 (95% CI = 1.07 – 1.96) times *less* likely to experience socio-economic disadvantage, and 1.51 (95% CI = 1.12 – 2.05) times *less* likely to be affected by social exclusion.

Clients who had a disability were 2.04 (95% CI = 1.44 – 2.88) times *more* likely to experience socio-economic disadvantage, and 2.29 (95% CI = 1.62 – 3.22) times *more* likely to be affected by social exclusion.

Table B.2 includes the descriptive statistics for client housing at service entry and exit. At SHLV entry, the greatest proportion of clients resided in a private rental or their own home (53.7%), followed by public/community housing (22.8%), and no housing (6.1%). One-third of clients resided where the domestic/family violence occurred (34.0%).

Around one-quarter (27.9%) of clients were rehoused at service entry. Of these clients, half (50.5%) were rehoused due to safety concerns. Most clients indicated that the program helped them obtain sustained stable housing/accommodation (54.2%), and that the program enhanced the safety of the client and their children (71.7%).

Table B.2. Client housing and safety descriptive statistics (n = 2201)

		n (%) / m (sd)
TYPE OF HOUSING AT ENTRY		
No housing (i.e., homeless, couch surfing)		134 (6.1%)
Public/community housing		501 (22.8%)
Private rental / Home owner		1183 (53.7%)
	missing	*383 (17.4%)*
HOUSING SITUATION AT ENTRY		
Living where DFV occurred		749 (34.0%)
Not living where DFV occurred		1279 (58.1%)
	missing	*173 (7.9%)*
REHOUSED AT ENTRY		
Yes		614 (27.9%)
No		1495 (67.9%)
	missing	*92 (4.2%)*
REASON FOR REHOUSING		
Safety concerns		310 (14.1%)
Other reason		304 (13.8%)
	missing	*1587 (72.1%)*
GOAL: SUSTAINED STABLE HOUSING/ACCOMODATION		
Achieved		1194 (54.2%)
Partially achieved		266 (12.1%)
Not achieved		116 (5.3%)
	missing	*625 (28.4%)*
GOAL: ENHANCED SAFETY OF THE VICTIM AND THEIR CHILDREN		
Achieved		1578 (71.7%)
Partially achieved		447 (20.3%)
Not achieved		111 (5.0%)
	missing	*65 (3.0%)*

Cross comparisons were conducted to identify significant differences in the proportion of clients based on their housing and safety factors by sex, Aboriginal status, age, migrant status, disability, and socio-economic disadvantage.

The comparison group for the following ORs are those who reside in a private rental or their own home. Aboriginal clients were 2.54 (95% CI = 1.69 – 3.83) times *more* likely to have no housing, and 4.56 (95% CI = 3.59 – 5.80) times *more* likely to reside in public or community housing, relative to those who resided in a private rental or their own home. By comparison, clients aged 45 years or older were 1.96 (95% CI = 1.13 – 3.42) times *less* likely to have no

housing and 1.41 (95% CI = 1.06 – 1.87) times *less* likely to reside in public or community housing. Clients who were not Australian citizens were 2.07 (95% CI = 1.39 – 3.10) times *less* likely to reside in public or community housing but were not significantly more or less likely to have no housing. Similarly, clients with a disability were 1.58 (95% CI = 1.13 – 2.19) times *more* likely to reside in public or community housing but were not significantly more or less likely to have no housing. Finally, clients who experienced socio-economic disadvantage were 3.30 (95% CI = 2.01 – 5.41) times *more* likely to have no housing, and 4.63 (95% CI = 3.42 – 6.25) times *more* likely to reside in public or community housing.

Clients who were rehoused were 1.37 (95% CI = 1.05 – 1.78) times *less* likely to be over 45 years of age and were 2.40 (95% CI = 1.78 – 3.22) times *more* likely to not be an Australian citizen.

Clients who were rehoused for safety concerns were 1.44 (95% CI = 1.00 – 2.10) times *more* likely to identify as Aboriginal and/or Torres Strait Islander and 1.78 (95% CI = 1.12 – 2.84) times *less* likely to be 45 years of age or older. No other significant associations were found.

We conducted cross tabulations by whether clients achieved their goal of sustained housing/accommodation. The comparison group for the following ORs are those who did not achieve their goals. Clients who identified as Aboriginal and/or Torres Strait Islander were 1.77 (95% CI = 1.02 – 3.06) times *more* likely to partially achieve their goal but were not significantly more likely to completely achieve their goal, relative to clients who did not achieve their goal. There were no other significant differences regarding whether goals were achieved based on demographic factors.

We conducted cross tabulations by whether clients achieved the goal of enhanced safety. The comparison group for the following ORs are those who did not achieve their goals. Clients who were disabled were 3.57 (95% CI = 1.73 – 7.35) times *less* likely to have their goal partially achieved and 2.72 (95% CI = 1.40 – 5.26) times *less* likely to have their goal fully achieved, relative to clients who did not achieve their goal. Likewise, clients who experienced socio-economic disadvantage were 2.31 (95% CI = 1.24 – 4.27) times *less* likely to partially achieve their goal and 2.07 (95% CI = 1.15 – 3.73) times *less* likely to fully achieve their goal.

Table B.3 presents the descriptive statistics for the wellbeing goals achieved by clients at the end of their first SHLV intake. Of those with non-missing data, most clients indicated that they fully achieved the goal of improving knowledge about dealing with domestic and family violence (68.5%), followed by increasing stability for children (66.6%), increasing community engagement and access to support (65.9%), improved health for the victim and their children (61.2%), and improved parenting capacity/skills (54.3%). Less than half of clients with non-missing data indicated that they fully achieved the goal of improving the management of finances (45.8%). Cross comparisons were conducted to identify significant differences in the proportion of clients based on achievement of their wellbeing goals by sex, Aboriginal and/or Torres Islander status, age, migrant status, disability, and socio-economic disadvantage. The comparison group for the following ORs are those who did not achieve the respective goal.

Table B.3. Wellbeing descriptive statistics (n = 2201)

		n (%) / m (sd)
GOAL: INCREASED COMMUNITY ENGAGEMENT AND ACCESS TO SUPPORT		
Achieved		1228 (55.8%)
Partially achieved		507 (23.0%)
Not achieved		129 (5.9%)
	missing	*337 (15.3%)*
GOAL: INCREASED PARENTING CAPACITY/SKILLS		
Achieved		546 (24.8%)
Partially achieved		342 (15.5%)
Not achieved		117 (5.3%)
	missing	*1196 (54.3%)*
GOAL: INCREASED STABILITY FOR THE CHILD(REN)		
Achieved		1020 (46.3%)
Partially achieved		390 (17.7%)
Not achieved		122 (5.5%)
	missing	*669 (30.4%)*
GOAL: IMPROVED HEALTH FOR THE VICITM AND CHILD(REN)		
Achieved		840 (38.2%)
Partially achieved		420 (19.1%)
Not achieved		112 (5.1%)
	missing	*829 (37.7%)*
GOAL: IMPROVED KNOWLEDGE ABOUT DEALING WITH DFV		
Achieved		1416 (64.3%)
Partially achieved		551 (25.0%)
Not achieved		100 (4.5%)
	missing	134 (6.1%)
GOAL: IMPROVED MANAGEMENT OF FINANCES		
Achieved		392 (17.8%)
Partially achieved		317 (14.4%)
Not achieved		146 (6.6%)
	missing	*1346 (61.2%)*

We conducted cross tabulations by whether clients achieved the goal of increasing their community engagement and access to support. Clients who identified as Aboriginal and/or Torres Strait Islander were 1.52 (95% CI = 1.01 – 2.29) times *less* likely to achieve their goal but were not significantly more likely to partially achieve their goal, relative to clients who did not achieve the goal of improved community engagement and support. Clients aged 45 years or older were 1.88 (95% CI = 1.04 – 3.39) times *more* likely to achieve the goal, but not significantly more likely to partially achieve the goal. By contrast, clients who experience socio-economic disadvantage were 2.53 (95% CI = 1.43 – 4.44) times *less* likely to achieve the goal, but not significantly less likely to partially achieve the goal, relative to those who did not achieve the goal of increased community engagement and access to support.

We conducted cross tabulations by if clients achieved the goal of increasing their parenting capacity and skills. Clients who identified as Aboriginal and/or Torres Strait Islander were 1.77 (95% CI = 1.11 – 2.82) times *less* likely to partially achieve the goal, and 1.64 (95% CI =

1.05 – 2.54) times *less* likely to achieve the goal of increasing their parenting capacity and skill, relative to clients who did not achieve this goal. Clients aged 45 years or older were 3.56 (95% CI = 1.24 – 10.19) times *more* likely to partially achieve their goal but were not significantly more likely to fully achieve their goal. Clients who were not Australian citizens were 3.20 (95% CI = 1.26 – 8.14) times *more* likely to achieve their goals but were not significantly more likely to partially achieve their goals. Clients with a disability were 3.71 (95% CI = 1.73 – 7.94) times *less* likely to partially achieve their goal, and 4.98 (95% CI = 2.36 – 10.53) times *less* likely to achieve their goal of increasing their parenting capacity and skill. Similarly, clients who experienced socio-economic disadvantage were 2.35 (95% CI = 1.15 – 4.78) and 2.93 (95% CI = 1.47 – 5.85) times *less* likely to partially and fully achieve their goal, respectively.

We conducted cross tabulations by whether clients achieved the goal of increasing stability for their children. Clients who identified as Aboriginal and/or Torres Strait Islander were 2.26 (95% CI = 1.33 – 3.84) times *more* likely to partially achieve their goal but were not significantly more likely to fully achieve their goal. There were no other significant differences in the proportion of clients who achieved their goals by demographic characteristics.

We conducted cross tabulations by whether clients achieved the goal of improving their health. Clients aged 45 years or older were 1.95 (95% CI = 1.02 – 3.73) times *more* likely to partially achieve the goal of improving their health but were not significantly more likely to fully achieve this goal compared to clients who did not achieve the goal of improving their health. Clients who were not Australian citizens were 3.13 (95% CI = 1.10 – 8.92) and 2.95 (95% CI = 1.06 – 8.23) times *more* likely to partially and fully achieve their goals, respectively. By contrast, clients with a disability were 1.99 (95% CI = 1.00 – 4.02) times *less* likely to achieve their goal but were not significantly less likely to partially achieve their goal.

We conducted cross tabulations by whether clients achieved the goal of improving their knowledge about dealing with domestic and family violence. Clients with a disability were 2.32 (95% CI = 1.17 – 4.59) times *less* likely to achieve their goal, but were not significantly more likely to partially achieve their goal of improving their knowledge about dealing with domestic and family violence. Clients who experienced socio-economic disadvantage were 1.95 (95% CI = 1.01 – 3.76) and 2.28 (95% CI = 1.21 – 4.29) times *less* likely to partially and fully achieve their goal, respectively.

We conducted cross tabulations by whether clients achieved the goal of improving their finances. Clients who identified as Aboriginal and/or Torres Strait Islander were 1.92 (95% CI = 1.20 – 3.08) times *less* likely to achieve the goal of improving their finances, but were not significantly less likely to partially achieve this goal, relative to clients who did not achieve their goal of improving their finances. By contrast, clients who were not Australian citizens were 4.09 (95% CI = 1.92 – 8.73) times *more* likely to fully achieve their goal but were not significantly more likely to partially achieve their goal. Clients who experienced socio-economic disadvantage were 2.01 (95% CI = 1.05 – 3.85) and 3.53 (95% CI = 1.90 – 6.58) times *less* likely to partially and fully achieve their goal, respectively.

Only 153 (7.0%) clients were issued with an SOS device at their first admission to SHVL. Figure 21 indicates that 88.7% of clients who received an SOS device, compared to 72.7% of clients who did not receive the device, achieved the goal of enhanced safety. Furthermore,

clients who received an SOS device were 2.95 (95% CI = 1.77 – 4.94) times *more* likely to achieve the goal of enhanced safety.

Next, it was examined whether demographic factors influence the odds of achieving the goal of safety for those who did and did not receive an SOS device. This was done separately for clients who were female (n = 1964), Aboriginal and/or Torres Strait Islander (n = 529), aged 45 years or older (n = 370), were not an Australian citizen (n = 213), had a disability (n = 234), and experienced socio-economic disadvantage (n = 1255).

Among all female clients (n = 1964), 89.0% who had an SOS device achieved the goal of enhanced safety compared to 72.8% who achieved their goal and did not have an SOS device. This corresponds to female clients with an SOS device having a 3.01 (95% CI = 1.71 – 5.30) times greater odds of achieving the goal compared to female clients without an SOS device. Similarly, among all clients who identified as Aboriginal and/or Torres Strait Islander (n = 529), 88.7% who had an SOS device achieved the goal of enhanced safety compared to 72.6% who achieved their goal and did not have an SOS device. The odds of achieving the goal of enhanced safety among Aboriginal clients were 2.96 (95% CI = 1.23 – 7.08) times greater for clients who identified as Aboriginal and/or Torres Strait Islander who received an SOS device. Among clients who experienced socio-economic disadvantage (n = 1255), 89.7% who had an SOS device achieved the goal of enhanced safety compared to 73.8% who did not have an SOS device achieved the goal. This corresponds to clients who experience socio-economic disadvantage having a 3.09 (95% CI = 1.59 – 6.03) times greater likelihood of achieving the goal if they had an SOS device. There was no significant association for clients aged 45 years or older (OR = 1.29 [95% CI = 0.42 – 3.99]). No significant association was also found for clients who were not Australian citizens (OR = 4.28 [95% CI = 0.55 – 33.52]) or had a disability (OR = 6.37 [95% CI = 0.83 – 48.79]), although this is likely a result of small cell sizes as indicated by unstable estimates.

Of the 743 clients with available data, 60.2% (n = 447) indicated that SHLV helped them manage their own finances and maintain employment, while 26.5% (n = 197) indicated that the service partially helped, and 13.3% (n = 99) indicated the service did not help. Figure 22 presents the cross tabulations for clients who indicated that SHLV helped with finances and maintaining employment by demographic factors. Clients who identified as Aboriginal and/or Torres Strait Islander were 2.53 (95% CI = 1.51 – 4.22) times *less* likely to indicate that the services helped with finances and maintaining employment, but were not significantly less likely to indicate it partially helped, relative to clients who indicated it did not help. By contrast, clients who were not Australian citizens were 2.07 (95% CI = 1.00 – 4.47) times *more* likely to indicate the service helped, but not significantly more likely to indicate it partially helped. Clients who experienced socio-economic disadvantage were 2.73 (95% CI = 1.15 - 6.49) and 4.61 (95% CI = 2.06 – 10.31).

Table B.4 presents the descriptive statistics for client services delivered. Most clients received an individual safety plan (67.5%) and safety audit in the home (57.4%). The lowest proportion of clients received safety equipment (36.1%). Clients received an average of 2.43 safety and security services. Just under half (48.1%) of all clients access the police and/or court services. Of those with available data, most indicated that services helped them access legal and court support (69.2%). Finally, most clients left the service because they met all their goals or no longer needed additional assistance (64.6%).

Table B.4. Client service delivery descriptive statistics (n = 2201)

	n (%) / m (sd)
SAFETY PLANNING AND SECUIRTY WORK	
Individual safety plan	1486 (67.5%)
Risk/lethality assessment	963 (43.8%)
Safety audit in the home	1263 (57.4%)
Safety equipment	794 (36.1%)
Security upgrade	850 (38.6%)
Number of safety/security work	2.43 (1.57)
ACCESSED POLICE AND/OR COURT SERVICES	
Yes	1058 (48.1%)
No	1143 (51.9%)
HELPED ACCESS LEGAL AND COURT SUPPORT	
Helped	960 (43.6%)
Partially helped	344 (15.6%)
Did not help	83 (3.8%)
Missing	814 (37.0%)
REASON FOR LEAVING SERVICE	
Case goals met/no more assistance needed	1421 (64.6%)
Client disengaged with service	387 (17.6%)
Client moved out of area	136 (6.2%)
Not eligible	132 (6.0%)
Unable to contact client	115 (5.2%)
Missing	*10 (0.5%)*

We examined the proportion of clients who achieved service success according to the safety planning and security work received. Herein service success status is defined as meeting case goals and/or assistance no longer being needed. The odds of service success were 1.57 (95% CI = 1.31 – 1.89) times greater for clients who received an individual safety plan, 1.32 (95% CI = 1.11-1.58) times greater for clients who received risk/lethality assessment, 1.88 (95% CI = 1.58 – 2.25) times for clients who had a safety audit in the home, 1.94 (95% CI = 1.60 – 2.35) times greater for clients who received safety equipment, and 2.23 (95% CI = 1.84 – 2.70) times greater for clients who had a security upgrade.

We examined the proportion of clients who achieved service success by the number of safety planning and security work services received. Overall, receiving a greater number of safety planning and security work services conferred greater likelihood of service success. Compared to clients who did not receive any safety planning and security work, receiving one service increased the odds of service success by 2.06 (95% CI = 1.50 – 2.82) times, two services by 2.55 (95% CI = 1.11 – 2.15) times, three services by 3.22 (95% CI = 2.27 – 4.56) times, four services by 3.70 (95% CI = 2.60 – 5.28) times, and five services by 4.80 (95% CI = 3.25 – 7.10) times.

We examined the proportion of clients who accessed police and/or court services by demographic factors. Clients who were not Australian citizens were 1.55 (95% CI = 1.16 – 2.06) times *more* likely to access police and/or court services, compared to clients who were

Australian citizens. There were no other significant differences in the proportion who accessed these services by other demographic factors.

We examined the proportion of clients who indicated that SHLV helped access to legal and court support by demographic factors. Clients who identified as Aboriginal and/or Torres Strait Islander were 1.64 (95% CI = 1.00 – 2.76) and 2.29 (95% CI = 1.40 – 3.75) times *less* likely to indicate that SHLV partially and fully helped them access legal and court services, respectively. Clients who experienced socio-economic disadvantage were also 2.82 (95% CI = 1.37 – 5.82) times *less* likely to indicate that SHLV helped but were not significantly less likely to indicate that SHLV partially helped them access legal and court services.

The following compares the service delivery and client outcomes between five new and 22 pre-existing services. Data for one of the new services, Mission Australia, was not available in the CIMS data. The remaining four new services are Linking Communities SHLV (n = 149), Momentum Collective (n = 109), Port Stephens FANS (n = 335), and YES Staying Home Leaving Violence (n = 48). Collectively, 30.7% (n = 675) of clients were admitted to these four new services at their first intake, compared to 69.3% (n = 1526) of clients admitted to pre-existing services. The odds of attending a new service were 5.35 (95% CI = 4.01 – 7.13) times *lower* for female clients, 1.75 (95% CI = 1.34 – 2.29) times *lower* for clients aged 45 years or older, and 1.97 (95% CI = 1.30 – 2.98) times *lower* for clients with a disability. By contrast, clients who were not Australian citizens or experiencing socio-economic disadvantage were 1.83 (95% CI = 1.37 – 2.45) and 1.35 (95% CI = 1.07 – 1.69) times *more* likely to attend a new service.

Clients who attended one of the new services were 1.31 (95% CI = 1.09 – 1.57) times *less* likely to receive a safety audit in the home, 1.43 (95% CI = 1.18 – 1.73) times *less* likely to receive safety equipment, and 2.47 (95% CI = 2.01 – 3.02) times *less* likely to receive a security upgrade, relative to clients who attended a pre-existing service.

Clients who attended one of the new services were 1.34 (95% CI = 1.10 – 1.63) times *less* likely to achieve the goal of improving knowledge about domestic and family violence, and 2.08 (95% CI = 1.64 – 2.65) times *less* likely to achieve the goal of sustained housing/accommodation, relative to clients in the pre-existing services. By contrast, clients who attended one of the new services were 2.02 (95% CI = 1.35 – 3.02) times *more* likely to achieve the goal of regaining parental responsibilities, relative to clients in the pre-existing services. Further examination indicated that an equal proportion of clients in the new (63.4%) and pre-existing (65.5%) services left the program because they met their case goals or no longer needed further assistance.

It is possible that the association between being admitted to one of the new service facilities and types of services provided and service outcomes may be influenced by client demographic factors. Therefore, a series of multivariate logistic regression analyses were conducted to assess the association between clients attending one of the new service facilities and the odds of receiving safety planning and security work, and achieving case goals, separately, independent of client gender, Aboriginal identity, age, citizenship, disability, and socio-economic disadvantage.

We calculated Odds Ratios (OR) and accompanying 95% confidence intervals of clients in one of the new service facilities receiving safety planning and security work, independent of

demographic factors. Results indicate that clients attending one of the new facilities were 1.37 (95% CI = 1.01 – 1.86) times *more* likely to receive a risk/lethality assessment, relative to clients who attended one of the pre-existing facilities. Similarly, clients in one of the new service facilities were 1.50 (95% CI = 1.08 – 2.07) times *more* likely to receive a safety audit in the home. By contrast, clients in the new service facilities were 2.77 (inverted OR = 0.36 [95% CI = 0.26 – 0.51]) times *less* likely to receive security upgrades, independent of demographic factors.

After adjusting for demographic factors, clients in the new service facilities were 1.58 (95% CI = 1.01 – 2.48) times *more* likely to achieve the goal of improving the management of their finances, relative to clients in the pre-existing service facilities. No other significant associations were found, indicating that demographic factors may account for differences between clients in the new and pre-existing service facilities achieving their case goals.

There were 7079 unique individuals referred to SHLV for the first time from 1 July 2019 to 30 June 2021. A very small portion of these individuals had multiple referral sources and/or outcomes at their first referral to SHLV (n = 277, 3.9%). The greatest proportion of individuals were referred from WDVCAS (n = 1794, 25.3%), followed by self-referral (n = 1106, 15.6%), other source of referral (n = 859, 12.1%), FACS (n = 594, 8.4%), internal referral (n = 530, 7.5%), and local coordination point (n = 466, 6.6%). The lowest proportion of individuals were referred from educational institutions (n = 30, 0.4%), followed by Centrelink (n = 45, 0.6%), court and/or legal services (n = 112, 1.6%), charitable organisations (n = 123, 1.7%), Brighter futures (n = 127, 1.8%), and NSW Health (n = 153, 2.2%).

The referral outcome for half of all individuals was case management plan (n = 3549, 50.1%), while around a quarter of individuals received a case co-ordinated plan (n = 1901, 26.9%). Almost one in six individuals received information and/or referral only (n = 1190, 16.8%), and one in ten received no services (n = 663, 9.4%).

Of the 2201 participants in the derived sample, just under half (n = 1031, 46.8%) received brokerage services at their first referral. The average amount received by these clients was $998.13 (sd = $1383.41). Half of those who received brokerage services (n = 515) received $490.00 or less, and 90% (n = 930) received $2475.30 or less. Ten per cent (n = 103) received between $2485.30 and $8250.00.

The most common use for the brokerage services were expenses relating to safety upgrades for the client's house (n = 665, 64.5%), followed by other expenses (n = 373, 36.2%), cash payments and/or vouchers (n = 236, 22.9%), groceries and/or clothing (n = 192, 18.6%), housing bills and household repairs (n = 97, 9.4%), educational items and support (n = 94, 9.1%), and external services (n = 44, 4.3%).

Clients who received brokerage services were 1.45 (95% CI = 1.19 – 1.76) times *more* likely to achieve the goal of improving the victims and child(ren)s safety, 1.38 (95% CI = 1.14 – 1.66) times *more* likely to improve their knowledge about domestic and family violence, 1.48 (95% CI = 1.17 – 1.87) times *more* likely to achieve the goal of sustainable housing, 1.36 (95% CI = 1.08 – 1.71) times *more* likely to effectively separate from the perpetrator, and 1.48 (95% CI = 1.18 – 1.87) times *more* likely to be able to access the courts and legal services. No other significant differences were evident.

Clients who received more money from brokerage services were significantly more likely to achieve the goal of improving the victim and child(ren)'s safety (m = $1073.09 (sd = $1417.17) vs. $750.56 (sd = $1217.13); $t(1012) = 4.49$, $p < .001$), engage in community and support services (m = $1058.28 (sd = $1397.64) vs. $887.72 (sd = 1316.87); $t(874) = 2.33$, $p = .02$), improve parenting skills (m = $1033.15 (sd = $1366.44) vs. $809.26 (sd = $1288.21); $t(419) = 2.12$, $p = .04$), achieve increased stability for the child (m = $1193.56 (sd = $1557.92) vs. $713.84 (sd = $986.46); $t(518.97) = 4.96$, $p < .001$), improve knowledge about domestic and family violence (m = $1108.68 (sd = $1464.75) vs. $768.23 (sd = 1179.78); $t(990) = 4.54$, $p < .001$), improve management of finances (m = $1158.79 (sd = $1567.72) vs. $895.52 (sd = $1368.95); $t(384) = 2.12$, $p = .03$), achieve sustainable housing (m = $1100.81 (sd = $1494.07) vs. $790.53 (sd = $1217.92); $t(731) = 3.11$, $p=.003$), separate from the perpetrator (m = $1052.91 (sd = $1382.40) vs. $749.96 (sd = $1059.78); $t(752) = 3.36$, $p = .001$), regain parental responsibilities (m = $1109.96 (sd = 1477.13) vs. $730.85 (sd = 1144.13); $t(164.67) = 2.02$, $p = .04$), and achieve financial and employment stability (m = $1379.15 (sd = $1764.32) vs. $911.63 (sd = 1421.52); $t(302.01) = 3.18$, $p = .002$). Note that the variable denoting the amount received from brokerage services had a skewness of 2.54 and kurtosis of 6.86, indicating the variable was not normally distributed. This variable was modified using the square-root transformation to normalise the distribution prior to conducting independent t-tests.

Appendix C: ORS Data Analysis

The ORS contains data for 2909 clients and 4881 corresponding surveys from 1 May 2000 to 21 October 2021. Data was limited to surveys completed from 1 July 2019 to 30 June 2021. Child survey data was also removed because unique child IDs that differentiated them from their parents or siblings were not provided. In other words, children shared the same ID as their parent, making it impossible to differentiate between siblings, or to link the correct child to the SHLV Incoming Referral List data set. Finally, only clients who completed the ORS at service intake *and* exit were retained. This ensures that within-individual improvements can be assessed. The final sample consisted of n = 664 unique clients.

ORS Scores range from 1 (not at all well) to 5 (extremely well), with higher scores indicating better wellbeing. Participants scored their wellbeing within the domains of *individual* (personal well-being), *interpersonal* (family and other close relationships), *social* (work, school, and friendships), and *overall* (general sense of well-being). Paired samples t-tests indicate that there were significant within-individual improvements in wellbeing scores from service intake to service exit. Specifically, there was a 56.8% improvement for individual wellbeing ($t(652)=32.17$, $p<.001$), 40.4% improvement for interpersonal wellbeing ($t(659)=23.72$, $p<.001$), 40.5% improvement for social wellbeing ($t(649)=23.94$, $p<.001$), and 49.6% improvement for overall wellbeing ($t(660)=29.63$, $p<.001$).

We examined the difference in wellbeing score from service intake to service exit for those who received assistance from a pre-existing and new service. Scores greater than zero indicate that wellbeing at service exit was higher than at service intake, indicating an improvement in wellbeing. The size of the difference in wellbeing scores reflects the magnitude of the improvement in wellbeing. For example, clients admitted to a pre-existing service scored on average 1.28 points higher at service exit for individual wellbeing, whereas clients admitted to a new service scored on average 1.41 points higher at service exit. However, the magnitude of the improvement in wellbeing scored did not significantly differ between the two groups. There was also no significant difference in the magnitude of improvement in wellbeing score for interpersonal, and overall wellbeing. However, participants who attended one of the new services were 1.22 (95% CI = 1.03 – 1.44) times more likely to report greater improvements in social wellbeing than those who attended the pre-existing services. In other words, the magnitude of improvement in social wellbeing scores were significantly greater for those who attended one of the new service providers.

Client age was not significantly associated with the magnitude of improvement in wellbeing scores.

Figure C.1 presents the average improvement in wellbeing score by participant citizenship status (n = 609). Clients who were not an Australian citizen were 1.32 (95% CI = 1.00 – 1.76) times more likely to report greater improvements in overall wellbeing than those who were an Australian citizen. No other significant differences were present.

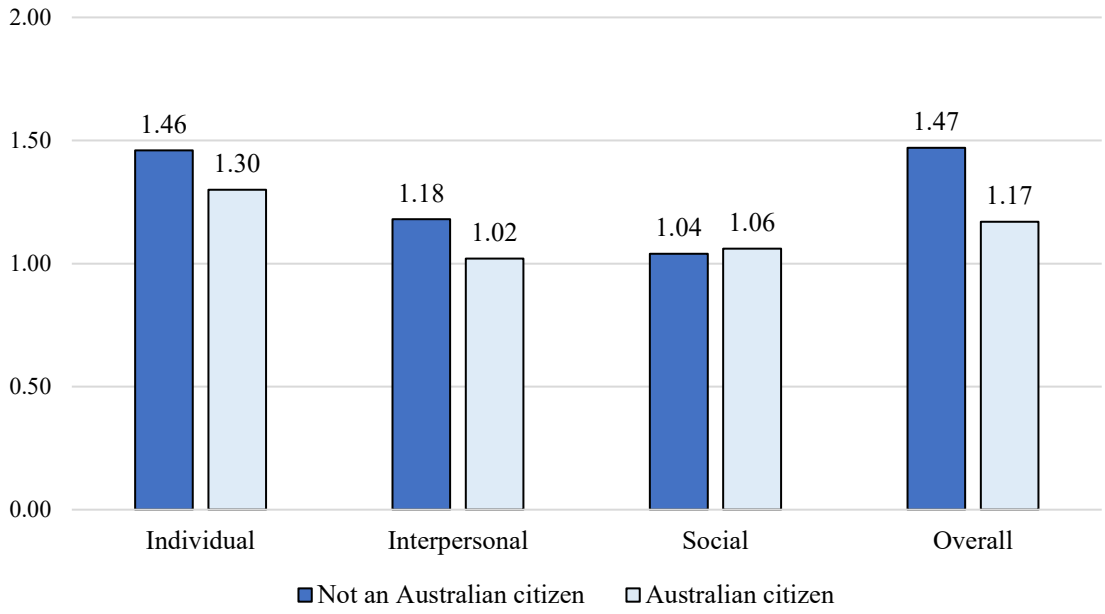


Figure C.1. Average improvement in wellbeing score by citizenship status.

Figure C.2 presents the average improvement in wellbeing score by participant Aboriginal and/or Torres Strait Islander identity (n = 621). No significant differences were found.

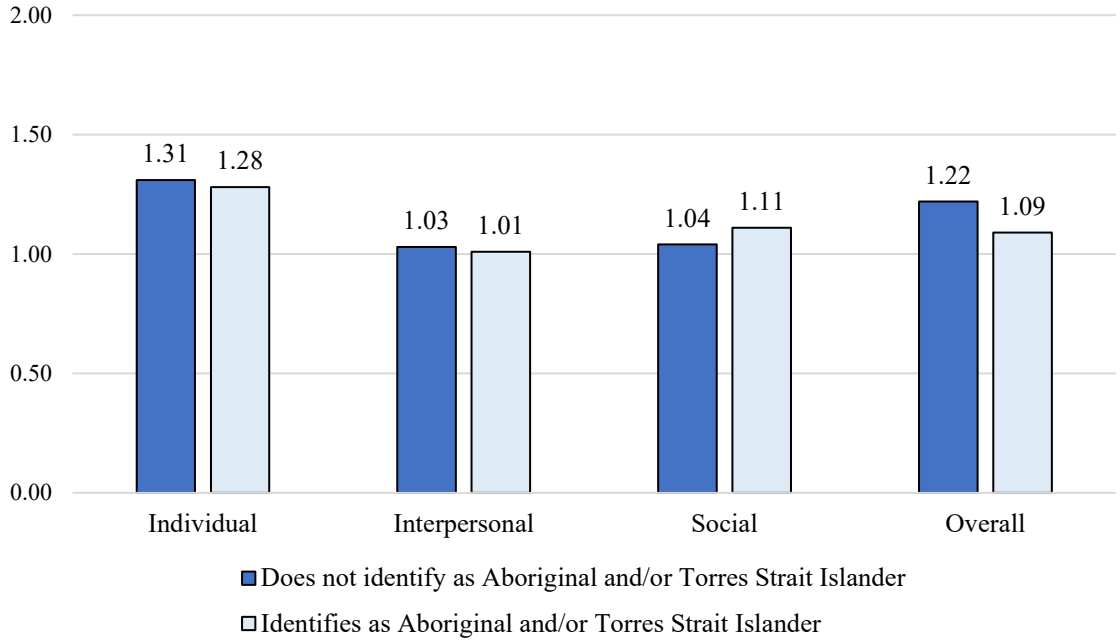


Figure C.2. Average improvement in wellbeing score by Aboriginal and/or Torres Strait Islander identity.

Figure C.3 presents the average improvement in wellbeing score by participant disability status (n = 436). Participants who were disabled were 1.22 (95% CI = 1.00 – 1.52) times more likely to report greater improvements in individual wellbeing, and 1.25 (95% CI = 1.01 – 1.54) times more likely to report greater improvements in interpersonal wellbeing, compared to participants who did not have a disability.

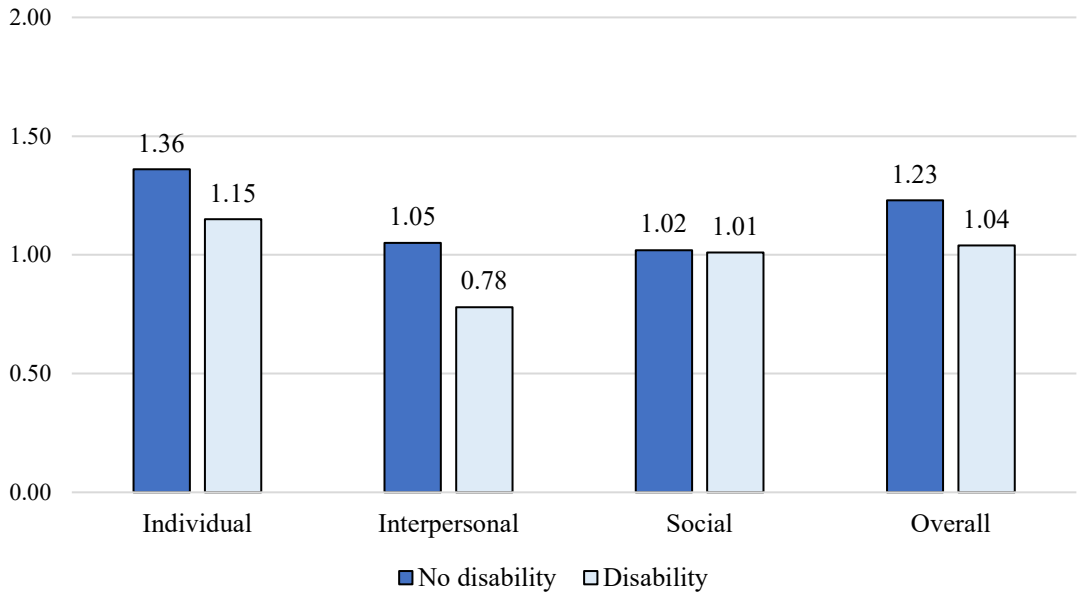


Figure C.3. Average improvement in wellbeing score by disability status.

Figure C.4 presents the average improvement in wellbeing score by participant socio-economic disadvantage (n = 462). Participants who did not experience socio-economic disadvantage were 1.28 (95% CI = 1.05 – 1.55) times more likely to report greater improvements in individual wellbeing, and 1.22 (95% CI = 1.00 – 1.47) times more likely to report greater improvements in overall wellbeing, compared to participants who experienced socio-economic disadvantage.

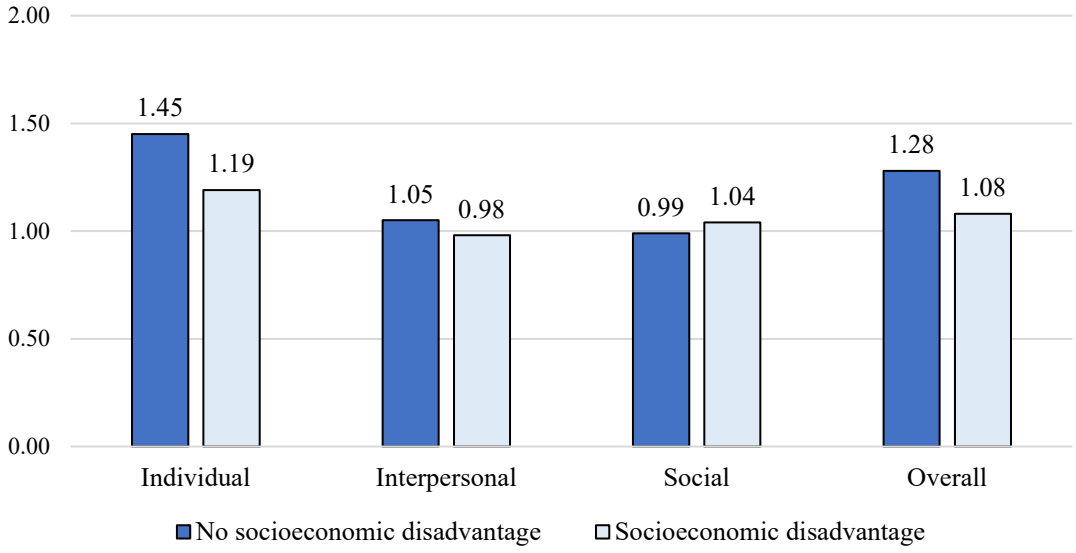


Figure C.4. Average improvement in wellbeing score by socio-economic disadvantage.

Figure C.5 presents the average improvement in wellbeing score by participant social exclusion (n = 463). Participants who did not experience social exclusion were 1.21 (95% CI = 1.00 – 1.48) times more likely to report greater improvements in individual wellbeing, and 1.23 (95% CI = 1.01 – 1.49) times more likely to report greater improvements in overall wellbeing, compared to participants who experienced social exclusion.

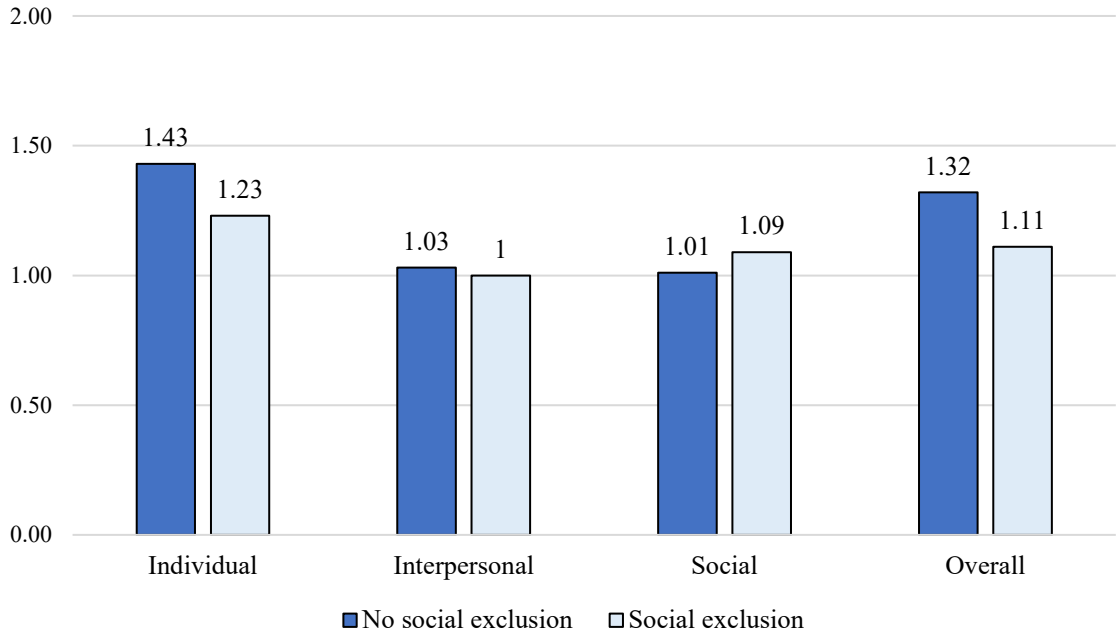


Figure C.5. Average improvement in wellbeing score by social exclusion.

Figure C.6 presents the average improvement in wellbeing score by service end reason (n = 520). No significant differences were found.

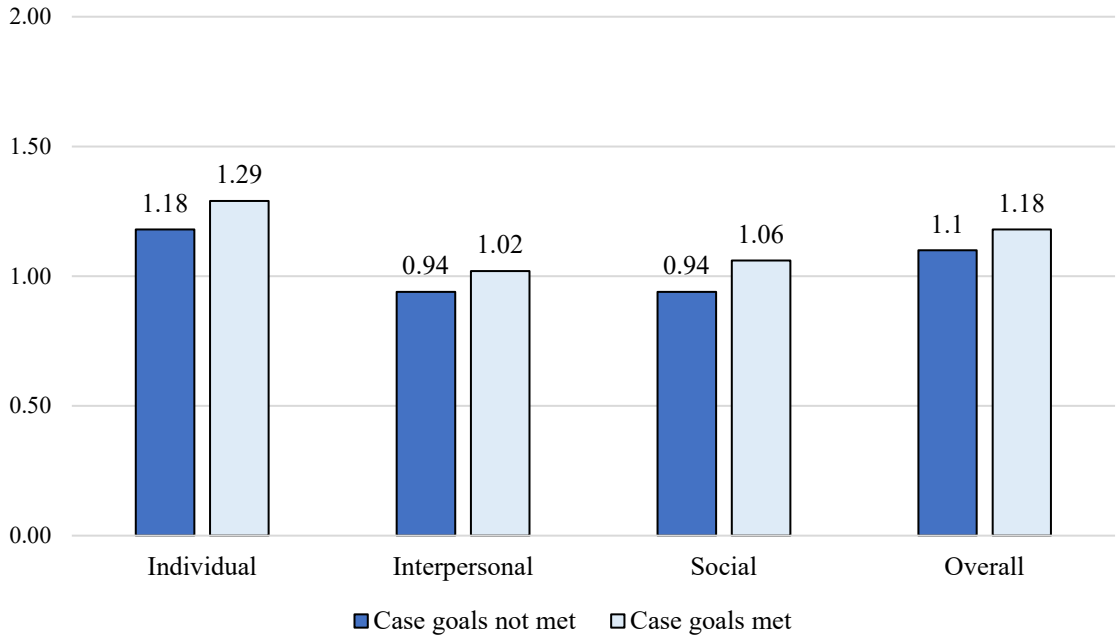


Figure C.7. Average improvement in wellbeing score by service end reason.

Figure C.8 presents the average improvement in wellbeing score by whether participants had taken out an AVO/ADVO (n = 532). No significant differences were found.

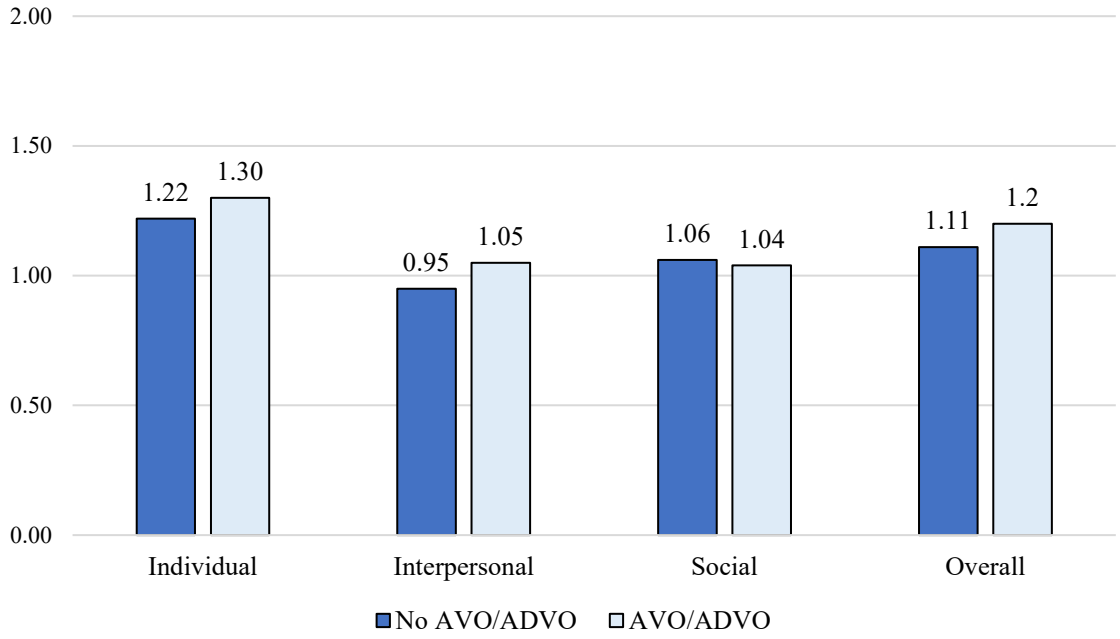


Figure C.8. Average improvement in wellbeing score by AVO/ADVO status.

Figure C.9 presents the average improvement in wellbeing score by whether the participants perpetrator was in custody (n = 515). No significant differences were found.

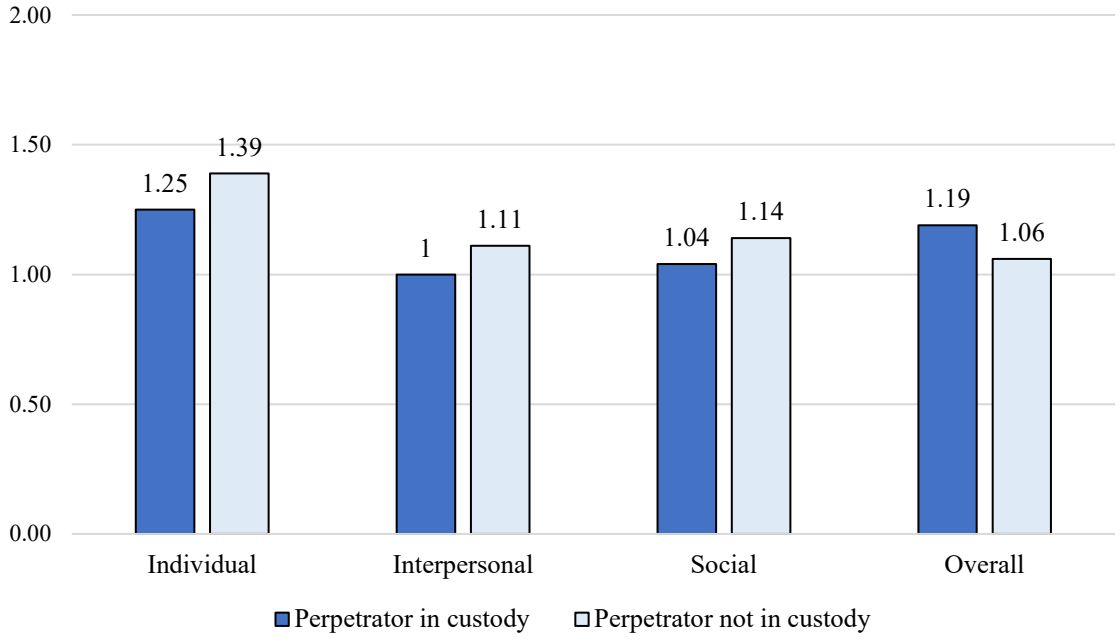


Figure C.9. Average improvement in wellbeing score by whether perpetrator is in custody.

Figure C.10 presents the average improvement in wellbeing score by housing type at intake (n = 474). Clients who were not a homeowner or resided in a private rental were 1.20 (95% CI = 1.00 – 1.43) times more likely to report greater improvements in interpersonal wellbeing, and 1.25 (95% CI = 1.05 – 1.49) times more likely to report greater improvements in social wellbeing, relative to clients who were homeowners or resided in a private rental.

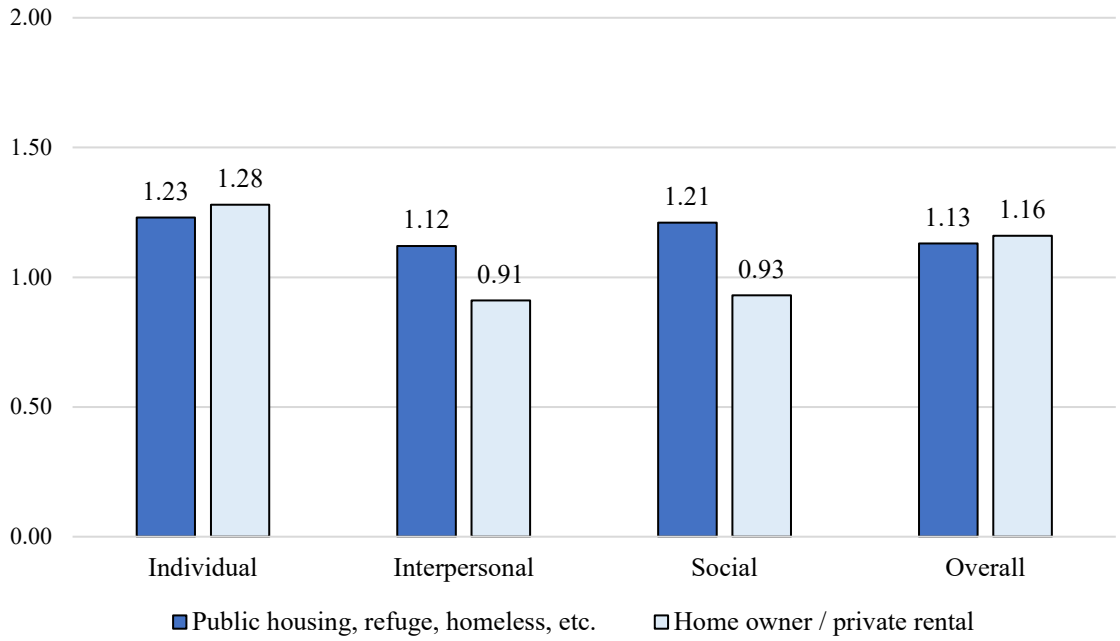


Figure C.10. Average improvement in wellbeing score by housing type at intake.

Figure C.11 presents the average improvement in wellbeing score by living situation at intake (n = 487). Clients who were living where the DV occurred were 1.29 (95% CI = 1.08 – 1.55) times more likely to report greater improvements in individual wellbeing, 1.33 (95% CI = 1.12 – 1.59) times more likely to report greater improvements in interpersonal wellbeing, 1.29 (95% CI = 1.08 – 1.53) times more likely to report greater improvements in social wellbeing, and 1.26 (95% CI = 1.05 – 1.51) times more likely to report greater improvements in overall wellbeing, relative to clients who were not living where DV occurred.

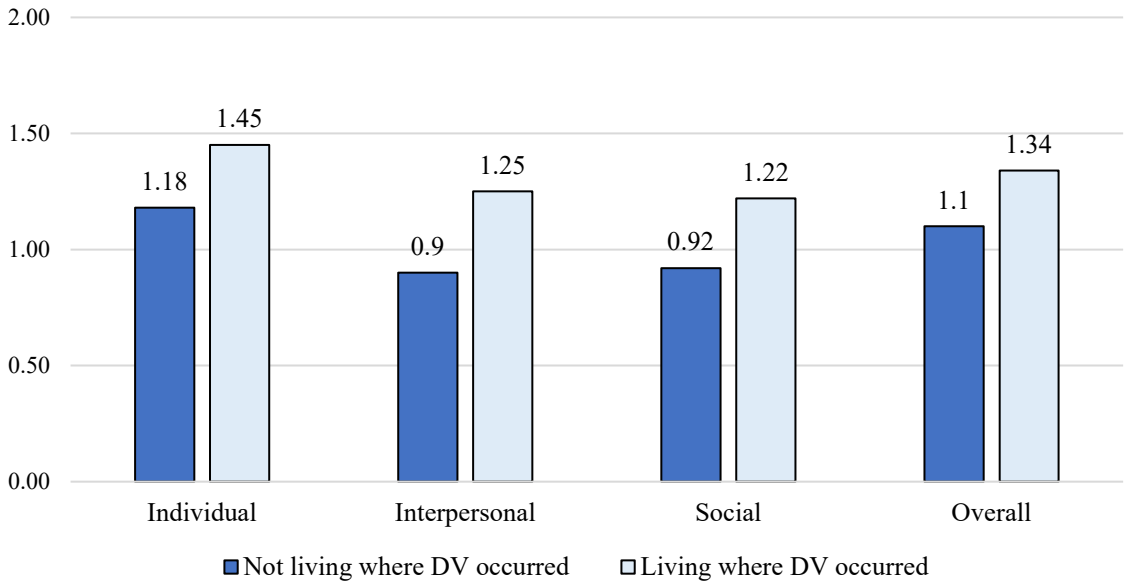


Figure C.11. Average improvement in wellbeing score by living situation at intake.

Figure C.12 presents the average improvement in wellbeing score by employment status at intake (n = 498). Clients who were employed at intake were 1.20 (95% CI = 1.00 – 1.44) times more likely to report greater improvements in individual wellbeing, compared to those who were not employed at intake.

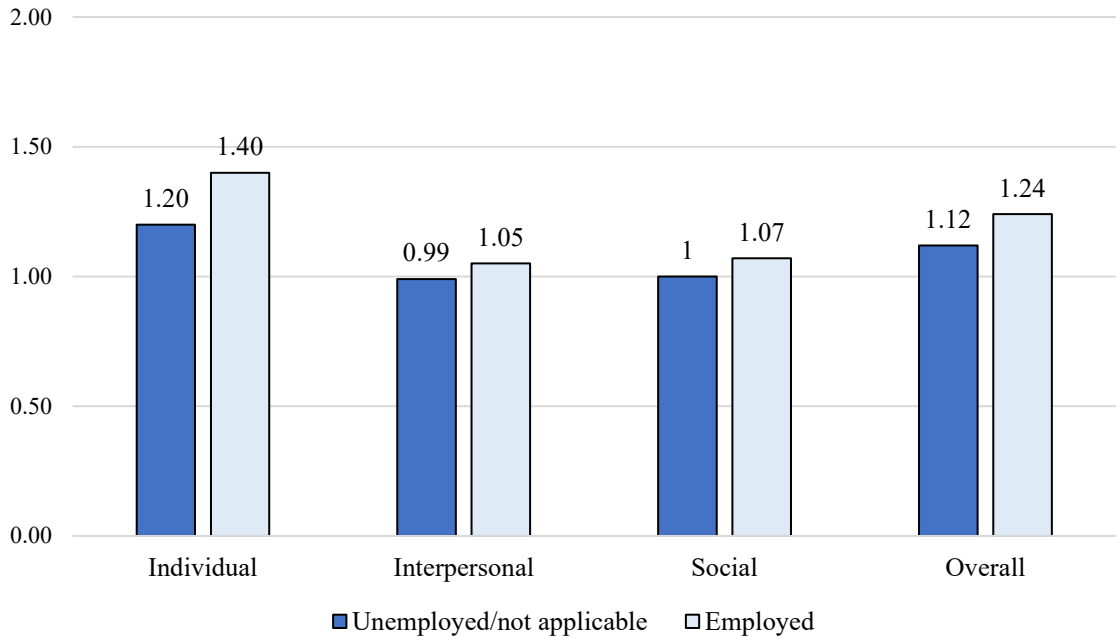


Figure C.12. Average improvement in wellbeing score by employment status at intake.

Figure C.13 presents the average improvement in wellbeing score by safety plan at intake (n = 586). No significant differences were found.

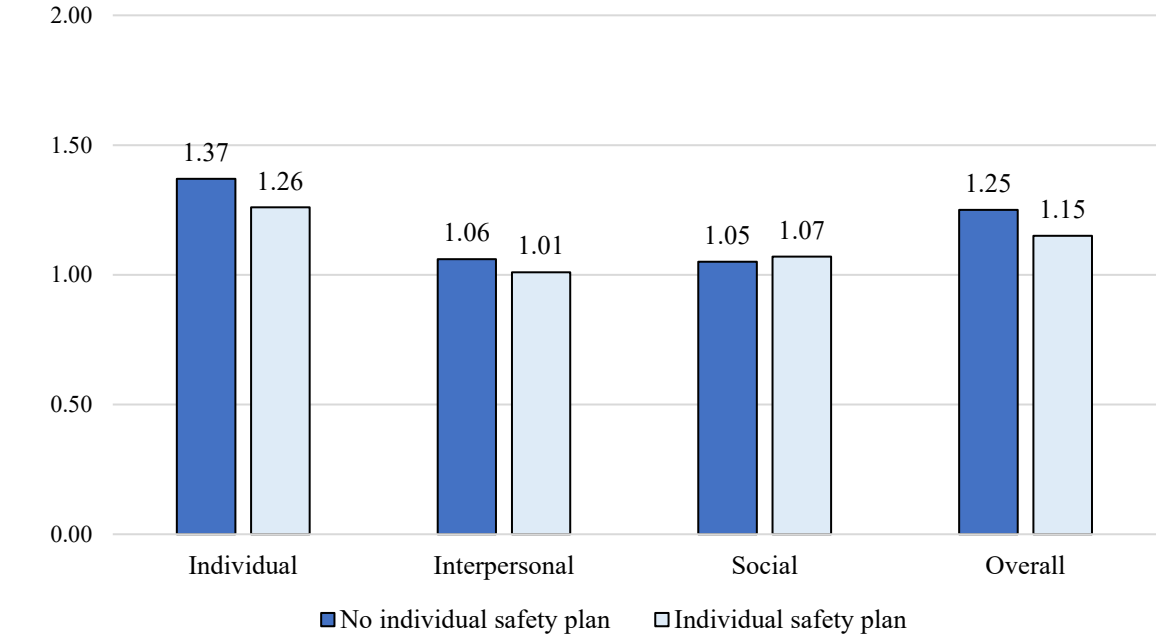


Figure C.13. Average improvement in wellbeing score by individual safety plan.

Figure C.14 presents the average improvement in wellbeing score by risk/lethality assessment at intake (n = 586). No significant differences were found.

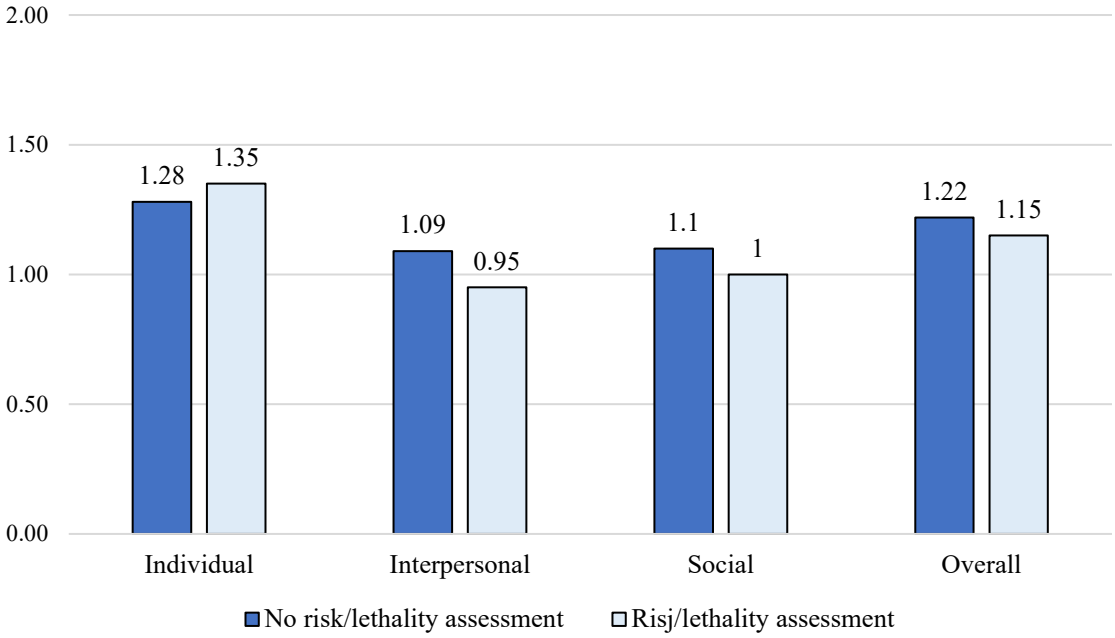


Figure C.14. Average improvement in wellbeing score by risk/lethality assessment.

Figure C.15 presents the average improvement in wellbeing score by safety audit in the home at intake (n = 586). No significant differences were found.

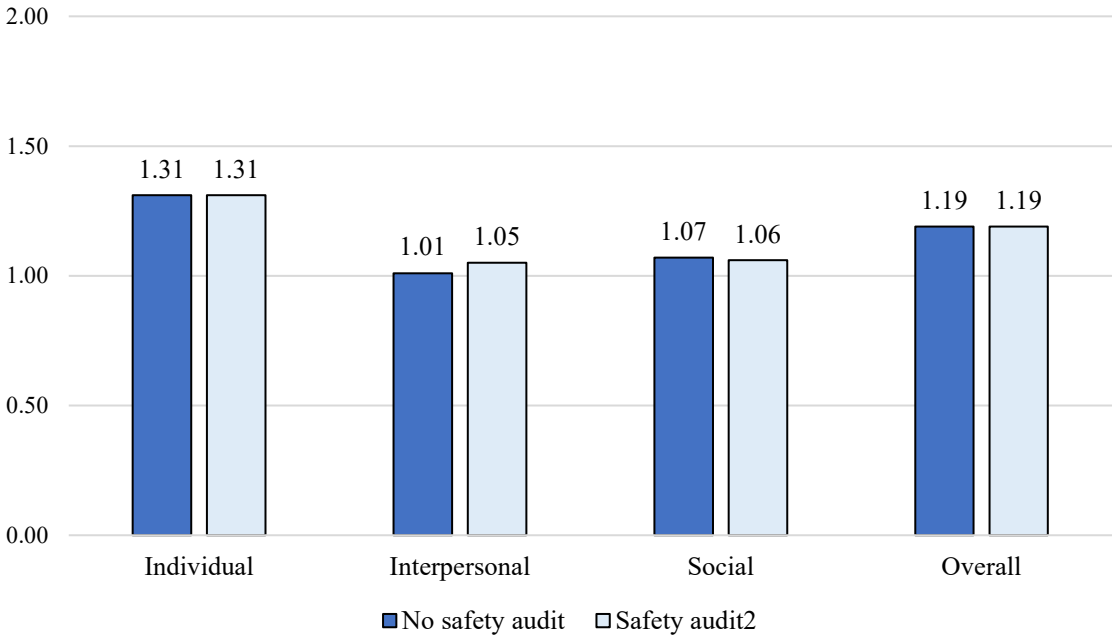
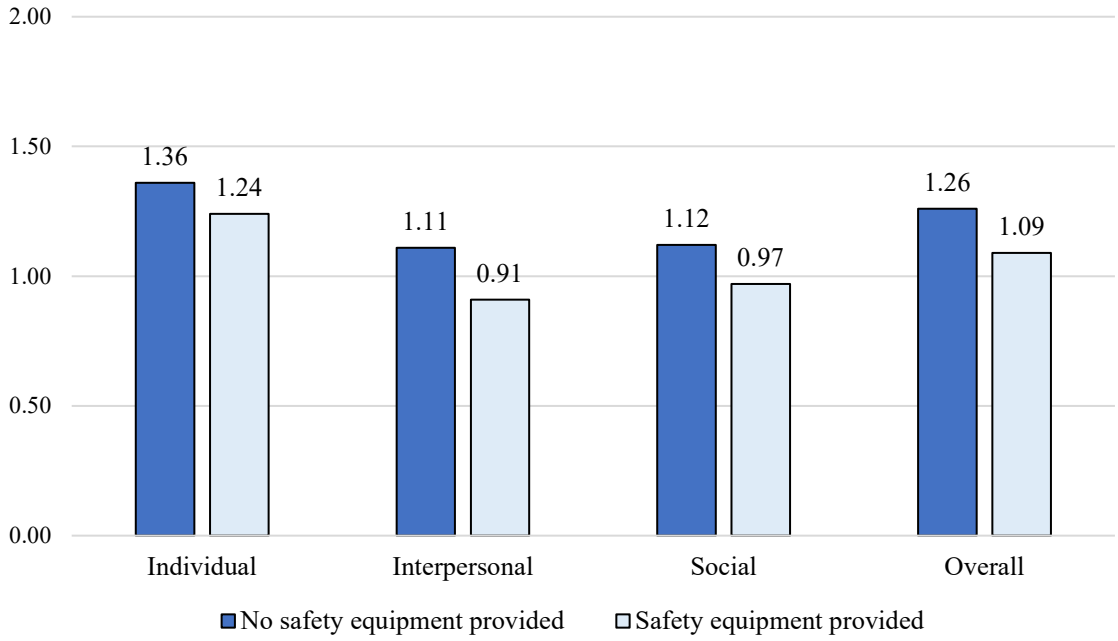


Figure C.15. Average improvement in wellbeing score by safety audit in the home.

Figure C.16 presents the average improvement in wellbeing score by safety equipment provided at intake (n = 586). Clients who were not provided safety equipment were 1.17 (95% CI = 1.01 – 1.35) times more likely to report greater improvements in interpersonal wellbeing, and 1.17 (95% CI = 1.00 – 1.37) times more likely to report greater improvements in overall wellbeing, compared to clients who were provided safety equipment.



FigureC.16. Average improvement in wellbeing score by safety equipment provided.

Figure C.17 presents the average improvement in wellbeing score by safety upgrade at intake (n = 586). No significant associations were found.

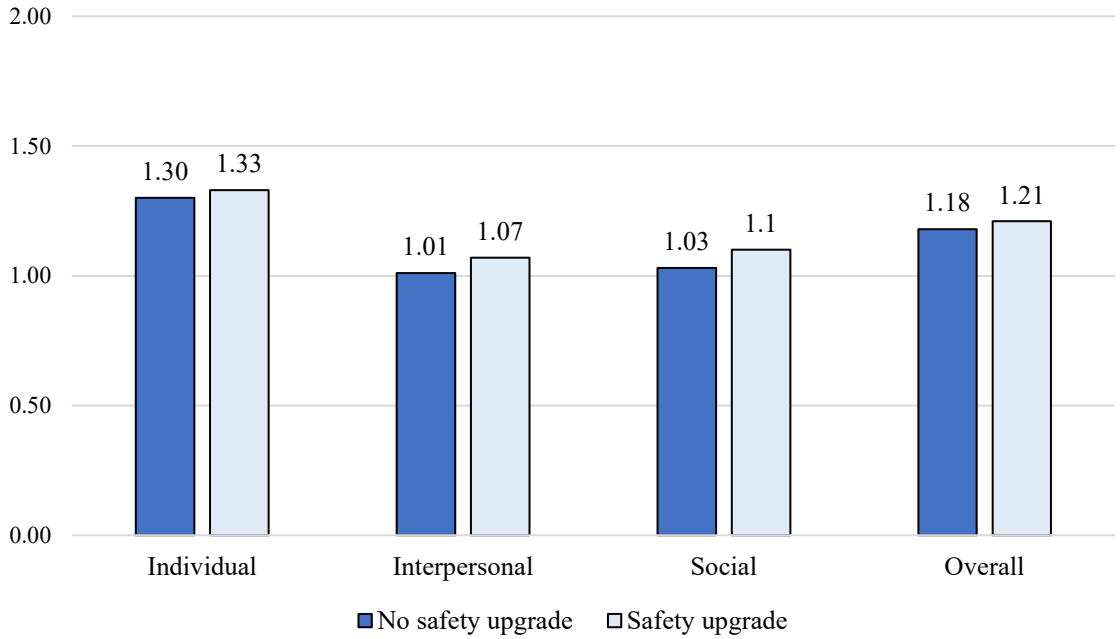


Figure C.17. Average improvement in wellbeing score by safety upgrade.

Figure C.18 presents the average improvement in wellbeing score by SOS device provided at intake (n = 586). No significant associations were found. This null result is likely due to the small number of clients who received an SOS device (n = 30).

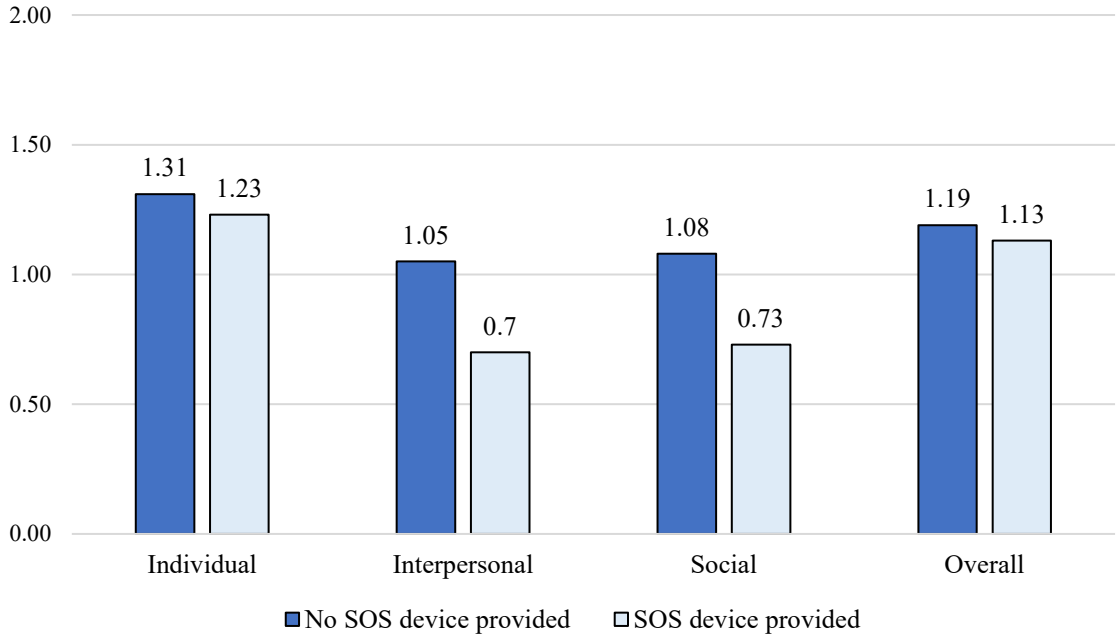


Figure C.18. Average improvement in wellbeing score by SOS device provided.

Figure C.19 presents the average improvement in wellbeing score by if participants accessed police and/or court services at intake (n = 586). No significant differences were found.

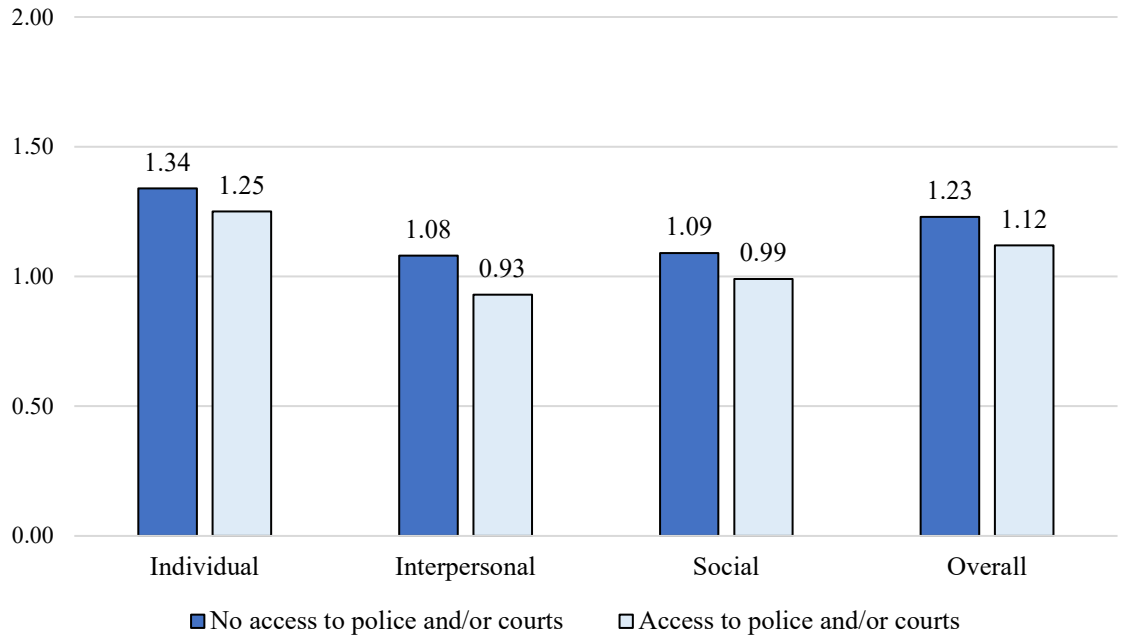


Figure C.19. Average improvement in wellbeing score by access to police and/or court services.

Figure C.20 presents the average improvement in wellbeing score by whether participants received brokerage services (n = 664). No significant differences were found.

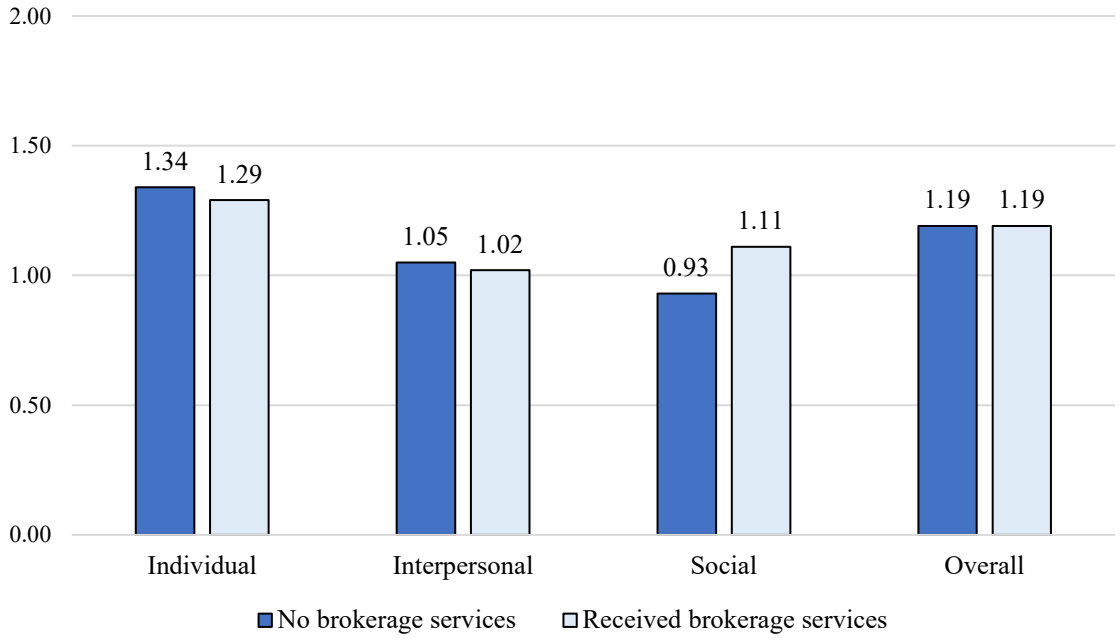


Figure C.20. Average improvement in wellbeing score by receiving brokerage services.

Figure C.21 presents the average improvement in wellbeing score by the amount received in brokerage services (n = 508; this excludes those who did not received brokerage services). Results indicate that clients who received $1000 or more from brokerage services were 1.27 (95% CI = 1.06 – 1.51) times more likely to report *lower* magnitude of improvement for interpersonal wellbeing, and 1.25 (95% CI = 1.05 – 1.50) times more likely to report *lower* magnitude of improvement in social wellbeing, relative to clients who received less than $1000 from brokerage services. Given this unexpected result, additional analyses were conducted, and revealed that clients who received $1000 or more from brokerage services had higher interpersonal (mean = 2.51 [sd = 0.98] vs. 2.70 [sd = 1.00]; $t(504) = 1.90$, $p<=.05$) and social (mean = 2.51 [sd = 0.96] vs. 2.60 [sd = 1.06]; $t(502) = 1.83$, $p=.06$) wellbeing scores at service intake than those who received less than $1000. By comparison, there were no significant differences in wellbeing scores between the two groups at service exit. Hence, the results of Figure C.21 appear to be attributable to the higher wellbeing scores at service intake for those who received $1000 or more from brokerage services.

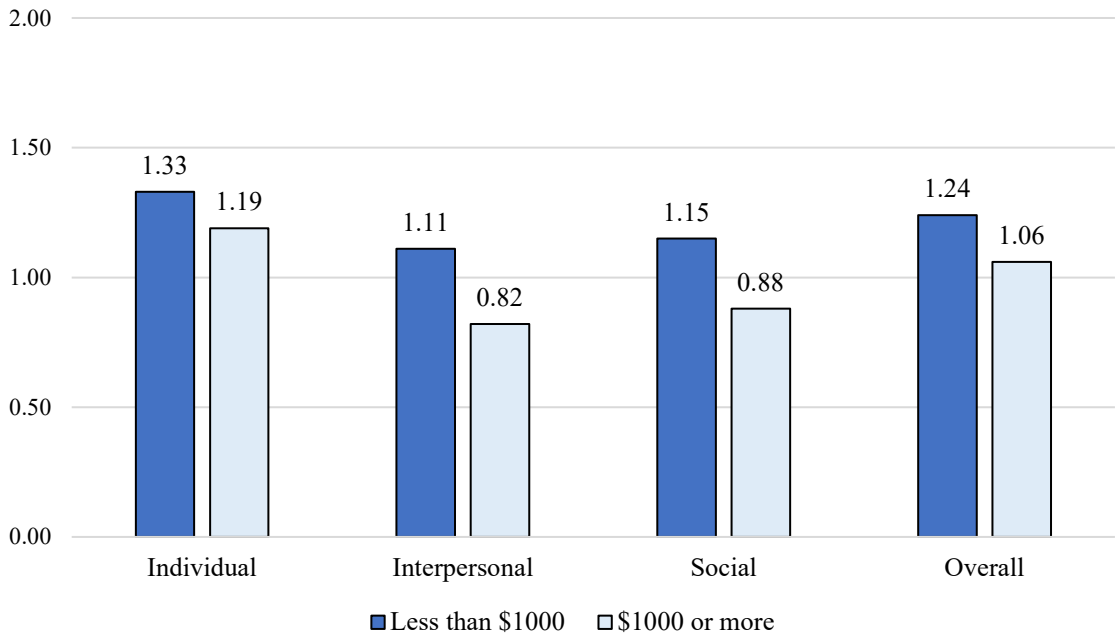


Figure C.21. Average improvement in wellbeing score by receiving brokerage services.