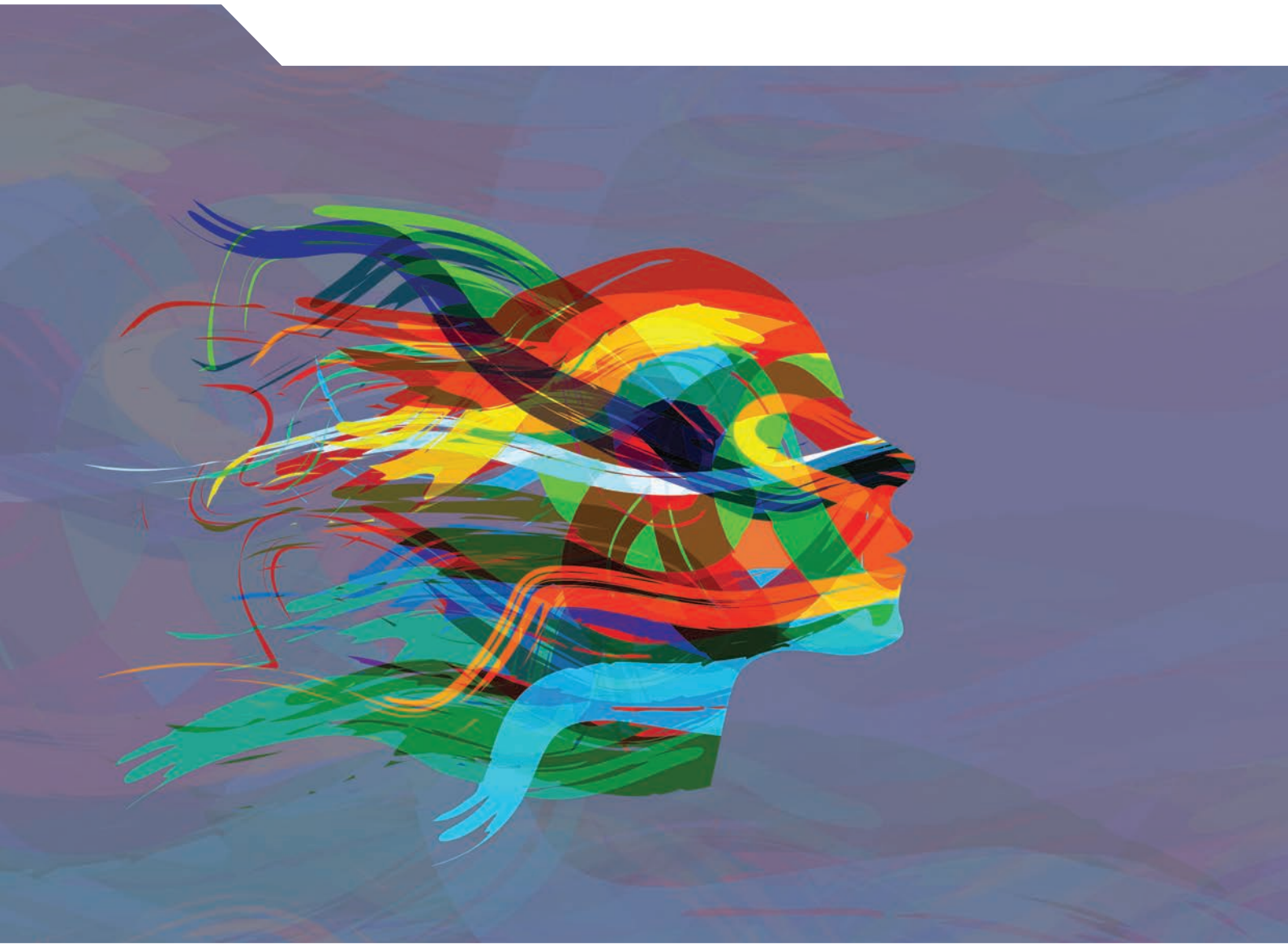
Supporting Lives Free from Intimate Partner Violence

TOWARDS BETTER INTEGRATION OF SERVICES FOR VICTIMS/SURVIVORS



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BETTER POLICIES FOR BETTER LIVES

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Foreword

Violence against women remains a violation of human rights around the world. Around one in three women, globally, report having experienced some form of gender-based violence in their lifetime – a rate that is surely a low estimate, given high barriers to disclosing violence.

OECD governments recognise the importance of this issue. In surveys of OECD governments both before and after COVID-19, violence against women has been reported as the top gender equality challenge governments say they face. Yet, in the face of this challenge, public policy responses have been inconsistent over time, disjointed across relevant actors, and insufficiently funded to meet needs on the ground.

This report, *Supporting Lives Free from Intimate Partner Violence: Towards Better Integration of Services for Victims/Survivors*, explores how OECD governments can improve their response to intimate partner violence (IPV) through an integrated service delivery approach. It explores how co-ordinated policies can improve victims/survivors' outcomes across the areas of health, housing, justice, and income support, and offers examples of best practice.

This report is the continuation of an important programme of work on gender-based violence at the OECD. Building on longstanding cross-national data collection on violence against women, including the OECD Family Database and the Social Institutions and Gender Index, the OECD elevated the issue of gender-based violence in February 2020 with its High-Level Conference on Ending Violence Against Women, entitled "Taking Public Action to End Violence at Home". This event resulted in a Call to Action from Ambassadors for the OECD to deepen its work in identifying and recommending key policy measures for governments to eliminate violence against women, in particular intimate partner violence.

Since then, the Directorate for Employment, Labour and Social Affairs (ELS) has carried out an extensive survey of OECD member countries and non-governmental service providers about integrated service delivery for victims/survivors of intimate partner violence – the results of which are presented in this report. ELS has also produced a podcast series entitled "Truth Hurts", featuring conversations with experts in service delivery to address intimate partner violence.

This report is part of the OECD's fruitful cross-directorate work covering gender-based violence, which includes the report *Eliminating Gender-based Violence: Governance and Survivor/Victim-centred Approaches* (OECD, 2021); *Man Enough? Measuring Masculine Norms to Promote Women's* Empowerment (OECD, 2021); and a forthcoming horizontal report (2023) co-ordinated across the OECD Directorate for Employment, Labour and Social Affairs; the OECD Public Governance Directorate; and the OECD Development Centre.

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The report was written by Valerie Frey, Maja Gustafsson, and Nancy Napolitano. Dorothy Adams and Hlöðver Hákonarson made valuable contributions, including in questionnaire implementation and data collection.

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Abbreviations and acronyms

COE	Council of Europe
DV	Domestic violence
EIGE	European Institute for Gender Equality
FRA	European Union Agency for Fundamental Rights
GBV	Gender-based violence
ILO	International Labor Organization
IPV	Intimate partner violence
ISD	Integrated service delivery
MARAC	Multi-Agency Risk Assessment Conference
NGO	Non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
QISD-GBV 2022	2022 OECD Questionnaire on Integrated Service Delivery to Address GBV
SIGI	Social Institutions and Gender Index
WHO	World Health Organization

Executive summary

As OECD countries slowly recover from the COVID-19 pandemic, another crisis continues unabated: that of gender-based violence (GBV) against women.

Violence against women (VAW) was aptly labelled the “hidden pandemic” at the height of COVID-19, when many women were trapped at home with their abuser. Yet heightened public discourse around VAW, OECD governments’ regular acknowledgement of VAW as a priority issue, and the transition to a post-COVID “normal” have done little to improve outcomes for victims/survivors.

For all countries, addressing this multifaceted issue presents a serious governance and implementation challenge. Women victims/survivors of GBV have complex needs both during and after experiences of violence. Threats to their health include physical injuries, unintended pregnancies, sexually transmitted infections, pregnancy complications, mental health problems, homicide, and suicide. Victims/survivors also often need legal advice, housing support, and help for their children, thus requiring a diverse range of services from government and other providers. Different policy and service delivery spheres such as health, housing, justice, employment, and education must work together seamlessly.

Far too often, however, the problem of gender-based violence is met with insufficient funding and inadequate co-ordination across the many stakeholders involved.

This report digs deep on a critical component of any public policy response to violence: integrated service delivery (ISD) for women victims/survivors, with a particular focus on intimate partner violence (IPV). The findings are drawn from a comprehensive survey of 35 OECD governments and a consultation with non-governmental service providers in twelve OECD countries.

This report finds that ISD is most frequently introduced at entry points in health care, emergency housing, and police services. These sectors are increasingly interconnected and have linkages to income support, child-related services, and legal assistance. Many of these ISD practices rely on case management, referral systems, and/or physically co-located delivery.

To promote ISD on the ground, governments must adopt a whole-of-state approach to gender equality generally and GBV specifically. This means ensuring reliable, adequate, and well-organised funding for co-ordinated services. It also requires policy coherence across agencies and levels of government so that policies reinforce each other. Local governance of ISD is crucially important, given that service delivery often occurs at the subnational level, yet central governments nevertheless play a key role in promoting ISD – for example by providing funding and frameworks for joint work.

This report also finds that data-sharing capabilities across agencies must be strengthened. Data sharing across providers can reduce clients’ application costs (in time and energy); reduce the trauma associated with repeating accounts of violence to different providers; and improve client safety by better tracking risks across repeated incidents of violence. Ideally, such a system would also integrate perpetrator-related interventions as a means of tracking accountability and recidivism. Of course, any data sharing strategy must include strong privacy protections to ensure victims/survivors’ security.

While OECD governments have trialled and implemented a multitude of ISD strategies, especially across the sectors of health, housing, and justice, very few of these programmes have been rigorously evaluated. Better and more regular programme evaluations are essential to understand whether – and to what degree – integrated approaches work better than more siloed strategies.

Most importantly, a trauma-informed, victim/survivor-centred approach is crucial. Clear lines of communication must connect local service providers with national policy makers to enable better and more victim/survivor-centred service delivery. Such approaches could include regular stakeholder engagements or surveys to promote the co-creation of good policies. At the same time, a focus on perpetrators is critical, too. Governments must prevent the reoccurrence of violence and make sure that perpetrators are held accountable. Governments can work with perpetrators not only through the criminal justice system, but in multi-dimensional ways that can improve offender accountability and potentially produce long-term behavioural and cultural change.

Gender-based violence has been, and continues to be, one of the greatest human rights challenges facing OECD governments. It is beyond time for governments to commit to planning, funding, and administering a co-ordinated policy response that puts victims/survivors at the centre of comprehensive service delivery.

1 Integrated policies to address gender-based violence

Chapter 1 discusses the global prevalence of gender-based violence (GBV) against women. It illustrates the importance of vertically- and horizontally-integrated policies to address the complex needs of women escaping GBV, focusing specifically on intimate partner violence (IPV). The chapter provides an overview of general organisational theories behind integrated service delivery (ISD) for victims/survivors, much of which is based on evidence from the health and social policy sectors, and identifies relevant international and national guidelines for effective, whole-of-state integration. The chapter concludes with the main findings and recommendations of the full report. These findings are based on 35 countries' responses to the 2022 OECD Questionnaire on Integrated Service Delivery to Address Gender-Based Violence and a consultation with 27 non-governmental service providers supporting victims/survivors of GBV.

Main findings of the report

A majority of OECD governments have identified violence against women (VAW) as the top gender equality challenge their country faces (Figure 1.1). Yet for all countries, addressing this multifaceted issue presents a serious governance and implementation challenge. Women experiencing gender-based violence (GBV) have complex needs both during and after experiences of violence. Threats to their health include injuries, unintended pregnancies, sexually transmitted infections, pregnancy complications, mental health problems, homicide, and suicide. They also often need legal advice, housing support, and help for their children, thus requiring a diverse range of services from government and other providers. Different policy and service delivery spheres such as health, housing, justice, employment, and education need to work together seamlessly.

To help improve the public response to GBV, this report presents a stocktaking of OECD governments' efforts to integrate service delivery to address the most prevalent form of gender-based violence against women: intimate partner violence (IPV), defined with other key terms in Table A C.1. It focuses on the most common services provided in OECD countries: prevention and crisis response strategies, health care, justice, housing, supports for children, and income support. The following key findings are elaborated further in Section 1.5 below.

- Integrated service delivery (ISD) is most frequently introduced at entry points in health care, emergency housing, and police services. Many of these practices rely on case management, referrals, or physically co-located delivery.
- To ensure ISD adequately supports victims/survivors, governments must adopt a "whole-of-state" approach to gender equality generally and GBV specifically. This means ensuring reliable, adequate and well-organised funding for co-ordinated services. It also requires policy coherence across agencies and levels of government so that policies reinforce each other.
- Local governance of ISD is crucially important, given that service delivery often occurs at the subnational level. Yet national governments play a key role in supporting ISD, for example by providing model frameworks to help local parties understand better their role in joint working.
- Data-sharing capabilities across agencies must be strengthened. Data sharing across providers can reduce clients' application costs (in time and energy); reduce the trauma associated with repeating accounts of violence to different providers; and improve client safety by better tracking risks across repeated incidents of violence. Ideally, such a system would also integrate perpetrator-related interventions as a way to track accountability and recidivism. Data sharing must include strong privacy protections to ensure victims/survivors' security.
- Better and more regular programme evaluations are essential. In general, ISD approaches to addressing GBV have not been systematically or quantitatively evaluated.
- A holistic perspective means treating everyone involved – including perpetrators. Governments can interact with perpetrators not only through criminalisation and the court system, but in multi-dimensional ways that can improve offender accountability and produce long-term behavioural change on individual and broader cultural levels.
- Most importantly, a trauma-informed, victim/survivor-centred approach is crucial. Clear lines of communication must connect local service providers with national policy makers to enable better and more victim/survivor-centred service delivery. Such approaches could include regular stakeholder engagements or surveys to promote the co-creation of good policies.

1.1. Intimate partner violence is a complex and pervasive problem

Gender-based violence (GBV) refers to a wide range of harmful acts that are rooted in unequal power relations and are carried out against a person because of their factual or perceived sex, gender, sexual orientation and/or gender identity (Council of Europe, 2022[1]). Women continue to bear the overwhelming consequences of GBV, most commonly at the hands of their current or former male intimate partners – a phenomenon known as intimate partner violence (IPV) (OECD, 2020[2]).[1] IPV is comprised of many forms (Box 1.1), and is reported by women across age groups, cultures, geographies and socio-economic backgrounds.

Gender-based violence affects women's safety, health and well-being. In the context of IPV – the focus of this report – this violence often compromises a woman's self-determination by restricting her agency and limiting her ability to engage in social or economic activities outside the home.

Tragically, IPV can become lethal. Around 34% of female victims of intentional homicide, globally, are killed by a current or former boyfriend, husband or partner. Pre-pandemic, this equalled around 82 women or girls being murdered by their intimate partner, every day, around the world (UNODC, 2019[3]).[2]

Worldwide, around 30% of all women aged 15 and older report having experienced some form[3] of GBV at least once in her lifetime. IPV is the most common form of GBV worldwide: around 26% of ever-married/partnered women aged 15 and older report having experienced some form of physical and/or sexual violence at the hand of an intimate partner (World Health Organization, 2021[4]). On average across OECD countries, specifically, nearly a quarter of all women report having experienced IPV in their lifetime (OECD Family Database, 2020[5]).[4]

As dire as these numbers are, these statistics actually *underestimate* the problem. Measuring GBV is challenging; it is underreported in population surveys and in administrative records, such as police reports, for a number of reasons (OECD, 2020[2]). Women may not report intimate partner violence if they feel incidents are not severe enough or that they will not be taken seriously by service providers; if they fear retaliation or stigma; if they prefer to deal with the matter privately; or if reporting violence risks jeopardising their safety, stable housing, financial security, and access to social support networks.[5] Estimating IPV prevalence was complicated further during the COVID-19 pandemic, when stay-at-home orders trapped women in close proximity to their abusers, further restricting their ability to disclose violence and initiate help-seeking (Kaukinen, 2020[6]).

This crisis of violence has not gone unnoticed. A strong majority of OECD governments have identified GBV against women as the top gender equality challenge facing their country (Figure 1.1). Many governments have made the prevention, treatment and eradication of IPV a policy priority. Yet for all OECD countries, addressing the multifaceted issues of IPV presents a serious governance and implementation challenge – a challenge for which most countries have fallen short.[6]

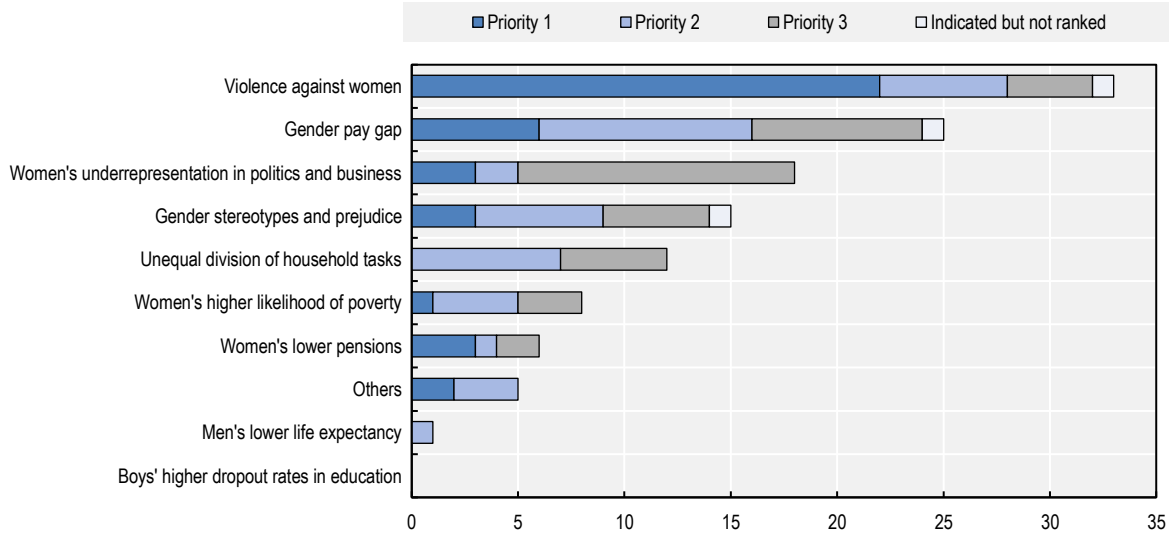
As a first stop, many women experiencing violence seek support from public authorities through entry points in emergency medical care, police interventions, and emergency housing shelters. Many women also (simultaneously or subsequently) need support services linked to safety planning, rehabilitative counselling, legal advocacy, childcare, income, housing, and immigration and asylum, as well as financial and job counselling. When violence occurs in a family home, the challenges are compounded: children and other co-habitating persons are also impacted by violence and may need support.

To address their needs, women experiencing IPV regularly have to navigate a wide range of health, legal and social services provided by a patchwork of governmental, non-governmental or private sector providers. They are often asked to repeat accounts of traumatic experiences multiple times, as services are infrequently "joined up" and providers rarely share client data with each other. Frequently, help-seeking women are met with administrative and bureaucratic challenges at the same time as they face the direct

and indirect consequences of violent acts – or remain under threat of continued violence (OECD, 2020[2]). These obstacles can be exacerbated by a lack of confidence in the help-seeking process more generally.[7]

Figure 1.1. OECD governments list violence against women as their top gender equality priority

Country count of top priorities for gender equality, reported by the 42 national government Adherents to the OECD Gender Recommendations, 2021



Note: The *2021 OECD Gender Equality Questionnaire* asked country adherents of the OECD Gender Recommendations to select the priority issues in gender equality in their country from a list of topics based on the OECD Gender Recommendations. The horizontal axis indicates the number of countries that ranked the issues among their top three priorities for gender equality (or in some case listed them without ranking). Respondents also had the possibility to suggest additional priorities. These are reported in the category "others", and include "unequal labour force participation" (indicated by 2 Respondents), "health difference between (diverse) genders" (1 Respondent), "undervaluation of female dominated jobs" (1 Respondent), and "women's safety (1 Respondent)". Figure presents 41 responses (of which one indicated only priority 1 and 2, and one indicated 2 items for priority 3) from 42 countries (38 OECD member countries plus four non-member Adherents).
Source: (OECD, 2022[7]), *2021 OECD Gender Equality Questionnaire*, as reported in the Report to the Council at Ministerial Level on the Implementation of the OECD Gender Recommendations, https://one.oecd.org/document/C/MIN(2022)7/en/pdf.

Leaving a violent relationship – and often the family home – is difficult in and of itself, and often constitutes the single most dangerous moment for women who are experiencing IPV. The burden of applying for and accessing diverse support services, often repeatedly, can compound the trauma of victimisation and contribute to women staying in a situation where violence continues. And these are not fleeting challenges: it often takes many attempts for a woman to extricate herself from an abusive partnership. Even after a woman has successfully escaped a violent situation, the physical, psychological, social and economic effects of IPV can persist for months or years.

Simply put, the crisis of gender-based violence is one of the most pressing human rights challenges OECD countries face today.

To help improve public policy responses, this report presents a stocktaking of OECD governments' efforts to integrate service delivery to better support victims/survivors of intimate partner violence. The evidence presented here is based on an extensive policy questionnaire completed by 35 OECD governments (OECD QISD-GBV, 2022, see Annex A), a consultation with 27 non-governmental service providers (the OECD Consultation 2022), and secondary research (Box 1.5).

This report illustrates how governments have integrated service delivery (ISD) to address IPV through preventative practices that aim to interrupt the cycle of violence and through services most commonly accessed by women experiencing violence:

- Preventative practices deployed to prevent the continuation or recurrence of IPV against women, such as coherent risk assessment procedures and perpetrator interventions (Chapter 2);
- Health care, in particular targeted mental health supports and emergency hospital-based services (Chapter 3);
- Housing, with a focus on emergency shelters, transitional shelters, and transitions to long-term affordable housing (Chapter 4);
- Social support for children, income supplements, and employment support (Chapter 4);
- Access to justice, including multidisciplinary police responses and integrated legal advocacy support (Chapter 5).

The results of the questionnaire (OECD QISD-GBV, 2022) focus largely on services that are nationally administered or co-ordinated with the support of local service providers. This report also presents the non-governmental service provider perspective on ISD, based on a survey-based consultation with 27 non-governmental providers of GBV-related services. These insights are summarised in Chapter 6.

This report finds that integrated service delivery (ISD) for victim/survivors is often difficult to plan, fund and implement in practice, given their complex needs and the many sectors involved. Yet successful ISD examples abound, particularly those rooted in health services, housing, and access to justice – the sectors where ISD has been most commonly implemented. OECD governments must continue to trial, replicate and – importantly – evaluate ISD practices to improve the lives of victim/survivors of IPV.

Box 1.1. Intimate-Partner Violence (IPV) can take many forms

Gender-based violence (GBV) refers to a wide range of harmful acts that are rooted in unequal power relations and are carried out against a person because of their factual or perceived sex, gender, sexual orientation and/or gender identity (Council of Europe, 2022[1]).

Intimate partner violence (IPV) is a subset of GBV. IPV refers to violence that occurs between current or former intimate partners, and which causes physical, psychological, sexual and/or economic harm. Like other forms of GBV, it can result in homicide or suicide. IPV is also often referred to as “domestic violence”, though domestic violence does not necessarily occur between co-habitating partners. The World Health Organization (WHO, 2012[8]) identifies common examples of IPV:

- Acts of physical violence, such as slapping, kicking, non-fatal strangulation and beating or hitting with or without a weapon;
- Sexual violence, such as forced sexual acts or sex-related coercion;
- Emotional and psychological abuse, such as intimidation, humiliation, insults, and threats of harm to the victim or victim’s loved ones;
- Controlling behaviours, such as stalking, excessive surveillance, restriction of mobility, isolation from social and family networks, or restricting access to financial resources, employment, medical care or education. Substance use coercion – where women are controlled through substance use-related tactics – also falls under this category (HHS Family and Youth Services Bureau, 2020[9]).

Most countries have developed broad strategies to prevent, address and end the various and complex forms of GBV. This is evidenced in national frameworks, co-ordinating bodies, and response systems.

This report focuses specifically on IPV *within* the context of GBV. This reflects the prevalence of IPV and violence against women in OECD countries, as well as the service sectors in which policies to address GBV are most developed. For further definitions, please see Table A C.1. of this report.

1.2. Integrated policies are key to a whole-of-state framework to end GBV

Policy makers have turned attention to *integrated policies* as a means of co-ordinating multi-sectoral solutions to GBV. This entails integration at *all* levels of government – not simply the service delivery level, which is the primary focus of this report. Some broader institutional context is therefore useful here to set the stage.

To address GBV, policy integration goes hand-in-hand with government efforts to *mainstream gender equality through a whole-of-state approach*. Gender mainstreaming is by now well-recognised as a critical tool for governments seeking to address gender inequalities from their earliest stages.[8] By embedding a "gender lens" in all aspects of government budgeting and policy design, reform, and evaluation, governments can tangibly reduce gender inequality in different aspects of life, including the sociocultural norms that enable GBV to proliferate. Successful mainstreaming entails co-ordination and integration across Ministries and throughout levels of government.

National and international GBV strategies recognise that integration must be applied across the entire governance of policies to end GBV.[9] This is especially true in the last decade, in the wake of the preeminent international agreement on violence against women: the 2011 *Council of Europe Convention on preventing and combating violence against women and domestic violence*, known as the Istanbul Convention. To date, 27 OECD countries have signed, ratified and/or implemented the Istanbul Convention.[10] The Istanbul Convention presents four pillars to address GBV: Prevention, Protection, Prosecution, and – of special relevance to this report – Co-ordinated Policies (Box 1.2).

Box 1.2. Integrated policies are central to the Istanbul Convention

Chapter II of the Istanbul Convention – entitled "Integrated policies and data collection" – offers important guidance aligned with the focus of this report. It calls for victim-centred, comprehensive, and co-ordinated policies and co-operation among all relevant agencies, institutions and organisations (Article 7); appropriate financial and human resources for the implementation of integrated policies and programmes, including those carried out by NGOs (Article 8); the recognition, encouragement, support of and co-ordination with NGOs and civil society (Article 9); the establishment of one or more official bodies to co-ordinate, implement, monitor and evaluate policies to prevent and combat violence (Article 10); and thorough data collection and research to support implementation of the Convention (Article 11).

Correspondingly, chapter IV of the Convention – "Protection and support" – calls on countries to implement measures based on a gendered understanding of violence against women; an integrated approach that takes into account the relationship "between victims, perpetrators, children and their wider social environment; an avoidance of secondary victimisation; a multi-dimensional empowerment of women victims; and a response which allows for a range of protective/support services to be located on the same premises to address the needs of vulnerable women and their children where applicable.

Despite the importance of this issue, most countries have fallen short of policy integration targets. The Group of Experts on Action Against Violence Against Women (GREVIO) – a monitoring mechanism of the Istanbul Convention – finds in a series of European country evaluations that countries rarely meet best practice standards on policy integration and ISD. This helps illustrate the need for a better understanding of how to implement ISD in practice.

Sources: (Council of Europe, 2011[10]; WAVE Network, 2019[11]).

1.2.1. Overview of vertical and horizontal policy integration

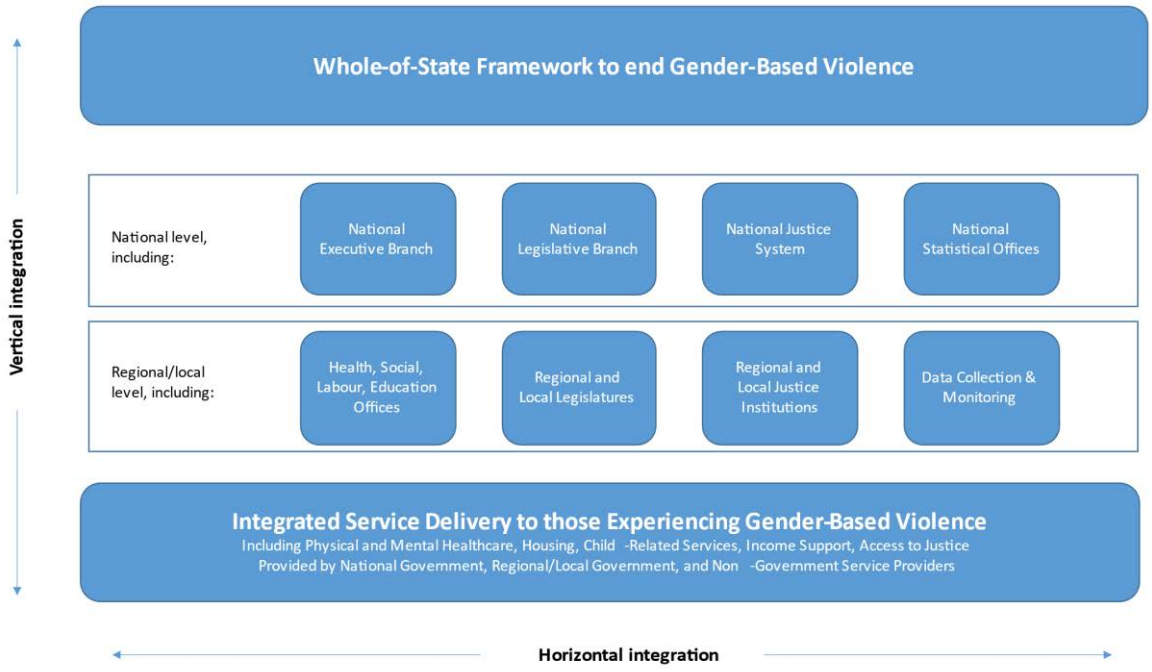
In a first cut, policy integration can be divided into two categories: vertical and horizontal.

Vertical integration refers to co-operation across different levels of government. National and local governments are often responsible for different levers and services to address GBV, making collaboration useful. This might entail co-operation, information sharing, and financing from national to local levels of government. In the case of social services, these linkages may connect from the Ministerial level to case worker level (and vice versa).

Horizontal integration refers to bringing together different Ministries, institutions or service providers to achieve a shared objective, such as joining up health and housing supports for women experiencing violence. Horizontal integration can take place at central, regional or local levels – and of course integration can be simultaneously vertical and horizontal. Figure 1.2 illustrates how these general concepts can be applied to policy responses to GBV.

Figure 1.2. Simple model of policy integration to address gender-based violence

Model of whole-of-state approach to integrated policy delivery for victims/survivors of GBV, 2022



Note: Stylised model presenting key actors, national-level integration strategy, local-level integration strategy, and the potential for both horizontal and vertical integration to improve service delivery for women experiencing GBV.
Source: OECD Secretariat, 2023.

1.2.2. Integrating from the top? National strategies and co-ordinating bodies to address GBV

To foster vertical and horizontal integration, many national governments in the OECD have *implemented national strategies* and *clearly defined roles for key state actors and partners* as part of a systems-level approach to preventing, addressing and ending GBV (Figure 1.3).

Strategic frameworks for GBV can help improve decision-making processes by focusing attention on the most crucial issues and challenges, as well as co-ordinating policy implementation and – importantly – funding across levels and functions of government (OECD, 2019[12]; 2021[13]). These frameworks often include targets, road maps and action plans. National frameworks in general tend to work better with clear tracking mechanisms and regular operational plans (OECD, forthcoming).

A holistic approach to GBV also requires defining roles and responsibilities of key state actors in the executive, judicial and legislative branches, and at national, provincial/state and local levels. In some OECD countries, this co-ordinated approach is managed by a ***central co-ordinating body focused on GBV*** (Figure 1.3). This strategy is strongly endorsed by GREVIO, the independent expert body responsible for monitoring the implementation of the Istanbul Convention.

GREVIO calls for co-ordinating bodies to be given dedicated, institutionalised budget and resources, a clear mandate, and set policy objectives to address GBV – but following many in-depth country reviews, including in OECD countries, GREVIO finds that these targets have rarely been met (Council of Europe, 2022[14]).

In the presence or absence of these national-level mechanisms, it is important to conduct ***monitoring and evaluation exercises*** to understand what GBV policies and programmes are effective. Even where countries have established frameworks or policy guidance at the national level, subnational and local authorities are often at liberty to interpret implementation, notably in decentralised governance structures. While this flexibility is essential to ensure a needs-based approach that best supports local contexts on the one hand, it also brings with it challenges to monitoring and evaluation. In the context of GBV against women, programme and pilot evaluations remain scarce.

Finally, ***reliable and adequate funding*** is crucial to effectively combat GBV in the long run. Integrated service delivery can also become easier if there are enough resources for everyone involved. It is difficult to compare public spending on GBV, as it can be hard to quantify pockets of money spent in different Ministries or by different levels of government. But published national spending estimates offer some clues.

Spain, for example, has made a serious budget commitment to combatting gender-based violence. In 2023, programmes to prevent address gender-based violence will make up 56% (320 million euros) of the entire budget of the Ministry of Equality (573 million euros) (Ministerio de Igualdad de España, 2022[15]) in Spain, a country of 47.6 million people (2022).

Australia (population 25.7 million) has committed to long-term spending plans: the October 2022–23 Budget provides 1.7 billion Australian dollars (around 1.1 billion euros) over six years for measures to address family, domestic and sexual violence under the first phase of the new National Plan to End Violence Against Women and Children 2022–2032. This builds on the 1.1 billion Australian dollars (around 700 million euros) for women's safety provided in the 2021–22 Budget (Parliament of Australia, 2022[16]).

In general, however, funding streams have been inconsistently committed to GBV across countries – even those with dedicated national frameworks on GBV. Among 20 OECD countries reporting having a standalone national plan on GBV[11], only 12 reported having a specific allocated budget, while 9 reported not having a specific allocated budget. Of the 6 countries that reported having integrated GBV as a key pillar/objective in broader gender equality strategies, only one reported having a specific allocated budget (OECD, forthcoming).

Box 1.3. Integrated, whole-of-state approaches to address GBV in OECD countries

A recent OECD stocktaking of national governance to end GBV highlights the importance of system-level factors like national strategic frameworks and co-ordinating bodies, among other tools (OECD, 2021[13]).

Examples of national strategic frameworks to address GBV

Australia's National Plan to End Violence against Women and Children: The Australian Commonwealth (national), state and territory governments worked with family safety experts, frontline services, the community and victim-survivors to develop a 10-year national plan, running from 2022-2032. The National Plan builds on the work developed under the previous National Plan to Reduce Violence against Women and their Children 2010-22. The National Plan focuses on ending GBV in one generation, and addresses violence across the continuum from prevention, early intervention and response through to recovery and healing. The plan will be supported by an Outcomes Framework to monitor and track progress. The progress of the National Plan will be monitored by Australia's Domestic, Family and Sexual Violence Commission established in 2022 to demonstrate the Australian Government commitment to ending GBV.

The National Plan is being delivered through two five-year action plans and a dedicated Aboriginal and Torres Strait Islander Action Plan. Each of these will be designed to look back at what has been

achieved, incorporate emerging issues and research to inform the next stage, and refocus on what actions might make the most difference going forward.

Scotland's "Equally Safe" strategy for preventing and eradicating violence against women and girls relies on collaboration between the national Scottish Government and local governments. The strategy is a cross-sector initiative with participation from the police, housing agencies, social services, children's services, health services and women's specialist non-governmental organisations. It recognises that multiple agencies are responsible for dealing with domestic violence. By bringing these agencies and ministries together, the strategy is led and owned collectively.

Spain's State Pact against Gender Violence and Contingency Plan: In 2017, the Spanish Parliament approved, with no dissenting votes, the first State Pact against Gender Violence, an agreement between political parties that aims to ensure efforts to address GBV are consistent, co-ordinated, and not subject to interference from whichever party is in government at any particular time. The Pact attracted the adherence of the National Government, the Autonomous Communities, the Spanish Federation of Municipal and Provincial Authorities (FEMP), and the State Observatory on Violence against Women, thereby ensuring a triple consensus – political, territorial, and social – was reached. The State Pact provided a roadmap for addressing GBV during a five-year period and outlined 292 measures structured around ten axes for action. These include improving co-ordination and connections between responsible authorities and agencies, improved training of public servants, financial commitments towards policies to end GBV, and monitoring processes to evaluate the Pact.

Spain applies the measures through the government Delegation for GBV, in co-ordination with the other ministries and their dependent autonomous bodies, as well as the Autonomous Communities and Local Entities represented in the FEMP. A total increase in funding of EUR 1 billion accompanied the adoption of the Pact to ensure the measures could be carried out.

Sweden's National Strategy to Prevent and Combat Men's Violence Against Women: In 2017, Sweden put in place a 10-year national strategy to prevent and combat men's violence against women as part of their wider National Gender Equality Policy. It includes measures against IPV, "honour-related" violence,and human trafficking for sexual purposes. The National Gender Equality Agency recently compiled details about all national initiatives launched in relation to men's violence against women and published these for public use in order to help agencies, organisations and politicians acting within the scope of the strategy to access previous experiences and existing knowledge. The website tool details all past and ongoing projects from 2017 and onwards, and attaches existing project evaluations alongside relevant entries. The tool is publicly available and continuously updated. It currently lists over 300 individual projects from 54 agencies.

The website resource is mainly a tool for co-ordination and knowledge-sharing. It helps agencies learn from others as they plan forthcoming projects. It is also used to provide insight into avenues for co-ordination and collaboration with other actors.

Switzerland's National Action Plan 2022-2026 for the implementation of the Council of Europe Convention on preventing and combating violence against women and domestic violence: the Federal Council adopted the Action Plan in June 2022. It focuses on the three main themes of public information and awareness, basic and continuing education for professionally-engaged people and volunteers, and prevention and response to sexual and gender-based violence. The implementation will occur across different levels of the federal government, and will include measures by the Confederation, cantons and communes. The plan has been developed through collaboration between different levels of government, in consultation with non-governmental organisations and civil society. The Action Plan is a part of Switzerland's wider Equality 2030 Strategy that aims to advance gender equality.

Many countries have introduced central co-ordinating bodies to manage a coherent response to GBV

In **Sweden**, the Division for Gender Equality Agency under the Ministry of Employment is tasked with co-ordinating the implementation of GBV actions in line with the Istanbul Convention, while the National Gender Equality Agency, established in January 2018, supports co-ordination between governmental agencies to implement the National Strategy to Prevent and Combat Men's Violence against Women.

In **Spain**, the government Delegation for Gender-based Violence, which is currently under the purview of the Ministry of Equality, has the responsibility of proposing public policy options to address the different forms of GBV, and promoting, co-ordinating, and advising on all relevant measures undertaken by the government in this area.

Finland established the Committee for Combating Violence Against Women and Domestic Violence, which operates under the Ministry of Social Affairs and Health. Comprised of members from various ministries and public institutions, including the Ministry of Justice, Statistics Finland, and the Ombudsman for Equality, the Committee is responsible for the co-ordination, monitoring, and impact assessment of measures required for the implementation of the Istanbul Convention.

In **Norway**, the Ministry of Justice and Public Security co-ordinates the Government's work against domestic violence and chairs the Inter-ministerial Working Group against Domestic Violence, which consists of representatives from eight ministries and several directorates. The Working Group is responsible for the implementation of measures in national action plans and regularly reports on the status of this work, proposing new strategies and measures.

Denmark has an Inter-ministerial Working Group against violence against women and domestic violence, which is responsible for co-ordinating the work against IPV in Denmark. In addition, Denmark has implemented a novel approach that includes horizontal and vertical integration with a non-governmental partnership. "Lev Uden Vold" ("Live without Violence") was established as part of the Adjustment Pool Agreement (satspuljeaftalen) of 2017-20, which intended to strengthen the work against IPV. The National Board of Social Affairs and Health put the task out to tender together with the Equality Department. Five non-profit organisations, all of whom have extensive knowledge and experience in the area of violence, bid together for the task and founded Lev Uden Vold. The five organisations are the National Organization of Women's Crisis Centers (LOKK), Dannerhuset, Dialog mod Vold, Fundamentet and Mødrehjælpen. Lev Uden Vold is established as an independent institution with an independent board of directors. In November 2020, a broad political majority of the parties in the Danish Parliament (Folketing) have allocated funds for the continuation of Lev Uden Vold until the summer of 2024.

Source: Examples from Norway, Spain and Sweden excerpted and summarised from *Eliminating gender-based violence: Governance and survivor/victim-centred approaches* (OECD, 2021[13]) and the Swedish National Agency for Gender Equlity (National Gender Equality Agency, 2022[17]; National Gender Equality Agency, 2022[18]). Example from Denmark derived from OECD QISD-GBV 2022 and the website of Lev Uden Vold: https://levudenvold.dk/om-lev-uden-vold/om-os/. Example from Scotland from (Council of Europe, 2022[14]). Example from Australia from Government of Australia (Department of Social Services, 2022[19]). Example from Switzerland from the Switzerland (Federal Department of Home Affairs, 2022[20]) and the Switzerland (Federal Office for Gender Equality, 2021[21]).

1.3. Integrated service delivery benefits governments and victims/survivors

1.3.1. Defining general concepts in integrated service delivery: Lessons from various sectors

In general, integrated service delivery (ISD) refers to the linking-up of different providers and levels of public services, for the benefit of users and to improve efficiency in service delivery (OECD, 2015[22]). ISD

re-imagines social, health and other human-service pathways for the mutual benefit of service users and providers.

The concept of ISD was first popularised in the health sector, in an effort to better care for patients with complex and long-term needs from a range of different health providers. A foundational definition can be drawn from the early health literature: "Integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between [different] sectors" (Kodner and Spreeuwenberg, 2002[23]).

Of course, a critical consideration for an integrated response to intimate partner violence (IPV) is the client's risk of exposure to continued violence and their heightened need for security. ISD for women experiencing IPV therefore must ensure the safety and security of the victim/survivor (and any children) from a perpetrator, at the same time as it ensures access to justice pathways through legal support. These conditions often require the involvement of police officers, judges, and legal advocates (elaborated in Section 1.4 and Chapter 5).

There is no single, universal strategy for integrating services.[12] Integration is a malleable approach through which services can be co-ordinated to varying degrees of intensity. In an exploration of ISD for vulnerable groups, the OECD delineates between three increasingly intensive ways of integrating services (OECD, 2015[22]):

- **Co-location** of services refers to having multiple service providers from different sectors – such as health, housing and legal services – represented in one location. This can help reduce complexity, travel, time and financial costs associated with service uptake. On the service provider side, co-location also makes it easier for providers and professionals to share information and deliver joint solutions.
- **Collaboration** implies a higher degree of integration across sectors than co-location, refering to agencies working together through information-sharing and training, and through the creation of a network of agencies to improve user experience. This kind of knowledge sharing can help service providers improve referrals and recommendations to other services.
- **Co-operation** implies the deepest level of integration, and refers to service providers communicating *and* working together on individual cases, toward pre-determined and consistent goals. This helps to ensure holistic service provision and should improve outcomes for users.

1.3.2. Integration has improved outcomes and efficiency in health and social sectors

Little empirical evidence exists on the benefits of ISD for GBV. Yet evidence from other sectors suggests ISD offers opportunities to realise sizable efficiency and effectiveness gains, while also improving outcomes for service users. This is particularly true for service users with complex needs, and who require a range of health, social, legal and housing supports, typically provided by more than one agency (NZ Productivity Commission, 2015[24]).

Cost effectiveness and savings

One *potential* – though not guaranteed – advantage of horizontal ISD at the service level is ***cost effectiveness and cost savings****,* both for service users and providers. By providing services in one place, streamlining administrative costs, and potentially reducing over-use of emergency health services, ISD has been identified as a potential tool to lower spending on elderly populations and people with mental illness (OECD, 2015[22]). ISD at the first point of intervention has also been shown to reduce downstream service use and costs. For example, effective hospital discharge plans and linkages to co-ordinated community care can reduce the likelihood of costly hospital re-admissions or intensive care services among people

with mental illness (Mares et al., 2008[25]; Rosenheck, 2000[26]; Stewart et al., 2012[27]). Effective horizontal integration can also help to reduce gaps and avoid duplication of services from different agencies.

Vertical integration has the potential to save costs, too, for example by helping to shift resources away from costly emergency services to more cost-effective preventative services (OECD, 2015[22]).

Cost effectiveness and costs savings are not guaranteed, of course. A co-ordinated policy and funding approach is needed to break down silos, avoid duplication of work, share costs, train workers, and share information (OECD, 2022[28]). A review of 65 case management studies targeting high-risk, high-cost patients in the health sector, for example, showed that two-thirds of these programmes achieved specific progress and outcome goals, though they were less successful than expected in cost-saving or cost-effectiveness (Swanson and Weissert, 2018[29]). The authors suggest these results might be improved if additional incentives, clear rules, guidelines, and algorithms relating to resource allocation among patients were applied. Importantly, costs can also rise when service providers expand coverage and address previously unmet needs (OECD, 2022[28]).

Before long-term cost savings are realised, significant and dedicated financial investments are required to establish a sustainable foundation for integrated services.

Accessibility and take-up

Accessing public services can be daunting. ISD can help improve service accessibility and user take-up in communities, especially for people with complex needs, such as persons with disability, those facing mental health issues, and people responsible for dependents. Victims/survivors of IPV also have complex needs – many face physical, mental and logistical barriers to accessing social services and support systems.

Integrated service models "can help vulnerable service users navigate the system for reasons of time as well as transparency and accessibility: co-located services, for example, enable access to multiple services [in one place], which in turn enables a fuller assessment of needs and a faster delivery of appropriate services" (OECD, 2015[22]). Case managers can also reduce the burden of multiple applications and data collections across providers by connecting those offices directly and advocating for survivors.

The challenges of accessing multiple services across multiple locations are particularly daunting for families in vulnerable circumstances – a particularly accurate characterisation of a mother and children fleeing violence. These women may be balancing programme applications against irregular work hours and income, struggling to find safe housing, and caring for children. In these and other cases, clear, direct and comprehensive information for service users, perhaps delivered by a known case worker, is conducive to full engagement with all available and appropriate services (OECD, 2015[22]).

Reducing administrative burden for clients can help improve take-up, too. Data-sharing across providers – for example, by providing digital access to personal information such as a history of social service use – can therefore be an important tool to ease service users' entry into the system.

Improving the quality of services and client outcomes

The benefits of ISD on client outcomes in other sectors has been well-studied. The integrated "Housing First" approach, for example, has reduced homelessness more effectively than emergency shelters, and children with mental health needs have benefitted from the integration of mental health services with educational institutions (OECD, 2015[22]).

When ISD is done well, the cost savings, improved access and higher-quality services should happen simultaneously (OECD, 2022[28]). In a review of over 120 integrated initiatives delivering children's services predominantly in the United Kingdom, inter-agency working improved accessibility and response time for service users; enhanced knowledge and sense of fulfilment among service providers; and improved

agency efficiency by reducing duplication of work (Statham, 2011[30]). Similar results are found in a study of ISD for child services in the United States (Manno and Treskon, 2016[31]).

Yet there are many barriers to successful integration

Despite the seemingly obvious benefits of ISD, there exist significant barriers to service delivery integration – both generally and in the context of services addressing GBV.

One major barrier is **funding**. ISD implies some negotiations between Ministries, levels of government, and/or local providers to determine who will pay fixed start-up costs to ensure successful co-ordination across various actors. There is also the issue of ensuring ongoing running costs – regular, sustainable funding streams are important both to ensure the continuity of specific services, but also to prevent a "'domino effect' in belt-tightening of closure" by partner service providers (OECD, 2015[22]). Joint working requires a balance of financial input across agencies, and time horizons matter – it can be difficult to get agencies or providers to commit fully if they see collaboration as a short-term or temporary arrangement (ibid). This can be especially difficult when providers have historically had to compete for resources.

Another major challenge is the **restructuring of roles and responsibilities** across levels of government, agencies, and – on the ground – governmental, NGO, and for-profit service providers. This involves potentially both the structure and management of provider organisations, as well as potentially retraining staff, changing work conditions, and adapting workplace cultures.

Finally, **data sharing** across providers can be difficult as it presents significant legal and logistical concerns. While there are benefits to providers and clients to having efficient access to background information on clients, it can be difficult to ensure adequate client privacy across a range of different providers with different technical standards.

1.4. How does integrated service delivery work in addressing gender-based violence?

Many of the approaches to integrated care in health and social policy also apply to the multi-sectoral nature of GBV. Services for victims/survivors of violence can be delivered through *general* support services, which are not exclusively designed for victims/survivors but instead serve the public at large; or through dedicated, *specialist* support services, which target people experiencing violence specifically. These general and specialist services should be complementary, and general services staff should be equipped to address the specific needs of women experiencing GBV through adequate resources and training (Council of Europe, 2022[14]).

While there is no "one-size-fits-all" approach to applying ISD to address GBV, Australia's National Research Organisation for Women's Safety (ANROWS) has identified helpful universal guidelines for ISD to address GBV (ANROWS, 2016[32]):

- Service delivery must involve two or more agencies/services;
- There exist clear co-ordination protocols for integrated service provision;
- The initiative is funded as an integrated service or partnership, with a view to respond holistically to women currently experiencing domestic and family violence or who have recently left a domestic and family violence situation, and/or who have experienced sexual assault;
- The programme operates according to a formalised partnership or joint service agreement between agencies;
- The programme abides by a formalised statement of shared principles/goals between agencies;

- ISD may include one-stop centres for women and children who have experienced domestic and family violence or sexual assault;
- ISD may include case co-ordination or case management services.

In the context of GBV, the overarching goals of integrated initiatives are to create "smoother referral pathways" between sectors, making the help-seeking process more accessible, and reducing the secondary victimisation associated with the duplication of work (ANROWS, 2016[32]). For example, it is easier to receive a proactive call from a network-connected counsellor following a police intervention, rather than having to call or visit several related service providers. This parallels goals identified in foundational health literature: that ISD should "enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long-term problems cutting across multiple services, providers and settings" (Kodner and Spreeuwenberg, 2002[23]).

Of course, the best way to end gender-based violence against women is to ***prevent it from happening in the first place*** – and this certainly requires an integrated, whole-of-society approach. This means dedicated efforts to change masculine norms, from a very early age, so that boys do not grow into perpetrators who replicate harmful masculinities (OECD, 2021[33]). Preventative measures also need to target adult perpetrators of IPV in order to achieve holistic and sustainable solutions to violence. Violent men are often re-offenders in multiple relationships and victims/survivors sometimes return to their abusers, so working with perpetrators is crucial to prevent re-victimisation and new victimisation. Information-sharing across differences within the justice sector as well as across different sectors can contribute to a reduction in violence.

1.4.1. Case management, referrals, and co-located services can support victims/survivors

ISD for women experiencing IPV is frequently co-ordinated through ***case management, referral systems, or co-located centres*** in order to provide joined-up access to mental and physical health care, safe and affordable housing, income and job support, support for children and access to justice.

The co-located approach is sometimes referred to as a "hub and spoke model" (Campo and Tayton, 2015[34]; Mantler and Wolfe, 2016[35]), language also used in other sectors. In this model, the "hub" – a centralised office or a caseworker – identifies, collaborates with, and connects clients with sectoral service providers who provide the needed supports. These related providers can be on-site or off-site.

The co-located approach has been implemented throughout much of the OECD, often by non-governmental service providers using public and private funding (for examples, see Box 1.4 and Chapter 6).

Although not grounded in systematic evaluations, an oft-praised approach for ISD for women experiencing violence is **case management**. In many of the ISD examples in this report, caseworkers play a prominent role, which can improve the experience for clients – though it can be very challenging for a single caseworker.[13] Case management can be provided, for example, by a social worker, a "domestic violence advisor" (typical in the United Kingdom), or a public health worker, typically at the local or regional level. Case management services are not commonly managed at the *national* level in OECD countries, with a few notable exceptions.

Figure 1.3. Re-envisioning the "hub and spoke" model of integrated service delivery for IPV victims/survivors

Simplified process model of how women experiencing IPV may access horizontally-integrated services

Note: This figure illustrates a stylised model of horizontally-integrated service delivery at the local level for women experiencing IPV.
Source: Adapted from (OECD, 2020[2]), *Issues Notes: OECD High-Level Conference on Ending Violence Against Women - Taking Public Action to End Violence at Home,* https://www.oecd.org/gender/VAW2020-Issues-Notes.pdf.

The OECD QISD-GBV 2022 revealed another relatively common and noteworthy local-level case management initiative: **multi-agency risk-assessment conferences (MARACs)**, or similar case conferences bearing slightly different names. These meetings bring together community police, health care workers, public prosecutors, social workers, child welfare providers and case managers, on a regular basis, to ensure the long-term safety and continuity of care for women who are particularly at-risk of severe IPV.

These kinds of case conferences are reported to exist in Australia, Austria, the United Kingdom, Finland and New Zealand, though service delivery arrangements may vary in different national and local contexts. The charity SafeLives estimate that if MARACs were implemented nationally across 300 sites, significant savings could be made: "for every GBP 1 spent on MARACs, at least GBP 6 of public money can be saved annually on direct costs to agencies such as the police and health services," (SafeLives UK, 2010[36]). These programmes should be evaluated further to assess clients' and providers' outcomes.

Box 1.4. Co-located service providers throughout Europe and North America

Family Justice Centres, various locations, Europe and the United States

The Family Justice Center Alliance originated in the United States as a subsidiary of Alliance for HOPE International, an organisation dedicated to domestic violence and sexual assault prevention with a mission to establish a network of service hubs around the world. Today, the Alliance works in Europe, the United States and Canada in close consultation with sub-national and national governments to implement multidisciplinary service delivery models known as Family Justice Centers (FJCs). FJCs offer co-located, multi-agency services to women who have experienced domestic violence, sexual assault, elder abuse, child abuse or human trafficking. Public and private agencies can assign service providers to the FJCs on a full- or part-time basis to deliver such services as: safety planning; legal advice; case management; evidence reporting, including making official statements and procuring medical evidence of violence; counselling; financial literacy and job training support; administrative support in applying for public benefits, and shelter or housing. FJCs also offer childcare and transportation assistance for women while they procure services. This also implies some data-sharing: 86% of US-based FJCs link their administrative data, and 87% report using a centralised intake procedure which facilitates information-sharing between providers.

Saskatoon Community Service Village, Saskatoon, Canada

The Saskatoon Community Village (SCSV) was a project borne of the Saskatoon Women's Resource Centre, which was established in 1986 and represented a coalition of 16 organisations. Over the course of ten years, planning, discussion and fundraising took place to eventually establish the SCSV in 1996, with the view to deliver women's services through co-location and collaboration. It currently joins up six non-profit, community-based agencies under one roof to provide services through joint planning, programming and advocacy. Services include youth and adult counselling; specialised services to respond to abuse, violence and sexual assault; 24-hour crisis intervention services related to child abuse, suicide prevention, substance use, gambling problems, and domestic violence; housing and in-kind support; short- and medium-term shelter for women and children; parenting support services; an employment and skills centre, including computer literacy and GED training; and an accessible fitness centre. The SCSV also engages in community-based education and awareness-raising initiatives related to IPV. The SVSC operations are outlined in jointly-developed plans, buttressed by legal agreements which clearly describe roles and responsibilities.

Kukui Center, Hawaii, United States

The Kukui Center opened in 2009 and, today, co-locates ten non-profit agencies to serve the region's families. This is an example of an integrated programme that has tried to mainstream the treatment of IPV in its support for vulnerable groups. While not exclusively focused on IPV, the Center offers emergency, short- and medium-term shelter for children, adolescents and families; independent living programmes; legal and mediation services; specialised services for children with disabilities; maternal and infant health services; multi-age literacy and financial literacy services; specialised services for homeless families; youth foster care; multi-age counselling services, including grief support; supports for children and adults experiencing abuse, violence and sexual assault, including a specialised "immigrant justice centre" focused on violence, sexual assault and human trafficking; and a social enterprise which employs at-risk youth. The Centers' leadership meet regularly to make decisions about the Center operations and to discuss caseloads.

Source: (ABT Associates, 2018[37]; Family Justice Center, 2022[38]; Saskatoon Community Service Village, 2022[39]; Kukui Center, 2019[40]).

1.4.2. Sharing client data across service providers, while also ensuring client privacy

The process of describing experiences of abuse, providing social and economic history, and going through (often extensive) application processes for services can be harrowing and implies high costs both for women and for service providers. Data sharing across service providers offers the potential to reduce some of these costs in time, effort and energy, and lead to a more efficient and timely public response when women experience violence. With a unique and secure personal identifier, information can be shared on individual clients across health, police, child services and housing providers, among others.

It is especially important for stakeholders in collaborative environments to jointly develop co-ordinated information-sharing protocols and procedures in order to perform informed risk assessments and deliver effective solutions to help-seeking women (CACP, 2016[41]). In the OECD Questionnaire, many countries report that data sharing is typically governed by legal frameworks and that information can be shared in situations where women are in immediate danger, when the information is essential, and where women have consented to the information being shared (OECD QISD-GBV, 2022). For instance, in the United Kingdom, relevant professionals in child protection can share data when this is needed for the overriding duty to protect children at risk (UK Home Department, 2003[42]).

Data privacy is of utmost concern when it comes to victims/survivors of GBV, not least in cases where their security depends on information being held from perpetrators. Personal information runs a higher risk of leaking when it is shared among many different agencies and sectors. Worries about data leaks were echoed in the OECD Consultation of NGO providers. One provider reported that they “are always concerned about sharing information with other services as we need to ensure that the client’s safety is paramount at all times. It is not uncommon for a client’s location to be compromised by other services/agencies, and once a client’s location is compromised, the client has to be moved to ensure that they remain safe.” The risk of data leaks may enough to deter some victims/survivors from reporting their perpetrators (Taylor et al., 2015[43]).

Processes for data sharing across providers will therefore need to be controlled by clear information-sharing protocols, policy guidelines and professional judgement based on information available. Indeed, these controls have been identified as good practice in contributing to facilitating a co-ordinated service delivery for people who have experienced GBV (Taylor et al., 2015[43]). Actors in different countries will also face different legal frameworks when they consider opportunities to share data. For instance, victims/survivors living in the EU are protected by the relatively stringent General Data Protection Regulation (GDPR) (CNIL, 2022[44]).

The police can usefully be involved in data sharing and be mandated to co-ordinate with relevant agencies. Austria, for example, has detailed data collection requirements for the police. The police are obliged to share data on barring orders and violations of these, as well as police charges files in cases of domestic violence and stalking. The police are also required to report cases of domestic violence and stalking to their local Invervention Centres – government-funded NGOs – within 24 hours of the occurrence of the crime. The police are also required to co-operate with youth welfare offices, the family court, the prosecutor office and the criminal court when cases relate to these (Brankovic, 2021[45]). In Australia, the Safety First Programme is an information-sharing and safety-planning mechanism for women leaving shelters. The model was found to be successful at managing high-risk matters due to its high degree of collaboration between the the lead agency, the police and Corrective Services (ANROWS, 2016[32]).

Another interesting example is a World Bank-funded project in Chile that intends to develop and implement an integrated case management database system. The motivation is to better track and respond to women experiencing violence. Following a rigorous mapping exercise to identify critical gaps in continuity of care, the proposed integrated platform will allow for follow-up of GBV cases across institutions, improve service delivery, and provide alerts in high-risk cases (World Bank, 2022[46]).

1.4.3. Local evolutions of ISD to address GBV are important

Although policy integration is prioritised in national GBV strategies (Box 1.3), integrated services have often evolved naturally, on the ground, to improve efficiency in the face of limited resources (e.g. staff, funding). This can involve local and regional public service providers, non-governmental service providers, advocates, and victims/survivors. Networking, relationship-building and community mobilisation have, together, led to a re-designing of service delivery by local and regional practitioners, offering hints to higher-level policy makers about the merits of ISD. Indeed, "local" knowledge and practices flowing upwards to high levels of government should be a key part of vertical integration.

A study of rural and remote women's shelters in Canada, for example, highlights three inter-related ways service delivery has evolved, through increasingly formalised networking, to benefit service users:

- Filling gaps: Social services and other supports are frequently undersupplied in rural areas, due to geography or insufficient funding. In response, women's shelter employees are compelled to fill social service gaps in order to fulfil needs that fall outside of direct shelter services. Much like the "no wrong door approach" to social services and support provisions, the idea of filling gaps helps to ensure help-seekers are not turned away or left without resources for any outstanding needs. This can entail some creative problem-solving when there are insufficient resources.
- Case management: To help fill gaps, shelter employees adopt case management roles, connect help-seekers to resources directly, and eventually develop a network of resources which they continue to draw on.
- System navigation: In performing case management duties, shelter employees facilitate system navigation for women, not only by identifying related service providers who "understand the context of violence", but also by preparing women to interact with related service providers who do not understand this context (Mantler and Wolfe, 2016[35]).

It is important to bring in lived experiences from those who have used services personally to make sure that victims/survivors' needs and rights are placed at the centre of all interventions and measures. One way countres can learn from the day-to-day lived experiences of victims/survivors is to conduct consultations (OECD, 2021[47]). For example, the Welsh Government was able to effectively consult survivors/victims under their "National Survivor Engagement Framework," where they brought in GBV survivors/victims' views in the design of governmental policies (Welsh Government, 2018[48]). In a similar vein, the Office of the Assistant Secretary for Planning and Evaluation in the United States collaborated with victims/survivors with varied lived experiences to develop a resource on emerging strategies and practices for federal human services staff to engage more equitably with clients in research, policy making, and programming (Office of the Assistant Secretary for Planning and Evaluation, 2021[49]). In Canada, following collaborative, whole-of-government efforts with provinces and territorities and engagement with indigenous partners, GBV experts and stakeholders, Canada launched their National Action Plan to End Gender-Based Violence (GBV NAP) in November 2022.[14]

Spain's new national strategy to counter GBV (*Estrategia Estatal para combatir las violencias machistas 2022-2025*) also involved a number of participatory methods, including meetings with victims/survivors, civil society and local governments, and roundtables on education and digital violence (Ministry of Equality, 2022[50]). Spain's new "Yes Means Yes" sexual consent law also reflects the participation of victims/survivors, feminist organisations and civil society in the design, implementation and evaluation of public policies, from an intersectional approach (Jefature del Estado, 2022[51]).

1.4.4. ISD has been infrequently evaluated for IPV

The advantages and disadvantages of ISD have rarely been systematically evaluated, perhaps in part because programmes are not always implemented with systematic planning for quantitative or qualitative

evaluations of implementation and outcomes (for providers or clients). While this points to a need for more research in the area, some existing evaluations suggest that there is potential for ISD to improve outcomes for victims/survivors.

For example, some encouraging results emerge from analyses of the *Pathfinder Project*, a pilot led by Standing Together as part of a consortium of expert partners and carried out in England's health sector from 2017 to 2020 (see Chapter 3). One analysis was led by academics at DECIPHer at Cardiff University using data from the eight Pathfinder sites and comparing it with data from across England to assess how service provision changed following the implementation of the pilot. The analysis found that the Pathfinder Project resulted in an increased number of cases being discussed at multi-agency risk-assessment conferences (MARACs) relative to non-Pathfinder sites. It also found an increased number of identified cases of domestic violence, over a wider range of risk classifications, relative to non-Pathfinder sites. Survey evidence from a separate analysis conducted by the Consortium indicates that users' self-reported well-being improved as a result of going through the programme (SafeLives, 2020[52]; Melendez-Torres et al., 2021[53]).

In general, evaluations should strive to measure relevant outcomes of an ISD intervention against an important counterfactual: *what would have happened had the ISD intervention not been deployed*? In other social policy areas across OECD countries, this increasingly takes the form of randomised control trials. In the face of limited resources – where there is not enough funding to support everyone through a new programme – this would imply that some clients are randomly assigned to a new treatment (e.g. an ISD intervention) while others receive the traditional treatment. Outcomes could then be compared across the two groups which – thanks to randomisation – ideally differ only in their access to ISD.

1.5. Main findings of the report

Reflecting their stated concerns about violence against women (Figure 1.1), OECD governments are trialling integrated approaches as a way to improve service delivery for women experiencing IPV. This report presents a stocktaking of these efforts to integrate service delivery to address IPV. It focuses on the most common service areas involved in OECD countries: preventative responses in the wake of violence, health care, justice, housing, childcare and income supports. Non-governmental service providers have also – perhaps even more commonly than governments – joined up multidisciplinary resources to better support their clients. The findings in this report are based on 35 country responses to the extensive 2022 OECD Questionnaire on Integrated Service Delivery to Address Gender-Based Violence ("OECD-QISD-GBV 2022") (see Annex A) and a survey-based consultation with 27 non-governmental providers of services to people experiencing GBV ("OECD Consultation 2022") (see Annex B) (Box 1.5).

Given the potential gains of ISD, what practices have been working well in OECD countries – and what are working less well? Can and should ISD be more broadly implemented to support women experiencing violence?

1.5.1. Policy patterns across OECD countries

Integrated service delivery to address gender-based violence is far from systematic: Fewer than half of responding OECD national governments (48%) report promoting ISD "somewhat" or "to a great extent"[16] in their countries. Barely half (51%) report targeted investments to support service providers in further expanding, improving or transitioning to ISD.

To improve policy responses to GBV, ISD takes a variety of forms. Across countries, this includes the physical co-location of services; the use of case managers; informal or formal referral networks; information-sharing and training co-ordination across agencies; and/or deep co-operation across agencies, working together on individual cases towards pre-determined and consistent goals.

OECD governments report applying ISD practices in health care, justice, housing, child-related services, and income support. ISD is reportedly most frequently introduced at entry points in health care, emergency housing, and police services.

Box 1.5. OECD questionnaire and consultation informing this report

2022 OECD Questionnaire on Integrated Service Delivery to Address Gender-Based Violence (OECD QISD-GBV, 2022).

In January 2022, Delegates to the OECD Employment, Labour and Social Affairs Committee were invited to complete a questionnaire about service-delivery arrangements designed to support women experiencing GBV in their countries. OECD QISD-GBV asked countries about service provision and delivery in a range of sectors, as well as how integration is prioritised at the national level. The full questionnaire that was shared with countries can be found in Annex A.

The questionnaire had a response rate of 92%: 35 out of 38[15] OECD countries responded.

2022 OECD Consultation with Non-Governmental Service Providers serving GBV Victims/Survivors (OECD Consultation, 2022).

There is a rich history of grassroots organisations, civil society and non-governmental organisation (NGOs) involved in delivering services in response to violence against women. In an effort to gain insight from non-governmental service providers at the delivery-level, an online, survey-based consultation was made available to non-governmental service providers working in the GBV space between 1 February and 30 April 2022. A link to the survey, along with an open call for participation, was shared through OECD social media channels and various e-mail lists. The survey was also distributed informally through providers in the European Family Justice Centre Alliance (https://www.efjca.eu/). Given that this sample was recruited non-randomly via social media and through "snowball" sampling, and that the survey was open to the public, its representativeness should be interpreted with caution. In total, 27 responses were received from service providers working in 12 OECD countries. Two of the responses came from service providers in non-OECD countries, and were retained for the discussion that follows. All responses were anonymous. A copy of the full survey consultation is available in Annex B.

1.5.2. The health sector is a common centre for ISD to address IPV

The health sector is one of the most common points of entry to public services for women escaping violence, as victims/survivors face a range of threats to their health: injuries, unintended pregnancies, sexually transmitted infections, pregnancy complications, and mental health problems. GBV can result in homicide or suicide. At the national level, governments seeking to integrate service delivery for

victims/survivors have most frequently connected services deployed from hospitals and embedded ISD in mental health supports (Chapter 3).

The role of hospitals

Within wider health care systems, hospitals have been shown to be an important site for ISD as these are where many victims/survivors come in time of crisis. Countries with publicly-funded health care systems are also well-placed to co-ordinate responses nationally to implement integrated GBV supports. Co-located case management and referral models to support victims/survivors are reported throughout the OECD (Chapter 3), and play an important role over time: they help respond to crises in the immediate aftermath of violence, while also providing the infrastructure for longer-term health resources.

Austria, in particular, has widely integrated related services for GBV in hospitals: all hospitals are obliged by law to establish "victim protection groups" for women experiencing domestic violence. These groups are responsible for facilitating early detection and prevention of domestic violence through awareness raising among hospital colleagues. These groups also establish networks of cross-sectoral actors, including police, shelters, social workers and helpline operators which can then be mobilised to support help-seeking individuals (Chapter 3). In Korea, the approach is also intensive, with multidisciplinary centres in hospitals which offer medical support in addition to psychotherapy and legal counselling for both the immediate victims and their family members.

At the same time, not all health needs are best met in hospitals. Community-based care is recognised as the preferred approach for the majority of mental health care, for instance (OECD, 2021[54]). All OECD countries either already deliver the majority of mental health services outside of hospitals, or have prioritised the transition to community-based care models – with the potential to deliver care that is less costly than in-patient care, more in line with service users' preferences, and better integrated with other public services. This relates to the use of IPV screening tools in routine medical care (Chapter 3) and could be reflected in ISD responses to IPV in the coming years.

Mental health programmes

The Lancet Psychiatry Commission lists a range of mental health disorders that are more common among people who have experienced IPV than those who have not, including "anxiety, depression, substance use disorder, post-traumatic stress disorder (PTSD), personality disorders, psychosis, self-harm, and suicidality" (Oram et al., 2022[55]). Reflecting these concerns, several OECD countries have established integrated mental health support co-ordinated at the national level

In Denmark, for example, since 2020, municipal governments are obligated to offer up to ten hours of free, psychological counselling to women who are staying – or who have stayed – at a shelter as a result of domestic violence. Municipalities are also obligated to offer at least four, and up to ten, hours of psychological support to children accompanying women in this context. Sessions can be used both during and after shelter stays (OECD QISD-GBV, 2022).

Other OECD countries provide mental health support through multidisciplinary counselling centres (Chapter 3). In Costa Rica, for example, the National Institute of Women operates regional units which provide multidisciplinary supports, including psychosocial support, to women experiencing IPV. Similarly, in Greece, the Ministry of Labour and Social Affairs funds a number of dedicated counselling centres which provide targeted mental health services for women experiencing IPV. And in Japan, the national and subnational governments jointly fund and operate several spousal violence counselling and support centres which respond to women's mental health needs and accompany them to related medical appointments (Chapter 3).

1.5.3. Housing is critical to supporting victims/survivors in crisis and in the long run

Intimate partner violence is a leading cause of women and children's homelessness throughout the OECD, and any efforts to address IPV must consider how to support victims/survivors in what often appears as rebuilding their lives (Chapter 4). National governments in the OECD finance and/or administer emergency, transitional and – occasionally – longer-term housing support for women and children fleeing violence.

Emergency shelters

Emergency shelters play a key role in offering safe haven for women escaping an abusive home and preventing homelessness for women at risk of violence. Emergency shelters are also an important intake site for integrated access to social services and housing support services. Shelters can be general (for anyone in the population) or dedicated to women experiencing violence. Yet while emergency shelters play an important role, very few countries actually offer an adequate number of spaces to meet demand. Some shelters offer counselling on-site, many offer linkages or referrals to health services, and many provide child-related services (e.g. counselling for children), legal advocacy, and linkages to long-term housing. In Italy, for example, income and entrepreneurship support can be applied for through violence protection centres (Chapter 4).

Transitional and longer-term housing

Some countries have policies to help *women transition out of shelters and into safe long-term housing*. Hungary, for example, has a system of transitional housing in place which offers temporary, highly-subsidised housing for up to five years.

Looking to the longer term, a few countries report special provisions within existing social housing schemes which prioritise access to women who are experiencing IPV. This is the case in Belgium, Ireland, Japan, the Netherlands, Portugal, and Spain, for example. Unfortunately, these provisions exist in an environment of social housing scarcity across OECD countries, which means few women are actually able to access social housing. In the United States, where federal housing funds are more often allocated sub-nationally, a portion of federal housing funding is reserved for sub-national agencies to provide shelter and support for women and children experiencing domestic violence. And in Greece, the "Housing and Work Project" is a recent example of integrating long-term housing subsidies, mental health resources and employment-related supports.

Australia has a novel, trauma-informed, empowerment-based approach that gives women and children greater stability and may help hold perpetrators accountable. Australia's "Keeping Women Safe in Their Homes" (KWSITH) initiative provides support for women and their children to *remain* safely in their homes in the wake of domestic violence. Importantly, this shifts the burden of uprooting one's life to the *perpetrator* when he harms his partner (Chapter 4).

1.5.4. The justice sector's role in a co-ordinated response

A critical consideration in ISD to address IPV is the client's risk of exposure to violence, their heightened need for security, and, often, their need for police involvement and access to justice. Consequently, ISD measures to address IPV are often connected with police and legal advocacy support. Because legal issues and procedures are tied with other social, economic, health, or employment issues, a holistic response to GBV requires strong collaborations among organisations *within* the justice system and *between* the justice system and other sectors (OECD, 2021[13]).

As with other sectors, there is room for improvement in support for victims/survivors. The legal system can be hard to navigate for non-experts, and many victims/survivors have low trust in police being able or

willing to support them (Chapter 5). To some degree, this reluctance may be justified given historical cultures of victim-blaming and down-prioritisation of GBV cases by police (see Chapter 2 on barriers to reporting).

Police

Police are sometimes gatekeepers to accessing justice and other important supports, as reporting a crime can be an entry point to access important interventions and safety. Police work on the ground to respond to emergencies, support women in administrative processes where civil or criminal charges are pursued or imposed, and initiate related, inter-disciplinary services.

Some police are embedded in formal referral networks to related providers. For example, in Austria, the Czech Republic, Luxembourg and the Slovak Republic, police are required to contact social support services and link them with the women experiencing violence (Chapter 5).

Co-location of related services in police stations is another strategy. Australia, for example, frequently co-locates community-based advocates within existing police stations – which also helps in training officers – while Denmark and Norway have established interdisciplinary service provision in police stations. Other countries (such as Portugal, Argentina and Brazil) have established specialised women's police stations that are well-trained to deal with cases of violence.

Police play an important role, too, in preventing the reoccurrence of violence. The effective use of risk/danger assessments by police – informed by specialised training – and the correct application of emergency restraining/barring orders are an important step to keep perpetrators from carrying out further harm (see Chapter 2 and Chapter 5).

Police are also well-placed to deal with perpetrators of violence and initiate an integrated response to address violence at the source. For example, in New Zealand, both victims and perpetrators of violence enter the "Integrated Safety Response" programme through police services. This integrated framework includes efforts to enforce perpetrator accountability through behavioural change programmes.

Legal advocacy services

To ensure that more victims/survivors are able to make use of the legal frameworks that exist to support them, targeted justice services have emerged to better support women in the wake of IPV. Legal advocacy services and the court system, including domestic violence courts, facilitate women's access to justice and enable ISD with other sectors.

Several national initiatives exist in the OECD to support women in accessing justice through legal support, including some policies with multidisciplinary or integrated approaches (Chapter 5, Table 5.1). In Austria and Portugal, for example, dedicated multidisciplinary counselling centres have been established which provide psycho-social counselling in addition to legal counselling and court navigation support to improve access to justice. In Australia, legal support services have been embedded in health care settings to streamline access to justice for women who are already accessing health services (Chapter 5).

Costa Rica, New Zealand, Türkiye and the United Kingdom have established dedicated domestic violence courts which apply trauma-informed practices to empower women as they appeal for justice. Domestic violence courts apply specialised knowledge to better enforce orders, jointly delivered with police, that protect women. Domestic violence courts can also play an important role in enforcing perpetrator accountability through offender intervention programmess (Chapter 5).

1.5.5. Challenges, opportunities and policy lessons to foster lives free from violence

Women experiencing IPV often require support from a number of policy sectors in order to re-assert their safety and independence. Integrated approaches to end IPV have the potential to mitigate the consequences of violence by delivering multiple, essential services simultaneously.

At the same time, major efficiency gains for providers are also possible. Integrated services can potentially reduce the costs of service delivery for governments when programming is backed by coherent policy integration, both vertically (across levels of government) and horizontally (across sectors). Despite variations in governance structures across the OECD, opportunities exist at the national level to facilitate and streamline ISD on the ground.

Policy coherence matters

Governments must ensure that existing policies across sectors and jurisdictions do not inadvertently undermine each other, either directly,[17] as a result of regulations, or indirectly, as a result of a competition for resources (Chapter 6).

Related to this, policies and services must reinforce each other to address the whole problem of GBV. This involves emergency responses in the wake of violent incidents, a continuity of support in the medium- and long-term, and ensuring that perpetrators of violence are held accountable.

One example of how to ensure policy coherence is via model administrative frameworks that can help facilitate collaboration at the service delivery level. A strong administrative foundation can help all parties understand clearly their role in joint working. As a first step, national Ministries can collaborate to develop guidelines for service delivery standards, based on stated goals to improve service quality, outcomes, and satisfaction among both service users and providers. Templates can be developed to facilitate shared mission statements, memorandums of understanding across sectors, and joint service delivery agreements between providers. These administrative pieces can also be incorporated into funding criteria, effectively incentivising integration where clear service delivery arrangements exist.

A whole-of-state approach is essential

A whole-of-state approach – including national frameworks, reliable and adequate funding, and the involvement of government co-ordinating bodies tasked with gender mainstreaming (and GBV mainstreaming) – can help ensure that national strategies reach the service delivery level well-integrated across Ministries and agencies.

Changing, unclear or overlapping responsibilities can create competing incentives in terms of funding and management. Different Ministries at the national level may be responsible for planning or ensuring service delivery to categorically separate subsets of the population which, in the context of GBV, can often overlap. Similarly, subnational governments may develop action plans or laws within their jurisdictional bounds that may or may not coherently align or engage with incoming national-level action plans. These issues are exacerbated in an environment of scarce public funding.

Part of this challenge, of course, stems from a more basic governance issue: multi-level governance structures present a common challenge for all OECD countries when integrating health, legal and social services of almost any kind (OECD, 2015[22]). Where governance structures are highly centralised, it may be difficult to ensure national policy reflects local needs and is adequately delivered on the ground. On the other hand, decentralisation and varying degrees of regional and municipal autonomy – both legislative and financial – can lead to gaps in service coverage, as well as a lack of monitoring and evaluation (Lovette, Coy and Kelly, 2019[56]). For example, NGO providers have criticised their inability to help relocate a victim/survivor to a safe location further away from her abuser if that location falls under a different funding or political jurisdiction.

Funding to address to GBV must be adequate and reliable over time

Irregular and inadequate funding for IPV-related service delivery was the top challenge cited by both countries and non-governmental service providers who participated in the OECD QISD-GBV 2022 (see Annex A) and the OECD Consultation 2022 (see Annex B), respectively.

A protected, legal basis for the funding of ISD to address GBV can help to circumvent pre-existing, siloed funding streams and ensure continuity of care by service providers. This must be prioritised in national budgets as part of broader frameworks on GBV.

A legislative basis can also shield budgetary allocations from changes in government. This can be done through funding rules which establish reinvestment criteria for central funds that are allocated to subnational entities. A parallel can be drawn from the United Kingdom, for example, which recently implemented a funding rule whereby National Health Service Clinical Commissioning Groups must increase investment in mental health services in proportion to the overall increase in their central funding allocations.

Opportunities also exist to empower local beneficiaries with flexibility to address specific, local needs with central funding allocations. One such example exists in Colombia, where local recipients of central funds allocated for the "Generación Explora" programme can choose two of 12 focal issues to finance (some of which explicitly address violence). Greater flexibility in local or regional funding could also help simplify resource distribution processes across jurisdictions, for example when nearby towns or regions are jointly aiding a client.

National governments can help standardise (and fund) regular, local needs assessments

An important first step for establishing and improving ISD is collecting data to understand a community's need for services on the ground. Local contexts are crucially important – especially where service delivery occurs at the subnational level or through partnerships with NGOs. A "one-size-fits-all" approach would not be effective in most countries.

Nevertheless, national guidelines for standardised needs assessments can prove useful (Kelly, 2018[57]), especially where targets related to ending GBV are outlined in national action plans. National guidelines and resources can also be useful when delivery-level entities lack the resources to coherently assess service needs – a common shortcoming.

Governments should prioritise improving local administrative data collection. This entails research into the local prevalence of various forms of GBV, in addition to tracking service uptake and system utilisation, for example through service usee numbers. Local prevalence rates can then be measured against social service "resource scans" – stocktakings or mapping of available local services. Together, these assessments can better inform the types of services that should be joined-up in order to respond accurately to needs on the ground. Where service delivery is decentralised, these assessments can inform the funding process for service delivery grants.

Regular needs assessments can also be qualitative in nature, such as a recent study to assess the special needs of children accompanying mothers in women's shelters in Greece (forthcoming). In the Czech Republic, the government surveyed regional authorities and local service providers to better assess the needs of people at risk of domestic violence as a precursor to implementing Istanbul Convention recommendations (EU Social Fund, 2021[58]).

Finally, while national population surveys on GBV have serious limitations – including underestimating actual rates of violence – it is nevertheless important to carry out such surveys (OECD, 2020[2]). Survey data can be used to identify regions or subgroups of women experiencing or at risk of experiencing a high prevalence/frequency of violence, perhaps based on underlying socio-economic conditions. These can be

dedicated surveys on GBV repeated over time, or modules on GBV within other population surveys, that can then be used to inform needs assessments.

Data sharing capabilities across agencies must be strengthened

Data sharing across providers can reduce clients' application costs (in time and energy); reduce the trauma associated with repeating accounts of violence to different providers in different locations; and improve client safety by better tracking risks across repeated incidents of violence. Ideally, such a system would also integrate perpetrator-related interventions to track accountability and recidivism, as well as monitor the risk posed to help-seeking women in real time.

Yet there exist serious gaps across providers and levels of government in most countries when it comes to sharing data on IPV cases. Data-sharing capabilities across agencies must be strengthened, possibly by way of a central, integrated case management system, while ensuring client privacy.

For providers, a data-sharing platform can create a secure environment for information sharing; facilitate co-operation; reduce administrative processing costs, coverage gaps and service duplication; and more accurately assess risk by making past appeals for help more visible to other providers. For governments, a central case management system can improve institutional co-ordination; more accurately track the prevalence of violence; and provide the foundation for monitoring service delivery costs and service delivery effectiveness on a case-by-case basis as a function of risk.

Importantly, shared information on clients can help early detection and prevent cases of violence by making providers better aware of the risk profiles and histories of different clients. Governments may gain long-term savings through early detection, prevention and increased efficiency in delivering services, ultimately reducing the number of appeals necessary to resolve problems.

Once established, such a system could also be mobilised to serve other vulnerable groups in addressing complex problems. Acknowledging the multi-dimensional utility of such a system, the World Bank is supporting the establishment of an integrated case management system in Chile for the specific purpose of improving service delivery to women affected by violence (The World Bank, 2022[59]). Australia has also introduced a data sharing strategy within the Safety First Programme, an information-sharing and safety-planning mechanism for women leaving refuges.

Of course, while women's privacy and security must be the top concern in data sharing strategies, it is important to note that the shift to digital data sharing does not necessarily imply increased risks, and may actually be an improvement over current conditions, which do not always adequately protect client privacy. In many cases, information is "transmitted between institutions either manually or by email, raising confidentiality concerns and significant delays in what are often life or death situations" (Inchauste, Bello and Contreras-Urbina, 2021[60]).

Better and regular programme evaluations are essential

On the whole, ISD approaches to addressing GBV have not been systematically or quantitatively evaluated. Integrated services need to be better evaluated both individually and in the context of broader social protection system supports for GBV.

Better evaluations could entail randomised control trial evaluations of outcomes for clients offered an ISD approach versus standard service delivery; monitoring and evaluation of costs and benefits of integrated versus standard programmes; and qualitative, survey-based evidence on client experiences. Importantly, clients should be compared across integrated services and standard services to understand a crucial counterfactual: what would have likely happened in the absence of policy integration?

Such evaluations can and should also consider interventions for perpetrators of violence, to help improve understanding of what works in keeping perpetrators from assaulting (again) their partners. Understanding how to prevent recidivism is crucial for breaking a cycle of violence.

A holistic perspective means treating everyone involved – including perpetrators

In addition to cross-sectoral and cross-jurisdictional coherence, policies aimed at addressing – and ultimately eradicating – GBV must consider all parts of the problem. This fundamentally requires targeting perpetrators of violence. Governments can interact with perpetrators not only through criminalisation and the court system, but in multi-dimensional ways that more holistically improve offender accountability and produce long-term behavioural change on individual and broader cultural levels (Chapter 2).

Most importantly, apply a victim/survivor-centred focus

Many of the policy prescriptions to address GBV are "top-down" in nature, encouraging national governments to offer guidelines, regular support, and data gathering tools to subnational and non-governmental service providers. While this line of communication is important, it is at least as important to ensure that national policy makers listen to experts and victims/survivors at the local level.

Local service providers and advocates are highly attuned to the needs of women on the ground, and they offer years of experience and knowledge of the diverse, often intersectional challenges women face. Many "best practice" integrated service delivery examples evolved from the ground up, such as the cases of the Family Justice Centres in Europe and North America or the evolutions of rural women's shelters in Canada. Clear lines of communication must therefore connect local service providers with national and regional policy makers, to enable better and more victim/survivor-centred service delivery.

Victim/survivor-centred approaches could include regular stakeholder engagements or surveys of service providers to ensure stakeholders can help to co-create good policies. To help advance stakeholder engagement, the United States Department of Health and Human Services also recently published research for government agencies on how to adequately capture and act on "lived experiences" of service users to understand better how programmes are working on the ground and how to improve them (Office of the Assistant Secretary for Planning and Evaluation, 2021[49]). The Canadian, Spanish and Welsh governments offer similar examples of incorporating victim/survivor feedback in programme design (see Section Local evolutions of ISD to address GBV are important).

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Notes

[1] It is important to note that men in heterosexual relationships and people in same-sex relationships also experience IPV, though in these cases, motivation for violence is more often rooted in interpersonal or psychosocial dynamics rather than in *gendered* conceptions of superiority. As with violence against women, violence against members of the LGBTI+ community is gender-based in that it is motivated by prejudice and an illusion of hetero-masculine superiority among offenders. Statistically, women experience GBV most often at the hands of their male partners, adding a layer of complexity to help-seeking. For this reason, this report focuses on intimate-partner violence against heterosexual women, and the supports required to address their many needs in escaping violence.

[2] These cross-nationally comparable homicide statistics from the U.N. Office on Drugs and Crime were last updated in 2019, prior to the COVID-19 pandemic.

[3] This includes intimate partner *and* non-intimate partner violence, i.e. all forms of violence.

[4] Note that these cross-nationally comparable estimates for the OECD include *all* women, not only ever-partnered women.

[5] See, for example (Shearson, 2021[61]; Glenn, 2021[65]; Mundy and Seuffert, 2021[66]; Moylan, Lindhorst and Tajima, 2017[67]; Fusco, 2013[68]).

[6] For examples of evaluations of compliance with Istanbul Convention minimum standards in European OECD countries, see (WAVE Network, 2019[11]; Council of Europe, 2022[14]).

[7] Affected women may feel as though their case may not be "taken seriously" through traditional reporting channels such as the police, or that help-seeking options may fall short of long-term solutions that ensure safety and security. For a review of these challenges, see, for example: (Glenn, 2021[65]; Mundy and Seuffert, 2021[66]; Moylan, Lindhorst and Tajima, 2017[67]; Fusco, 2013[68]).

[8] See https://www.oecd.org/governance/gender-mainstreaming/ for an overview of work on this topic in the OECD; https://www.coe.int/en/web/genderequality/what-is-gender-mainstreaming for an overview of work

by the Council of Europe; and https://eige.europa.eu/gender-mainstreaming/what-is-gender-mainstreaming for a descriptive overview from the European Institute for Gender Equality (EIGE).

[9] For examples of international approaches, see (OECD, 2021[13]; OECD, 2020[69]; Council of Europe, 2011[10]), for a small selection of national strategies, see Box 1.3.

[10] Austria, Belgium, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Latvia, Lithuania, Luxembourg, Netherlands, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, United Kingdom. See https://www.coe.int/en/web/conventions/full-list?module=signatures-by-treaty&treatynum=210.

[11] These results come from a questionnaire sent to countries via the OECD Public Governance Committee. 26 countries responded in total.

[12] International literature highlights a lack of common terminology when describing collaborative, multi-agency working, making classification and comparison challenging. See, for example: (Atkinson, Jones and Lamont, 2007[62]).

[13] Of course, on the provider side, the appointment of a single co-ordinating case worker (often social workers or, in the United Kingdom, "domestic violence advisors") also implies considerable emotional dexterity and stress. Deteriorating mental health is not uncommon among case workers, often related to "inadequate organisational resources, lack of training, and poor integration with other community resources." (Kulkarni, Bell and Rhodes, 2012[63]). In the United States, burnout worsened among providers during COVID-19 (Garcia et al., 2022[64]).

[14] Stakeholder engagement is relatively common in Canada. One example of findings from multi-stakeholder consultations can be found the report "Breaking the Silence: Final Report of the Engagement Process for the Federal Strategy to Address Gender-based Violence" (Status of Women Canada, 2018[70]).

[15] France, Poland and Sweden did not respond to the questionnaire, but evidence from desk research has been included when possible.

[16] Countries were asked "To what degree does the national/federal/central government actively promote the integration or co-location of services at the subnational and/or non-governmental level, or via private service providers?" Response scale choices were "to a great extent," "somewhat," "very little," "not at all," or "don't know."

[17] For example, "nuisance property laws" at play some US municipalities impose eviction (and even criminal charges, in some cases) for tenants who use a pre-determined number of emergency service calls. This is particularly harmful for women who may appeal to emergency police services for protection in repeated situations of IPV (Chapter 4).

2 Preventing violence from taking root: Integrated services from prevention to crisis support

Gender-based violence (GBV) and intimate partner violence (IPV) often escalate over time. Early and preventative interventions are therefore critical to limiting harm. Co-ordination across service providers can ensure that women undergo appropriate danger assessments and receive adequately tailored support, and that perpetrators are consistently held to account to prevent violence from escalating. Unfortunately, stigma, distrust of public authorities, and other factors mean that many women only report their perpetrators and seek help when their relationship reaches the point of crisis. At this point, it is crucial that crisis response teams provide accessible services and can refer victims/survivors to co-ordinating partners for rapid intervention to save lives.

Key findings of this chapter

Intimate partner violence (IPV) often escalates over time, which makes timely and effective intervention key to limiting exposure to prolonged and/or increasing severity of violence. This chapter takes stock of how countries use integrated services to achieve as early intervention as possible, and to provide timely and effective interventions as soon as women report their perpetrators. This chapter finds that:

- Barriers to reporting IPV are high, making it too challenging for many women to report their partners and/or seek help. Understanding these barriers is one step towards being able to lower them.
- One way for countries to combat gender-based violence (GBV) against women is to focus prevention efforts on highlighting sexist acts and behaviour resulting from harmful gender norms that may not qualify as severely enough to be classified as violence under the Istanbul Convention, but that can be precursors for later GBV and IPV. Countries should also aim to speed up society-wide normative changes that support gender equality and nonviolence.
- When victims/survivors overcome reporting barriers, the degree of danger they face should be appropriately assessed. Risk assessments tend to be most accurate when they are well-co-ordinated and standardised across agencies and providers. Service provision – especially for high-risk cases – works well when it is co-ordinated through case management and/or MARACs since these can help agencies share relevant information about the case and victims/survivors to navigate complex systems and access appropriate services at the right time.
- Preventative measures need to target perpetrators of IPV in order to achieve holistic and sustainable solutions to violence. Violent men are often re-offenders in multiple relationships and victims/survivors sometimes return to their abusers, so working with perpetrators is crucial to prevent re-victimisation and new victimisation. Information-sharing across different actors within the justice sector as well as across different sectors would contribute to making measures more effective.
- Reporting often first occurs at a point of crisis, so initial points of contact with crisis and emergency services crucially need to offer effective referrals to partners to keep victims/survivors safe in an emergency. Two cornerstone sources of crisis support are telephone helplines and crisis centres, and these work best when they have established partners and immediately applicable referrals.

2.1. Partner violence often escalates over time, making timely intervention key

Intimate partner violence (IPV) often escalates in frequency and/or severity over time (Kebbell, 2019[1]). Abusers may escalate their violence, for example, if they feel that they no longer have control or worry that their partner is preparing to leave the relationship (National Domestic Violence Hotline, 2022[2]). Women exposed to escalating violence may find themselves in increasingly precarious situations where earlier intervention could have prevented harm.

This chapter takes stock of how countries use integrated services to achieve as early intervention as possible, and to provide timely and effective interventions as soon as women report their perpetrators. It first discusses how barriers to reporting are particularly problematic in cases of escalating violence, making early intervention key to limit the length of time and severity of violence from partners. Second, the chapter describes the value of co-ordinating services through case management and risk assessment, to ensure that the risks of the occurrence and escalation of violence are not underestimated. Third, it discusses how interventions can incorporate the treatment of perpetrators to ensure that the intervention is holistic and sustainable. Finally, the chapter explains that effective and integrated cornerstone services such as emergency helplines and crisis centres are essential to give immediate assistance as a first stop when women do report.

2.1.1. Barriers to formal reporting can enable violence to escalate

Leaving an abusive relationship is difficult and often takes months or years. Some victims/survivors stay with (or return to) their abuser because they find value in other aspects of the relationship. They may miss aspects of their life they shared with their abuser, such as their children, their social circles, their home, or their pets. They might be able to compartmentalise the violence as only one facet of an otherwise tolerable or enjoyable relationship (Patrick, 2021[3]). Many are highly committed to achieving a non-violent relationship, are emotionally attached, and think that things may change in future (Nicholls et al., 2013[4]).

But inadequate public supports for victims/survivors can also make it harder for women to leave a relationship. Not least because violence tends to escalate over time, it is critical for service providers to understand and lower barriers to *reporting* violence.

Across countries, there are widespread problems with under-reporting of GBV and IPV (UN Women, 2022[5]). Violence goes unreported for various reasons, including (but not limited to) financial dependence on the abuser, stigma, a lack of social and formal support networks, not believing that the legal system (including police) will work with the victim/survivor, and a fear that the perpetrator might retaliate or take away children (Marchbank, 2020[6]). In a cross-national survey of victims/survivors in the European Union,[1] on average 9% of victims/survivors reported not contacting the police after their most serious incident of physical and/or sexual violence because they felt that the police would not believe them. 7% believed that they did not think the police *could* do anything, and 4% felt they would not be believed (Chapter 5).

Interviews conducted by a legal advocacy group in Canada illustrate the apprehension of the time, money and mental investment required to report perpetrators. One victim/survivor respondent illustrates the burden of reporting sexual assault made worse by their concern with being met by disrespect by the justice system: “I don’t have the time or the energy to have somebody treat me like I’m dumb or question my motivations” (Prochuk, 2018[7]).

Women are most likely to report violence and seek support from public services when violence becomes unbearable or when they fear for their lives (Barrett, 2011[8]; Barrett, Peirone and Cheung, 2020[9]; Fanslow and Robinson, 2010[10]). This finding is supported in diverse cultural contexts. For instance, a study from the Czech Republic indicates people are more likely to report IPV when it is perceived as more severe, and especially when there is a fear that the victim’s life is in danger. At the same time, the likelihood of reporting to police is lower for sexual assaults compared to non-sexual forms of physical violence, perhaps

because stigma around sexual assaults is more prevalent than for non-sexual acts of violence (Podaná, 2010[11]). A study in India finds that women were most likely to report spousal violence (albeit still rarely to formal institutions) when they experienced it in multiple forms: sexual, physical and emotional abuse (Leonardsson and San Sebastian, 2017[12]). Similarly, research in Korea finds that women are most likely to initiate help-seeking from formal institutions when they experience violence-related injuries or the perpetrator abuses their child (Kim and Lee, 2011[13]).

Women facing multiple and intersectional disadvantages may find it harder to report and seek help (Chapter 6). The ease with which women feel able to report their crime can be influenced by factors like citizenship status, language fluency, financial means, employment status, overall physical and mental health and parental status (Marchbank, 2020[6]). Historical tensions also exist between police and marginalised populations that could make people less inclined to seek help from these formal institutions. Members of Black, Indigenous or other ethnically marginalised communities, as well as sex workers, members of the LGBTI+ community, and homeless women may be hesitant to seek help due to negative past experiences with formal institutions, and especially the police (Mundy and Seuffert, 2021[14]; OECD, 2020[15]).

2.1.2. Prevention measures should target sexist acts as precursors to gender-based violence

Prevention and early intervention are key strategies to avoid escalating violence and critical moments of crisis. Indeed, GREVIO – the monitoring arm of the Istanbul Convention – stresses the importance of measures and policies targeting *any* sexist act, and not only measures targeted at helping women in crisis (Council of Europe, 2022[16]). For example, the 2015 amendment to the French Labour Code does this well in that it prohibits any act related to a person's sex where the purpose or effect is to violate the dignity or create an intimidating, hostile, degrading, humiliating or offensive environment (Council of Europe, 2022[16]). Awareness-raising and sensitising among the public, firms and public institutions can speed up the ongoing progress toward more gender-equal cultures and norms.

Measures targeting early stages of violence, toxic masculinities and negative social norms are useful because they target gender-based behaviours that may not reach the threshold of severity that would be classified as violence under the Istanbul Convention. These behaviours are useful to address in themselves, but also because they often are the precursors to violence and manifest the structural gender inequalities that in many cases are the foundation for more severe forms of violence against women (Council of Europe, 2022[16]). Similarly, the Council of Europe's work on addressing GBV among young people highlights a range of preventative and early intervention efforts, including training professionals, educating children and young adults, and raising public awareness, as critical to addressing the root causes of GBV (Box 2.1) (Pandea, Grzemny and Keen, 2019[17]).There are few evaluations from OECD member countries on how well preventative programmes and pilots work to address GBV against women. It is therefore encouraging that the UK Home Office has committed to invest GBP 3 million in 2022-23 towards programmes that improve the understanding on what works to prevent violence against women and girls (UK Home Office, 2022[18]).

Box 2.1. Addressing deep-seated gender inequality is key to combatting gender-based violence

GBV and IPV against women need to be considered in the context of the historically unequal relationship between men and women in society. This form of violence is rooted in pervasive gender inequality, discrimination and harmful cultural norms that benefit men over women. Both the driving cause and motivation behind GBV against women is for a man to exert power and control over a woman. This can involve one or several aspects of a woman's life, including her body, her mind, her economic situation, her sexuality and/or her reproductive functions. As such, GBV is part of a social mechanism that keeps women in a subordinate position to men.

To end gender-based violence, there need to be sustained efforts to address society-wide gender inequalities and traditional gendered norms. Societal acceptance of these harmful traditional gender norms helps perpetuate cycles of violence. Preventative measures should aim to empower women and combat gendered norms in order to achieve longer-term attitudinal changes. An important part of this work will involve work with boys and men to sensitise them to GBV and provide tools to help perpetrators use non-violent forms of communication.

Importantly, any preventative efforts targeting gender-based violence must be accompanied by a comprehensive and holistic effort to ensure gender equality in education, employment, political life, and society at large – to ensure that women are participating on an equal playing field in all walks of life.

Source: (UN Women, 2015[19]; Council of Europe, 2022[16]; UN Women, 2022[20]; Malghan and Swaminathan, 2021[21]; OECD, 2016[22]; OECD, 2017[23]; OECD, 2019[24])

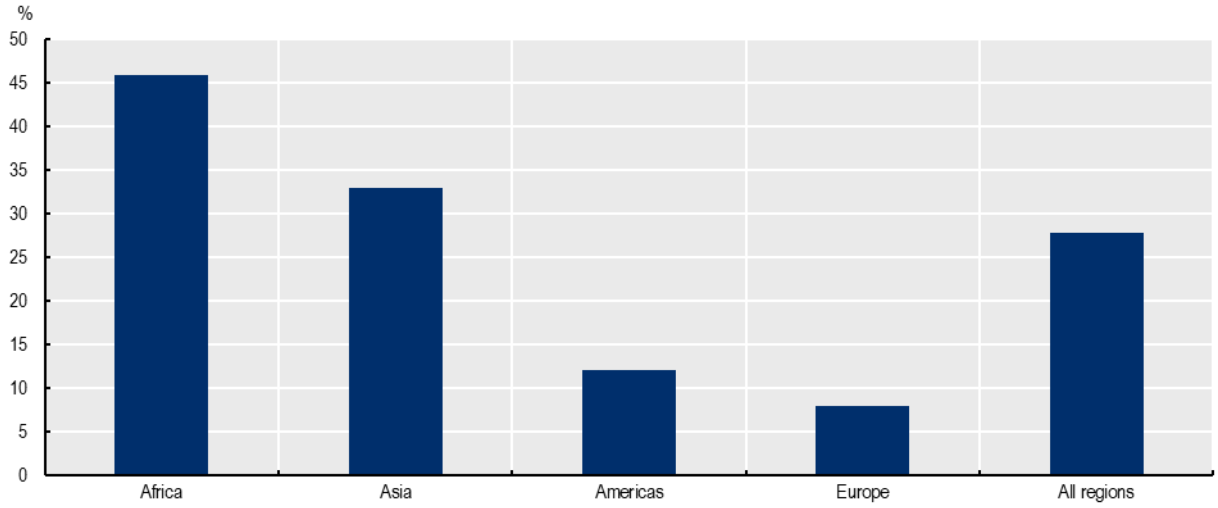
2.1.3. Promoting gender equality through society-wide normative change

Eradicating IPV is often framed as a responsibility of women to escape violent relationships, but at the societal level there is nothing that is more important than addressing the harmful norms that perpetuate violence. Violence has become embedded in the socialisation of children, and perhaps especially in boys and young men. Violence represents a prominent element of the coming-to-be of patriarchal masculinities to varying degrees across cultures (Box 2.1) (UN Women, 2016[25]; Pappas, 2019[26]; OECD, 2020[27]).

Internalised harmful gendered norms means that some men and women are able to justify violent behaviour. Indeed, many women accept that violence can be justified behaviour in certain circumstances: over one-quarter of women think IPV can be justified across countries in the world (Figure 2.1). The acceptance of IPV is more common in countries in Africa where 46% of women on average think that husbands can be justified in beating their wives, compared to in European countries where only 8% of women think so (Figure 2.1). It is important to challenge and transform the harmful social norms that justify IPV into ones that promote gender equality and nonviolence (OECD, 2020[27]).

Figure 2.1. Over one-quarter of women across world regions think IPV can be justified

Proportion of 15-49 year-old women who think a husband can be justified in hitting or beating his wife, 2019



Note: Data illustrate the share of women who think husbands are justified in hitting or beating their wives for at least one of the specified reasons, including if she burns the food, argues with him, goes out without telling him, neglects the children or refuses sexual relations. Regional averages refer to simple (unweighted) averages over countries.
Source: (OECD, 2019[28]), OECD Gender, Institutions and Development Database (GID-DB), https://stats.oecd.org/Index.aspx?DataSetCode=GIDDB2019.

It is critical to target social norms among both men and women that historically have played a role in normalising violence, creating stigma against speaking out, and allowing violence to be perpetuated in society. In practice, such norms take shape in practices such as victim-blaming, the internalised acceptance of domestic violence by women themselves, and inadequate response by law enforcement agencies. Victim-blaming attitudes contribute to sustaining a climate of tolerance that discourage actions to combat IPV and allows social indifference.

Restrictive norms of masculinities, such as belief in the male breadwinner mode, or the idea that important decisions – such as matters of financial, sexual or reproductive nature – should be taken by men, foster a culture of power imbalances in heteronormative couples. Challenging these norms, or the feeling that these norms are being challenged, can also initiate and exacerbate IPV. For example, men who report being stressed due to lack of work, or who report feeling ashamed about their financial or economic situation, are almost 50% more likely to commit violence against their female partner than those who do not report feeling stressed (OECD, 2021[29]). Such financial and other stressors can become more prevalent in economic crises, such as that experienced during the COVID-19 pandemic. Stress and other factors can provide false justification or excuses for violence in the minds of both victims/survivors and perpetrators, and discourage disclosure or intervention.

Stopping violence against women needs to start well before the onset of a perpetrator's violent behaviour. Most behaviours are learned in early childhood and it is very hard to undo violent tendencies, as was established in the UK's public consultation Violence Against Women and Girls Call for Evidence in 2020 (UK Home Office, 2022[18]; UK Home Office, 2020[30]).

Although the OECD QISD-GBV 2022 (Annex A) did not ask specifically about country interventions and sensitising men and boys from a young age, some examples have emerged. For example, the Government of Japan reported dedicating 33 million yen to early prevention programming in school education in 2022.

Specifically, thematic textbooks have been created to raise awareness and prevent children from becoming perpetrators, victims or spectators to sexual assault over the life course. In addition, utilising the textbooks, the Ministry of Education, Culture, Sports, Science and Technology has launched a project that accumulates guidance examples (OECD ISD-GBV, 2022). Similarly, in 2022, the Spanish Government Office against GBV allocated 6.5 million euros in subsidies and grants to raise awareness and prevent GBV, including programmes to raise awareness and prevent digital GBV or centred in working masculinities with young boys and teenagers (Ministry for Equality, 2022[31]).

A third example can be taken from Costa Rica, where the National Policy for the Care and Prevention of Violence against Women of All Ages Costa Rica 2017-2032 (PLANOVI) has a considerable focus on promoting an anti-sexist culture and masculinities for gender equality and anti-violence (Alonso and Valverde, 2017[32]).

At the international level, strategies promoted by UN Women to achieve sustained normative changes include focussing on early education, working with men and boys, supporting advocacy, awareness-raising, community mobilisation, legal and policy reforms. One example of this is the NGO Equimundo in Brazil that focuses on engaging men and boys as allies in gender equality, by working to promote healthy manhood and violence prevention (Equimundo, 2022[33]). Equimundo has also launched a Global Boyhood Initiative in several countries, including the UK, to help foster healthy and inclusive norms among boys (Equimundo, 2023[34]).

2.2. Co-ordinating services can ensure that risk is appropriately assessed

Too often, tragedy strikes when early warning signs are overlooked or minimised, and violence subsequently escalates. Co-ordinated risk assessments and case management can be valuable tools to help ensure that the risk of violence is appropriately assessed, and that adequate services are then provided to the help-seeker.

2.2.1. Risk assessments are a key preventative tool, especially if co-ordinated well

Cases of IPV need to be adequately assessed for risk by service providers so that immediate risk can be reduced, a safety plan can be developed, and the appropriate services and/or referrals can be provided (Roeg, Hilterman and van Nieuwenhuizen, 2022[35]; Council of Europe, 2011[36]). Often categorised as “danger assessments” (Campbell, Webster and Glass, 2009[37]), risk assessments aim to establish the degree of threat an abuser poses, produce transparent and defensible indicators for intervention and treatment decisions, and be informative for providing the services required to help prevent further IPV to those who need it most (Nicholls et al., 2013[4]; Northcott, 2012[38]).

Risk assessment tools may consider the perpetrator and their likelihood to re-offend, while others may consider the victim and their likelihood of re-victimisation. In other words, some tools are designed to *predict recidivism*, while others focus on *violence prevention and risk management* – and some do both (Northcott, 2012[38]). Risk assessment tools are most commonly used by justice agencies such as police and courts, though their use has been adopted by social workers addressing both victims and perpetrators, by health professionals, and staff in shelters and related protection centres (EIGE, 2019[39]).

IPV risk assessments can be deployed following three general approaches: (i) unstructured clinical judgment; (ii) structured clinical judgment; and (iii) the actuarial approach (Northcott, 2012[38]; EIGE, 2019[39]).

- Unstructured clinical judgement, also known as clinical enquiry, is an informal method employed by service providers assessing risks related to IPV (WHO, 2013[40]). Using this method, professionals such as police, social workers and health care workers do not use official guidelines, but instead use information collected through conversation and make a subjective judgement

about the threat posed in the current situation. Without proper training about IPV and its various, context-specific aggravating factors, service providers may not be able to assess risk accurately.

- Structured clinical judgement, also known as guided clinical approach, follows a set of guidelines describing specific, minimum risk factors associated with IPV. It subsequently provides recommendations about information gathering to inform safety planning, risk management and case management (Northcott, 2012[38]; EIGE, 2019[39]). Structured clinical judgement is therefore more consistent and transparent than unstructured clinical judgments (Northcott, 2012[38]). For an example of a structured clinical judgement tool, see Box 2.2.Structured clinical is more flexible than third risk assessment method, the actuarial approach (EIGE, 2019[39]).
- Actuarial risk assessments incorporate a value scale for each of the items in the assessment inquiry and use an algorithm to then generate a "score" used to assess risk. On the one hand, the actuarial approach provides a standardised method for assessing risk, which can be methodically deployed by professionals who may not necessarily be trained in addressing cases of IPV. Because risk here is based on set criteria, results are perceived as more reliable and can be easily replicated across settings. On the other hand, the actuarial approach limits professionals to a fixed set of criteria that may not accurately capture context-specific or intersectional risk factors, or may underestimate dynamic factors which may change the level of risk beyond the time of assessment (Northcott, 2012[38]; EIGE, 2019[39]). This can lead providers to underestimate risk and refer the help-seeker to inadequate services. For an example of an actuarial risk assessment tool, see Box 2.2.
- Among OECD countries in the European Union, a majority have developed or endorsed specific risk assessment tools at the national level to encourage standardised implementation (Table 2.1 and Box 2.2). In the United States and Canada, subnational governments have done the same, and in Australia, subnational governments may develop their own frameworks in conjunction with national risk assessment principles for domestic violence (Toivonen and BackHouse, 2018[41]).

Box 2.2. Structured clinical approach versus actuarial approach to risk assessment in the OECD

Spousal Assault Risk Assessment Guide (SARA)

SARA is cited as one of the most commonly-deployed **structured (or guided) clinical approaches** to assessing risk in situations of IPV. It was developed by scholars to measure the level of risk through non-actuarial, professional judgement guided by a 24-item framework, though an abridged version was developed in parallel (the Brief Spousal Assault Form for the Evaluation of Risk, B-SAFER). The guide has since been updated on three occasions to keep up with IPV research, most recently in 2015. SARA, as well as B-SAFER, have been adopted by providers, and have been cross-validated for predictive accuracy, in a number of countries in the OECD.

The tool guides practitioners through items related to the nature of abuse, perpetrator factors and victim vulnerabilities. Importantly, SARA requires that professionals are properly trained to assess situations of IPV, have access to all relevant information, including clinical and justice sector files, and for both victims and perpetrators participate in interviews.

Ontario Domestic Assault Risk Assessment (ODARA)

ODARA is a commonly deployed **actuarial approach** to assessing risk of recidivism in situations of IPV in Canada. It was first developed in Ontario, Canada, using police data which was collected from over 500 known IPV offenders over five years. ODARA gained currency in Canada in the early 2000s and has been adopted on the ground – and cross-validated in studies – across the OECD.

The tool focusses on predicting whether a perpetrator will reoffend based on statistical analysis of 13 items. Each item is assigned a value of zero ("no") or one ("yes"), and level of risk is determined by

the sum of values across 13 items, including, for instance, prior domestic or non-domestic assault in police records, victim/survivor fear of future assaults and if victim/survivor is facing barriers to support such as lack of resources or geographical isolation. Although it can be helpful to quantify risk on a scale, some scholars argue that lower mid-range scores are "a point of ambiguity" which may require additional or complementary risk assessment approaches, including professional judgement facilitated through structured or unstructured means. Indeed, one survey of Canadian police officers nationwide found that one-third of police officers use more than one tool when assessing cases of IPV for risk.

Source: for SARA (EIGE, 2019[39]; Northcott, 2012[38]; The Risk Management Authority Scotland, 2019[42]) and for ODARA (Hegel, Pelletier and Olver, 2022[43]; Saxton et al., 2020[44]; GR Counselling, 2005[45]; Waypoint, 2021[46]).

Table 2.1. Many countries have risk assessment tools standardised at the national level

Main actors of risk assessment and risk management, and level of standardisation

Country	Main actors of risk assessment and risk management	Regulated and/or standardised at national level
Austria	Police, intervention/violence protection centres, justice system, health professionals in hospitals, men's counselling centres	Yes for police and intervention/violence protection centres
Belgium	Police, social workers, health professionals, public prosecutors	No
Czech Republic	Police, victim support centres	Yes
Denmark	Police, social services	Yes, the police have a risk-assessment guide
Estonia	Police, probation services, victim support services, social services (child protection, social workers), NGOs	Yes
Finland	Police, social services, health services, victim support centres	Yes
France	Victim support centres, health services	No
Germany	Police, specialised counselling services, victim support centres, perpetrator programmes, women's shelters, youth welfare agency, social workers, law-enforcement agencies	No
Greece	Victim support centres, NGOs, police	No
Hungary	National Crisis Management and Information Telephone Service, crisis centres, secret shelters, transitional housing services, crisis management clinics, victim support centres. Also through a signalling system which mandates reporting (for some members by law) across a range of sectors, including (but not limited to) health care service providers, the police, the public prosecutor's office, the Court of Law, probation services, victim support as well as compensation organisations, correctional institutions, and children's rights representatives.	Yes, legal and/or uniformly used professional protocols (by type of institution)
Ireland	Police, probation services, health professionals, social services	Yes
Italy	Police, law-enforcement agencies, victim support centres, perpetrator programmes, emergency departments, judiciary	No
Latvia	Police, social departments, victim support centres	No
Lithuania	Police	Yes
Luxembourg	Police, public prosecutor, victim support centres, service in charge of perpetrators	No
Netherlands	Victim support centres, health professionals, law-enforcement, child protection, social workers	Yes
Poland	Police, social services, health professionals, education professionals, victim support centres	Yes
Slovak Republic	Police, victim support centres	Yes
Slovenia	Police, social workers, victim support centres, NGOs working with perpetrators	Yes

Country	Main actors of risk assessment and risk management	Regulated and/or standardised at national level
Spain	Police, victim support centres, forensic assessment units inside institutes of legal medicine and forensic sciences, prison and probation services. Viogén System is a web application that integrates all information of interest in specific cases to make a risk estimation, monitor the case, provide protection and a "Personal Safety Plan", and carry out preventive steps by issuing warnings to the different institutions involved.	Yes
Sweden	Police, social services, prison and probation services, victim support centres	Yes
Türkiye	Police, gendarmerie, social services	Yes
United Kingdom	Police, victim support centres	Yes

Source: Table excerpted and edited from (EIGE, 2019[39]) "Risk Assessment and Management of Intimate Partner violence in the EU". Additional country comments incorporated following OECD member country feedback.

Once a risk assessment is made, service providers must determine the best course of action to manage risk for women experiencing IPV. The EIGE contends that multiagency arrangements for risk management are most effective, citing multi-agency risk-assessment conferences (MARACs) as a prominent example.

As with many other public responses to intimate partner violence, however, risk assessments face challenges in implementation. The European Institute for Gender Equality (EIGE) highlights how little empirical evidence exists to evaluate the accuracy and effectiveness of risk assessment tools and related risk management practices (EIGE, 2019[39]). Scholars have also cited the inconsistent application of various tools across different frontline responders and service providers (Kebbell, 2019[1]; Roeg, Hilterman and van Nieuwenhuizen, 2022[35]). There is the persistent challenge of ensuring that victims/survivors are linked up with adequate service provision and protection after a risk assessment is made.

Finally, for any of these risk assessments, time is of the essence: a process that takes too long can leave women in severe danger of an escalation of violence.

2.2.2. Co-ordinating services through case management gives victims/survivors a lifeline

The landscape of possible services available to victims/survivors of IPV is often complex and hard to navigate – from locating a provider and getting the right referrals, to applying for services, and finally accessing services for which they are eligible. Navigating complex systems can be especially difficult for women who might have experienced traumatic brain injuries, mental health issues, long-term stress and psychological trauma, including Post-Traumatic Stress Disorder (PTSD). This makes cognitive function more challenging (Valera et al., 2019[47]).

Case management services can help women find and receive the support they need from the system, and they are a common tool for service integration, along with referral systems, physically co-located services and data sharing (Chapter 1). Most OECD countries have systems where experts help women navigate support systems through case management.

Case management services focused on IPV are often established and operated by non-governmental providers specialised in supporting victims/survivors of violence, especially where they take a lead on offering as many services as possible for help-seeking women (Chapter 6). In many of the ISD examples presented in this report, caseworkers play a prominent role, which can improve the experience for clients – though it can be very challenging for a single caseworker.[2]

As the chapters in this report illustrate, many national and local governments in OECD countries have partnered with local non-governmental providers on the ground to build up a case management infrastructure. In Estonia, for example, the Government has partnered with local service providers to assign

case co-ordinators to support women in navigating the help-seeking process. In addition to counselling and emergency shelter, *women's support centres* also offer case management services to co-ordinate supports offered by a variety of partner organisations, including public services, through regular meetings. Case workers create a safety plan which includes a schedule of inter-related activities and, importantly, an agreement on the safe exchange of information between parties (OECD QISD-GBV, 2022, see Annex A).

Similarly, in Australia, a national GBV case management scheme exists. Social workers at Services Australia identify family and domestic violence by applying a risk-assessment model. Social workers at Services Australia provide professional casework to people impacted by family and domestic violence, through support and interventions including referral to external support services. Last year, social workers at Services Australia assisted over 100 000 people experiencing family and domestic violence (OECD QISD-GBV, 2022). Women benefitting from the *Keeping Women Safe in their Homes* (KWISITH) initiative in Australia (Chapter 4) also benefit from case management support.

2.2.3. MARACs help ensure communication between relevant providers for the highest risk cases

Results from the OECD QISD-GBV 2022 reveal a relatively common and noteworthy regionally or locally deployed case management initiative: multi-agency risk-assessment conferences (MARACs), or similar case conferences bearing slightly different names (Box 2.3). These meetings are conducted for the most severe cases of GB and bring together relevant police officers, health care workers, public prosecutors, social workers, child welfare providers and case managers, on a regular basis (sometimes weekly), to ensure the long-term safety and continuity of care for clients who are particularly at risk of severe IPV. These are valuable for ensuring that case-relevant information is shared to promote the stability and security victims/survivors most at risk of serious harm and escalated violence.

Such case conferences are reported to exist in countries like Australia, Austria, the United Kingdom (England, Scotland and Wales), Finland and New Zealand, though service delivery arrangements – such as how frequently they meet and how referral pathways work – may vary in different national and local contexts depending on need and resources. In the United Kingdom, the first MARACs were established over 20 years ago, and although the mechanism is not enshrined in law, it has now been adopted in 260 jurisdictions nationwide. The non-governmental organisation SafeLives UK acts as a steward for the initiative, supporting regional and local authorities to establish or improve MARACs according to pre-determined standards and guiding principles that place help-seekers at the centre of service delivery (Jaffré, 2019[48]).

A past evaluation of the MARAC initiative across the United Kingdom suggests that "for every GBP 1 spent on MARACs, at least GBP 6 of public money can be saved annually on direct costs to agencies such as the police and health services," (SafeLives UK, 2010[49]). Respondents to the OECD's non-governmental provider consultation (Chapter 6) also point out the value of case conferences, albeit under the condition that partners are well-co-ordinated and take seriously their input. Indeed, participants can more easily take part in MARACs on equal footing when participants see all contributions, including their own, as equally valuable to the GBV case management (Cleaver et al., 2019[50]; Moylan, Lindhorst and Tajima, 2017[51]; Ekström, 2018[52]; Mundy and Seuffert, 2021[14]). For instance, one respondent to the Consultation thought that cross-sectoral case meetings were extremely helpful, but only if representatives from other sectors had the relevant training and interest. To understand better the conditions under which these conferences work, further evaluations to assess clients' and providers' outcomes should be conducted.

Box 2.3. MARACs: Multi-agency risk assessment conferences show promise

Case conferences in Austria increase co-operation and limit re-victimisation

MARACs were first piloted in two police districts of Vienna in 2011 with the overarching aim of preventing domestic and family violence through improved, co-ordinated responses by service providers. The Viennese MARACs were subdivided into two sections: a section for case-related co-operation, and a section for structural networking. The first group deals with concrete cases of domestic violence by inviting relevant providers from the police, the Youth and Family Office, and the legal sector together with violence intervention centre staff to meet monthly to discuss cases of repeat and severe violence. The second group is a steering committee involving a broader range of agencies, including the 24-Hour Women's Emergency Helpline, the children's protection centre, women's shelters, health organisations, counselling services and probation services. This second group serves as a platform for professional exchange and networking and meets once per year with the aim of preventing DFV at the structural level.

In 2014, additional MARAC pilots were launched in several districts of Tyrol and Lower Austria. These more recent pilots are led by the police and meet monthly or bi-monthly depending on the case load.

In addition to MARACs, informal, ad hoc case conferences (MACCs) have been implemented by local violence protection centres. The participating institutions are the same as with MARACs and vary according to cases' requirements. For example, the Upper Austrian Violence Protection Centre invites the victim (and if necessary an interpreter) to meetings in an effort to promote transparency. In other provinces, violence protection centres invite local public prosecutors and judges in order to improve co-operation and the acceptance of risk assessments.

Evaluations of the pilots have shown promising results by improving the level of inter-institutional co-operation. It was found that the Austrian MARACs prevent further victimisation through co-ordination and joint effort of the organisations involved. A few areas of improvement were identified. Qualifying risk criteria should be standardised to ensure maximal case inclusion and the benefits of MARACs can be promoted within police institutions, to increase police attendance.

Integrated Safety Response in New Zealand de-escalate violence and improve provider collaboration

In 2016, two family violence Integrated Safety Response (ISR) pilots were launched in Christchurch and Waikato. Like MARACs, ISRs are hosted by Police and bring together service providers from Ministry of Children (Oranga Tamariki), the Department of Corrections, the Ministry of Justice, the Ministry of Social Development, the Ministry of Education, District Health Boards, the Accident Compensation Corporation, local specialist family violence non-government organisations and services that emphasise Maori culture and values (kaupapa Māori services). These multi-agency interventions aim to provide immediate safety of victims/survivors and children. The ISRs also work with perpetrators to prevent further violence. ISR locations have weekly Intensive Case Management meetings to discuss new episodes of family violence that have been identified as "high risk" during daily Safety Assessment Meetings, to create a joint response plan, and to follow up on previously identified cases that require continued attention and action.

The ISR is supported by a dedicated electronic case management system that tracks tasks and enables information sharing between service providers. This System is updated during regular case meetings and as agencies complete agreed-upon actions in support of families.

Evaluation of the pilots (2017 and 2019) showed that one-third of included cases had been successfully de-escalated in terms of risk, and two-thirds presented no further episodes of violence. A majority of

service providers reported improved information sharing (90%) and improved collaborative working relationships (88%).

Service provision has been integrated, with 73% of people that had experienced violence, and 50% of people who used violence, received additional services including access to counselling, legal support, parenting programmes, safety programmes, alcohol and drug programmes, and mental and physical health support.

The evaluations recommended increasing coverage of rural areas, improving responses for children and youths, and improving efficiencies in managing increasing number of referrals.

MARACs are mainstreamed nation-wide in the United Kingdom

The first MARAC in the United Kingdom was organised at the grassroots level in 2003 and was eventually mainstreamed nation-wide by the organisation SafeLives, with government support. Nearly 300 MARACs now exist in every district of England and Wales, with increasing presence in Scotland and Northern Ireland.

MARACs are chaired by local police, with the support of a dedicated co-ordinator who receives referrals, drafts meeting agendas and ensures follow-up on agreed courses of action. Independent Domestic Violence Advisers (IDVAs) attend the meetings to advocate for the help-seeking individual. They are joined by members of local police, housing authority, health authority and education and child service authority. They regularly convene – sometimes weekly or bi-weekly – to share relevant information about each case, according to the existing data protection protocols established by SafeLives. Together, MARAC participants write tailored action plans for each of the cases, and the IDVA holds the other agencies to account.

In 2021-22, over 120 000 cases were addressed in the United Kingdom via MARACs; 15.3% of cases involved ethnic minority victims/survivors, 8.5% of cases involved victims/survivors with disability; 6.2% of cases involved a cis-gendered male victim and 1.4% of cases involved victims who identify as LGBTI+.

While these case conferences are meant to address only the most severe cases of domestic and family violence, where individuals may be at risk of serious harm or murder as a result of domestic abuse, this is not always the case in practice. In some places, it is not uncommon for cases that do not meet risk qualification to nonetheless be referred to MARACs as a result of insufficient general services for people experiencing GBV that is not (yet) life-threatening.

Source: (OECD QISD-GBV, 2022, see Annex A); (Amesberger and Haller, 2016[53]; Joint Venture, 2019[54]; New Zealand Police, 2020[55]; SafeLives, 2022[56]; SafeLives, 2022[57]).

2.3. Managing perpetrators is essential to sustain violence-free lives

To achieve holistic and sustainable solutions to IPV, services supporting women escaping violence should also integrate perpetrator responses in parallel. Violent men are often re-offenders who affect the lives of multiple victims/survivors for years. In addition, it is often difficult for women with violent partners to leave their partners completely, especially if they have children together. Working with perpetrators can help prevent further violence and new victimisation.

The immediate response to perpetrators' violence may come from the justice sector, e.g. the police. Compared to other sectors, such as health or housing, the justice sector is particularly well-placed to interact directly with perpetrators of violence to prevent further violence from occurring (Chapter 5). However, the justice sector alone cannot correct perpetrator behaviours, especially when rates of

reporting, prosecution and conviction in the justice system remain low (EIGE, 2019[58]; Garner and Maxwell, 2009[59]).

Perpetrator intervention programmes have sometimes been integrated into broader, integrated systems of accountability and justice, where national standards are developed to consistently hold perpetrators accountable across sectors and systems, including police, courts, corrections, perpetrator offender programs and services, child protection services, community services etc (Australian Government, 2016[60]). The Australian Department of Social Services acknowledges "a strong need for integration and co-ordination between those services and systems directly intervening with perpetrators, those that support women and their children and those that engage with perpetrators on other issues" (Australian Government, 2016[60]).

Yet more can be done to co-ordinate across sectors for sustained change and to target the reasons behind violence. Interventions can be initiated at the point when women seek help to promote enduring behavioural change in perpetrators, even if no civil or criminal charges are pursued. This approach can help find holistic solutions in individual cases and also contribute to a norm change that can help reduce the prevalence of IPV on a broader scale.

Drawing on the well-established example of MARACs in the United Kingdom, some scholars have suggested that MARACs offer a good framework for incorporating and monitoring perpetrator responses. Through this lens, MARACs are not only well-suited to offer protection to women experiencing violence; they can also be critical in preventing further violence through more systematic tracking and engagement of perpetrators (Tapley and Jackson, 2019[61]).

Although the 2022 OECD Questionnaire did not ask explicitly about services targeting perpetrators, a number of countries do offer perpetrator-related programming (Table 2.2) – suggesting that this is a policy area receiving increasing attention across countries. Several countries focus on counselling and behavioural interventions.

Table 2.2. Perpetrator-focused responses in the OECD

Australia	The Men's Referral Service provides national direct telephone and online support for men who are using violent and controlling behaviour. No To Violence, which provide the Men's Referral Service, received additional funding during the onset of COVID-19. In 2021-22, the Men's Referral Service provided support to over 7 000 contacts.
Austria	A number of Counselling Centres for Violence Prevention have been established for help-seeking perpetrators of violence, in addition to related, regional men's counselling centres. Perpetrators of violence are legally obligated to receive counselling where restraining or barring orders are issued. Counselling is required by law for everyone who has been expelled and must be completed for at least 6 hours at a Counselling Centre for Violence Prevention. The Austrian Chancellery also funds 380 "Family Counselling Centres" across the country to address family issues including IPV. Family Counselling Centres are staffed by a multidisciplinary team of social workers, doctors, psychotherapists, and law professionals; and some of the Centres are specialised in working with perpetrators of violence.
France	30 "Centres de prise en charge des auteurs de violences conjugales" (CPCA) were created in 2020-21, offering perpetrators of domestic violence psychological and medical support, as well as socio-professional support aimed at integration into employment.
Ireland	Following the "Second National Strategy on Domestic, Sexual and Gender-based Violence" (2016 – 2021), the Department of Justice and the National Office for the Prevention of Domestic, Sexual and Gender-based Violence (COSC) have partnered with non-governmental organisations to deploy the "CHOICES Program", which offers male perpetrators of violence individual and group counselling sessions with the goal of long-term behavioural change. The Program also offers a parallel, independent women's support service for the partner or ex-partner of the perpetrator, for the duration of the programme implementation, and for three months following his completion of the programme.
New Zealand	In New Zealand, the Ministry of Justice contracts NGOs to deliver safety and non-violence courses and support services to parties to protection orders and their children. In addition, perpetrator intervention programming and specialist staff are part of local Integrated Safety Response.

Note: This table presents a non-exhaustive list of perpetrator interventions in the OECD. OECD QISD-GBV 2022 (Annex A) did not ask about perpetrator intervention programmes and these services were offered spontaneously by responding countries.
Source: OECD QISD-GBV 2022 (Annex A); (Irish Department of Justice, 2022[62]; Ministere Charge de l'Egalite Entre les Femmes et les Hommes, 2022[63]).

There are challenges to implementing perpetrator-focused programmes. When perpetrator interventions are put in place with aims to prevent further violence, it is not always clear how and in what ways perpetrators are to be held accountable (ANROWS, 2020[64]). Investing in domestic violence perpetrator programs, especially when public funds are limited, may also be politically challenging as it may detract from the immediate need of victims/survivors. Even where service providers acknowledge that perpetrators need support to effect behavioural change, there is a concern that offering such services trivialises the violence and its effects on victims/survivors (Bellini et al., 2019[65]).

More evaluations of programmes and best practice can help ensure that funds are used in a way that best supports victims/survivors. The European Network for the Work with Perpetrators of Domestic Violence (WWP) acknowledges a lack of monitoring and evaluation of perpetrator programs, making it difficult to define elements of effective intervention (Pauncz, 2020[66]). In the United Kingdom, a five-year investigation into the effectiveness of perpetrator programmes suggests significant behavioural improvement among participants across all measured outcomes, though the report emphasises that programme completion could actually exacerbate risk "if professionals and the courts consider that the risks are being managed by a programme and so de-escalate the case," (Verney, 2021[67]). In Australia, monitoring and evaluation of perpetrator programmes are fairly advanced, with national standards established in 2015 in an effort improve coherence between victim and perpetrator systems and to direct reform in the area of perpetrator interventions (Box 2.4).

Box 2.4. Setting national standards for perpetrator programmes helps limit further violence

Focussing on perpetrator accountability, the Australian Government established the *National Outcome Standards for Perpetrator Interventions* (NOSPI) in 2015 to act as guiding principles for *targeted perpetrator interventions*, such as limitations on interactions between male perpetrators and the women and children against whom they have used violence, as well as behavioural change initiatives.

The six National Outcome Standards are:

1. Women and their children's safety is the core priority of all perpetrator interventions;
2. Perpetrators get the right interventions at the right time;
3. Perpetrators face justice and legal consequences when they commit violence;
4. Perpetrators participate in programmes and services that change their violent behaviours and attitudes;
5. Perpetrator interventions are driven by credible evidence to continuously improve; and.
6. People working in perpetrator intervention systems are skilled in responding to the dynamics and impacts of domestic, family and sexual violence.

These are supported by a number of tools, including risk assessment frameworks, and a set of outcomes and indicators. After data quality has been assured, the set of indicators should help policy makers quantify results of targeted programming.

The NOSPI create inter-sectoral connections between police and correctional services; courts; perpetrator and offender programs; child protection agencies; and various community services related to mental health, alcohol and other substance use services, housing and homelessness services, employment support, and family-related services for all affected parties. Strategies include improved and increased information sharing between agencies, streamlined referral pathways between sectors, expedited protective orders and case management services for all parties involved in domestic violence incidents.

While the standards were developed at the national level, they create a framework against which state and territory governments can monitor local initiatives to hold perpetrators of violence accountable, and to reduce overall incident of violence, as well as offender recidivism. In Victoria, for example, perpetrator programs are evaluated through over 35 indicators which span domains of *appropriateness, effectiveness,* and *efficiency* and are populated through primary and secondary data collection, notably through personal interviews and a tailored, service provider data collection tool.

Source: (OECD QISD-GBV, 2022, see Annex A); (Australian Department of Social Services, 2016[68]; Deloitte, 2019[69]; Australian Institute of Health and Welfare, 2021[70])).

2.4. When crises emerge, an integrated response helps

By the time a victim/survivor finally reports violence, they are often in a situation that is very risky or unbearable. Integrating crisis and emergency services with the sector that a help-seeker first comes into contact with in a crisis situation, such as police services or the healthcare system, is therefore essential. Crisis response services refer to dedicated resources that exist to respond to IPV-related events as they occur. Crisis response services need to connect to related supports that can be mobilised to ensure continuity of care in aftermath of crisis.

The first point of contact in a violent crisis can be sector-specific or more general. In case of an IPV crisis, the first responders are often sector-specific actors including the police, health care professionals or emergency shelter staff. These sector-specific crisis responses are discussed in the following chapters.

Two more general crisis-response mechanisms exist in all countries however: dedicated telephone helplines and dedicated crisis centres. These services play cornerstone roles in supporting women to seek help if the police or emergency health care services are not directly involved.

2.4.1. Ensure that common helplines operate established referral pathways

Telephone helplines play an important role in making specialised support, advice and services accessible to women affected by all forms of violence (Council of Europe, 2022[16]). Reflecting their important role in service provision, the Istanbul Convention mandates that states set up state-wide telephone helplines available 24 hours, seven days a week, free of charge. These helplines should provide advice to callers, confidentially or with due regard for their anonymity, in relation to all forms of violence covered by the Convention" (Council of Europe, 2011[36]). Several countries have set up helplines to assist victims/survivors of violence. Recently, the EU also set up a common helpline to support victims/survivors of GBV, as announced in November 2022 (European Commission, 2022[71]).

Telephone helplines should aim to connect those affected by violence with trained professionals to ensure easy and confidential access to information and counselling in all relevant languages. Some countries have taken special measures to ensure that the helplines are accessible to all people.

The 016 helpline in Spain, launched in 2007, provides advice in cases of all kinds of violence against women in 53 languages. It is accessible to callers with disability, using visual interpretation services, textphone and an on-line chat function (Government of Spain, 2019[72]; Council of Europe, 2022[16]; Ministry of Equality, 2023[73]). Austria makes use of interpreters to overcome language barriers and ensure that callers still access advice from expert social workers (Lobnikar, Vogt and Kersten, 2021[74]).

It is important that the helpline number is widely advertised to the public and that professionals are able to refer callers to face-to-face services (Council of Europe, 2022[16]). For instance, the Swedish national telephone helpline on violence against women (Kvinnofridslinjen) can be one model of practice. The

helpline addresses all forms of violence against women and more than half of women in Sweden knows that the helpline exists. Well-trained and experienced social workers and nurses are able to refer callers to locally-available specialist support services (Council of Europe, 2022[16]).

The helplines are often delivered with support from non-governmental providers. For instance, the government in Denmark funds the national non-governmental organisation Lev Uden Vold (Live without Violence) to provide more and better assistance to people affected by all forms of domestic violence and rape, including intimate partner violence. As part of its work, the unit operates the Danish national helpline. The helpline is open 24 hours a day, 7 days a week and accepts calls from victims and perpetrators of violence, their relatives and professionals seeking assistance and advice (OECD QISD-GBV, 2022).

It is encouraging to see that several countries have set up national helplines in recent years as a response to the Istanbul Convention entering into force, including Albania, Finland, Monaco, Montenegro, and Serbia (Council of Europe, 2022[16]). Japan has also extended their domestic violence counselling helplines to 24 hours a day, 7 days a week, and also incorporated text messaging services and email consultations (UN Women, 2020[75]).

2.4.2. Digital tools became more common during the COVID-19 crisis

During the COVID-19 pandemic, many countries responded to confinement policy measures by introducing innovative solutions to traditional help-seeking resources. During confinement it was difficult for many women experiencing abuse to call a helpline while trapped at home with their abuser. Many helpline services therefore established internet-based lines of communication, including via e-mail and through web- or application-based chat services (OECD QISD-GBV, 2022); (UN Women, 2020[75]). Many helpline services therefore established internet-based lines of communication, including via e-mail and through web- or application-based chat services (OECD QISD-GBV, 2022); (UN Women, 2020[75]).

For instance, victims/survivors of violence in Madrid can now access an instant messaging service that offers psychological support, and across Spain, one helpline-style initiative combines crisis and case management services by using technology to connect emergency support workers, case workers and qualifying women experiencing IPV in real time (Box 2.5).

Spain is not alone in having used technology to better reach women in need of support: many of the respondents to the OECD Questionnaire were able to provide further examples of how the COVID-19 pandemic had prompted them to come up with innovative ways of providing support and services (Table 2.4). In Lithuania, for example, technology providers have developed an algorithm that can detect and identify victims/survivors and refer them to support services (UN Women, 2020[75]).

The private sector, too, has teamed up with government to respond to IPV-related crisis. Vodafone, for example, developed an app that is now in use in at least 11 countries that enables women to local support during a crisis and access other local resources (Box 2.5).

Box 2.5. Using technology in new ways during the pandemic

Crisis and case management service for women experiencing IPV and GBV in Spain

Since 2005, the *Servicio telefónico de atención y protección para víctimas de violencia de género* (ATENPRO) has provided 24/7 crisis and case management services to women experiencing intimate-partner violence. Financial support from the Recovery, Transformation and Resilience Plan Funds will help update ATENPRO devices and extend the service beyond IPV to include all forms of violence against women.

ATENPRO is a service available by request or referral, and requires users to meet two conditions:

- they must no longer be cohabitating with perpetrators;
- they must participate in a special care programme offered in their autonomous region.

Service users are equipped with a mobile device which acts as a direct line to support workers nearby. Whenever necessary, service users can contact the help-centre staff, who either guide them or mobilise the necessary resources to care for and protect them. In some cases, electronic devices may also be imposed on perpetrators of violence to ensure compliance with active judicial measures.

ATENPRO seeks to achieve three main objectives. First, it provides users with a sense of security and peace of mind by offering information, advice and a guaranteed line of communication at all times. Second, it creates a social network of support within users' known environment, including non-aggressive family and friends, which can help boost users' self-esteem and improve their quality of life. Third, it actively monitors users' situations through regular contact via the mobile application. It is also inclusive, in that the mobile nature of the service can improve access for women living in rural and remote communities, elderly women and women with disability. It also helps ensure that the care response is continuous.

ATENPRO is delivered by the Ministry of Equality through annual collaboration agreements with the Spanish Federation of Municipalities and Provinces. In 2022, more than 17 000 users used the service across regions. In November 2021, the Minister of Equality announced that the service will be extended to cover all forms of GBV against women – including sexual exploitation and trafficking – by 2023. The Ministry estimates that this marked increase in service coverage will extend protection to 50 000 women – around three times the current uptake level.

Additionally, since 2009, a remote monitoring system – *el Sistema de Seguimiento por Medios Telemáticos de las Medidas y Penas de Alejamiento en el ámbito de la Violencia de Género* – has attempted to monitor the movements of perpetrators. In situations where the court system has limited perpetrator's movements, this system makes it possible to monitor perpetrator's compliance with precautionary measures and restraining orders that prohibit proximity to the victim/survivor.

The monitoring system consists of two essential elements: devices for the victim/survivor and the perpetrator, as well as the services from a control centre (*Cometa*). The devices are GPS-controlled in order to prevent perpetrators from approaching victim/survivors in sensitive locations such as their home, children's school, supermarket, workplace or gym. Victims' devices have a panic button in case of emergency. *Cometa* is responsible for installing, maintaining and removing the devices. They also handle all events that the devices indicate on a 24/7 basis.

The main purpose of the monitoring system is to increase the safety and protection of victims of IPV. It provides permanently-updated information about issues that affect compliance or non-compliance of precautionary measures or sentences, or any possible (accidental or deliberate) incidents in the operation of the equipment used.

Remarkably, there have been zero cases of femicide against the women protected within the *Cometa* system since its introduction in 2009.

Vodafone Foundation apps against abuse provide information, support and services

The Vodafone Foundation provides a good example of how technology can be used to help connect victims/survivors of GBV with services. The Foundation has a portfolio of apps available free of charge in many countries, including in 8 OECD countries. The apps offer a range of services, support and advice available directly on smart phones.

One of the larger platforms, BrightSky, launched in the United Kingdom in 2018, has since been made available in 10 countries. For those with immediate need for help, the app helps users to locate their nearest domestic violence support centre. It also contributes to awareness-raising by providing information that enables users to assess the safety of a relationship, find out about different forms of abuse and how to help a friend that may be affected. The Foundation has teamed with postal workers in the Czech Republic so that postal workers who have received training about how to recognise signs of abuse also have been encouraged to recommend the app to women who are affected (Chapter 6).

Source: For Spain: (OECD QISD-GBV, 2022) (Government Office against Gender-based Violence, 2022[76]; Council of Ministers, 2021[77]; Minisitry of Equality, 2021[78]; Ministry of Equality, 2015[79]) and for Vodafone: (PostEurop, 2020[80]; Vodafone, 2022[81]; Ministry of Equality, 2023[82]).

Table 2.3. The COVID-19 pandemic confinement policies prompted more and new service delivery

Help-line related policy measures that supported victims/survivors during COVID-19 confinement periods

Belgium	Since the start of the COVID-19 crisis and confinement, the Brussels line has received three times the number of calls as pre-COVID-19. The listening ranges have been extended from 20 to 30 hours of listening per day and the chat has also been extended from 2 to 10 hours per day.
Chile	SernamEG's services were provided differently to meet the needs of beneficiaries during COVID-19. Silent communication channels were incorporated as alternatives for women in a situation of confinement, the Web Chat 1455 and WhatsApp +56997007000, as confidential, private and secure guidance tools, operating 24 hours a day and attended by specialists in communication on support protocol. In the case of the improvements made to the 1455 helpline, in particular the silent channels, Web Chat and WhatsApp, these were financed in 2020 by Facebook for a period of 3 months. After this period, the resources were reallocated from SernamEG's budget.
Finland	Additional funding was allocated to Nollalinja for opening a chat service in 2021-22, although future funding of the service has not been confirmed.
Germany	The project "Helpsystem 2.0" supports women's shelters and specialist support services with the professional handling of the digital challenges of the COVID-19 pandemic. The core of the project is improving technical equipment, the necessary digital qualification of staff and the professional translation of support for women and girls affected by violence.
Israel	New tools were developed, including a) so-called "quiet lines", which are secret referrals or inquiries by designated SMS messages; b) technological platforms; and c) increased accessibility to services, including phone lines computer-based communication and social media applications is being developed.
Portugal	New means of communication and distanced assistance were developed and reinforced. These include video call, SMS, Messenger, WhatsApp and email. The telephone service was also reinforced, while keeping in place face-to-face assistance in urgent situations, with rotating teams.
Türkiye	Helpline service started being offered through WhatsApp and BİP applications.

Note: This table presents a non-exhaustive list of measures that supported victims/survivors during COVID-19 confinement periods.
Source: OECD QISD-GBV 2022 (Annex A).

2.4.3. Crisis centres provide services to help those in the most urgent situations

Physical crisis centres can be effective to help victims/survivors when they need most urgent help. Despite efforts to support early intervention and effective service provision to prevent women from becoming

seriously injured, there are still many who are not able to report their perpetrator before they end up in critical situations and require urgent assistance. This is reflected in the Istanbul Convention, where specialised sexual violence crisis centres that provide medical and forensic examinations, trauma support and counselling (Council of Europe, 2011[36]). In line with the Convention, many member countries have in place dedicated crisis centres, both for sexual violence and for GBV that is not necessarily sexual (Table 2.4).

Hungary's response to QISD-GBV 2022 (Annex A) illuminates the necessary continuum of support from prevention to crisis response. Hungary offers a national network of 20 crisis centres, 8 secret shelters, 22 halfway houses and 7 crisis management clinics. Of the crisis management clinics, "the priority for victim support is to provide assistance as soon as possible, *in order to resolve problems before they escalate into violence* and to prevent the need to flee home if problems that indicate or lead to domestic violence develop" (emphasis added). In these facilities, legal, psychological and social work support is also available. At the same time, the crisis centres, shelters and halfway houses offer an important source of cross-sector care when violence does occur.

Table 2.4. OECD countries report that they operate at least some dedicated crisis centres

Examples of national-level, multidisciplinary GBV crisis support centres, including sexual violence centres

Finland	Seri Support Centres are accessible 24/7 to individuals of any gender identification aged 16 and older who have experienced sexual violence occurring less than one month from their visit. Services include crisis care and support, forensic medical examinations, access to psychologists and social workers, medications, vaccinations or emergency contraception, treatment follow-up plans and a referral service to psychiatrists and third sector or municipal officials. Services are offered without necessarily having to make a police report. The first Seri Support Centre was established in 2017 in Helsinki; there are now 21 SERI Support Centres in Finland, and three more centres are planned to be established by end of 2023
Hungary	Complex services are provided by 20 crisis centres, 8 secret shelters, 22 halfway houses and 7 crisis management clinics. These services include sheltered accommodation and full physical care as needed, assistance from professionals (lawyer, psychological counsellor, social worker), and assistance through social work tools. This can include finding a safe housing solution, assistance in solving life management problems, identifying and managing sources of income, identifying external family contacts, strengthening parenting roles, psychological counselling, referral to health care services, providing community programmes, legal as well as childcare advice. These services are often provided by NGOs but are publicly funded and involve the participation of different Ministries.
Israel	A nationally funded domestic violence emergency centre (the "Aluma Centre") was recently opened to act as a 24/7 "emergency room for domestic violence". The Centre provides interdisciplinary support to women and their children, including access to specially trained police officers, mental health specialists for adults and children, mediation services, legal experts and a network of relevant community-based service providers. The Centre is also equipped with dormitories to provide temporary emergency shelter. In addition, the Welfare Ministry established 165 regional domestic violence centres, 59 of which are dedicated to the Arab sector, and four of which serve the ultra-Orthodox sector.
Japan	"One-stop Support Centres for Victims of Sexual Crimes and Sexual Violence" exist in every prefecture and offer immediate medical assistance, psychological support and legal support.
Korea	One-stop centres known as "Sunflower Centres" have been established within 32 metropolitan hospitals to respond to adult-survivors of violence, including sexual violence, and their families. Sunflower Centres offer psychological and legal counselling, in addition to medical support, including forensic medical services in the wake of sexual violence. Regionally operated "1366 Hotline Centres" offer 24/7 support to women experiencing domestic or sexual violence in 18 cities, the first of which was established in 2001. The Centres collaborate with other counselling centres, shelters and Sunflower centres to provide multidisciplinary support to help-seeking women through referrals.
Latvia	The central government funds, in part, the Marta Centre, which provides women experiencing violence with access to a social worker, legal advisor, and psychologist. The social worker also acts as a case manager to facilitate help-seeking.
The Netherlands	There are 16 Centres for Sexual Violence (CSG) offer 24/7 access to doctors, nurses, psychologists, social workers and sexologists.
Slovenia	The Ministry of Labour, Family, Social Affairs and Equal Opportunities funds, in whole, two crisis centres for women and their children. The Centres provide an integrated, multidisciplinary approach in the prevention of domestic violence, and includes accommodation for up to 3 weeks which can be extended for an additional 3 weeks. After this period of emergency accommodation, they have the option of moving to NGO-operated safe houses for up to one year.

Spain	Since 2020 there are two crisis centres in Spain: one in Asturias and one in Madrid. The Government Office against GBV is currently working to establish a crisis centre in each Spanish province, and in the autonomous cities of Ceuta and Melilla. It will establish 52 centres by December 2023 using financial support from the Recovery, Transformation and Resilience Plan Funds. In addition, Crime Victim Support Offices provide a public service of integrated support and care in legal, psychological and social aspects for victims of crime. Support for victims is offered in four stages: shelter advice, information, intervention (in legal matters, in psychological matters and social aspects) and supervision.
Türkiye	The Ministry of Family and Social Services oversees 81 nation-wide "Violence Prevention and Monitoring Centres" (VPMCs) which provide psychosocial, legal, health-related, educational and vocational support, in addition to counselling services and police liaison officers on site. The Centre staff is employed by the ministry, and specific services are staffed through inter-ministerial and inter-governmental agreements, whereby interdisciplinary staff are paid by their own institution. For example, the police liaison officer is paid a salary through the Provincial Security General Directorate; the expert who comes to the VPMCs on certain days of the week to provide vocational consultation works at the Provincial Directorate of Labour and Employment Agency.
United Kingdom	The Secretary of State for Health commissions 47 sexual assault referral centres (SARCs), which provide an integrated response to sexual violence and rape, irrespective of age, gender or when the assault or abuse occurred. Services include comprehensive forensic medical examination; follow up services which address the client's medical, psychosocial and ongoing needs; and direct access or referral to an Independent Sexual Violence Adviser (ISVA) who supports help-seekers by way of case management services.

Note: This table presents a non-exhaustive list of ISD practices related to crisis support in the OECD for survivors of violence. Additional comments incorporated following OECD members' review.
Source: OECD QISD-GBV 2022 (Annex A); (Consejo de Ministros, 2021[83]; Government of Spain, 2019[72]).

Similar to other forms of social service provision, it is difficult for countries to achieve equitable geographic coverage to support victims/survivors, especially in rural areas. This is true even in countries with relatively strong policy commitments to crisis centres. For example, a recent report by the Pauktuutit Inuit Women of Canada assesses the shelter and resource needs of women living in the remote northern communities of Canada. Their data suggests that "90 to 150 beds are available across Inuit Nunangat for an estimated population of 15 850 Inuit women, resulting in a maximum average of one bed per 106 women" (Pauktuutit, 2019[84]). And in the most remote communities without shelters, housing support is even more difficult to come by for help-seeking women. They also highlight the comparatively higher cost of travel (both in money and time) to and from services as a unique barrier to help-seeking for women living in rural and remote communities.

Similarly, although Finland has shown a serious commitment to mainstreaming the issue of GBV through the creation of a national network of crisis centres, the sparse population density in the north of Finland means that service provision at accessible distances is difficult to implement. The Seri Support Centres for Victims of Sexual Violence that Finland first launched in 2017 and subsequently rolled out across the country have achieved good coverage in the south of the country, where those living in major cities and towns are able to access a Centre in or under around an hour by car. While there are some gaps in coverage in the centre of the country, many women living in the north lack access to Centres. Indeed, victims/survivors of IPV in the northern parts of the country may have to travel for a significantly longer time to reach one of the two centres in the north of Finland, Rovaniemi and Ivalo (Figure 2.2) (Finnish Institute for Health and Welfare, 2022[85]).

Figure 2.2. Seri Centres are typically close by in the south, but northern inhabitants must travel far

Seri Support Centres for Victims of Sexual Violence in Finland, 2022

Source: (Finnish Institute for Health and Welfare, 2022[85]), Seri Support Centre for Victims of Sexual Violence, www.thl.fi/seri.

In Italy, where a network of *anti-violence centres* has been established across the country to provide multi-disciplinary support for women escaping violence, the distribution and accessibility of services appears to be a function of population density. The number of anti-violence centres totals 350 across Italy and ranges from 55 to one across regions, suggesting that even with this robust framework in place, women living outside of urban centres are left more vulnerable (Greppi, 2022[86]). This is a common problem in all forms of social service provision, and it highlights the need for countries to continue to invest in both physical and (remote) digital tools to support women experiencing IPV (Greppi, 2022[86]).

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Notes

[1] The European Union Agency for Fundamental Rights (FRA) 2012 survey on violence against women reports the proportion reporting that they did not contact the police following the most serious incident of partner violence because they "did not think the police could do anything", they "did not think the police would do anything", or they "would not be believed", among women who report having been the victim of at least one serious incident of physical and/or sexual violence by a partner since the age of 15 and who say they did not contact the police about the most serious such incident.

3 Integrated service delivery to support victims/survivors' physical and mental health

Intimate partner violence (IPV) has long been characterised as a health crisis. As it is a common point of entry to social services for victims/survivors, the health sector offers meaningful opportunities to mainstream and integrate responses to IPV. This chapter explores how OECD countries have used integrated service delivery (ISD) based in health care to support women affected by IPV. It examines integrated responses in hospital and outpatient settings, as well as targeted mental health initiatives. While most health care systems in the OECD use referral protocols to link victims/survivors with specialised services, governments must ensure that sufficient specialised services exist and are better linked to meet victims/survivors' needs.

Key findings of this chapter

The health care sector is a common point of entry to social services for women experiencing gender-based violence (GBV), or more narrowly, intimate partner violence (IPV) – the focus of this report. Women affected by IPV often seek help from health care providers to address the physical or psychological consequences of their abuse, and in many ways the health sector is historically the most advanced in terms of offering an integrated, multisectoral response for victims/survivors.

- Screening for IPV in health care settings is a helpful way to encourage women who experience violence to come forward, and it offers an opportunity to ensure that appropriate supports are provided.
- While there is already evidence that health care facilities are central hubs for cross-sector co-operation, co-location and referral pathways, more can be done to strengthen their central role in co-operation – for instance, through more training for staff.
- OECD member countries frequently report initiating integrated service delivery (ISD) out of hospitals, either based on co-location or referrals to local partners. These often play a dual role in that they help respond to crises in the immediate aftermath of violence and provide the infrastructure for longer-term health resources.
- Victims/survivors of IPV often experience deep and long-term effects on their mental health, so mental-health services are crucial in helping women exposed to violence. Many OECD members have made integrated service delivery in the form of multidisciplinary counselling centres, often co-ordinated at the national level, that help ensure that victims/survivors receive holistic support.

3.1. The health sector frequently encounters women experiencing IPV

The health sector is one of the most common points of entry to public services for help-seeking women affected by gender-based violence (GBV), and more specifically, intimate partner violence (IPV), the focus of this report. Most women access medical care at some point in their lives, and women experiencing IPV, in particular, are more likely to need repeated health care interventions than women who are not abused by their partner (Dillon et al., 2013[1]; Garcia-Moreno and Amin, 2019[2]; World Health Organization, 2009[3]). The health sector is therefore uniquely placed to offer safe and confidential spaces for women to receive support (World Health Organization, 2009[3]).

IPV presents numerous threats to women's health (Box 3.1). Physical injuries can vary from superficial bruising to injuries that can require long-term rehabilitation, interrupt daily routines such as work attendance and social engagements, or leave women disfigured. Physical violence has also been shown to have (often undocumented) cognitive and neuropsychological consequences as a result of traumatic brain injuries caused by blows to the head (Valera et al., 2019[4]). Other physical health consequences include sexual and reproductive health issues in the wake of forced sexual activity, such as sexually transmitted infections, unintended pregnancies, and pregnancy complications (Oram et al., 2022[5]).

IPV can also severely affect women's mental health and well-being. Mental health issues – such as depression, anxiety, post-traumatic stress disorder and suicidal ideation – frequently co-occur alongside physical injuries, especially when these are inflicted by a known and (formerly) trusted individual like an intimate partner. IPV can and does also directly affect women's mental health and well-being even in the absence of physical abuse/injury. Psychological and emotional abuse is also often directly deployed by

perpetrators in an effort to control their partners (Oram et al., 2022[5]). Emotional and psychological abuse and coercive control can then in turn significantly impact mental health and well-being, with knock-on effects on physical health, social and economic participation, income.

Box 3.1. Substance use coercion complicates escape from a violent partner – and complicates treatment by service providers

The United States Department of Health and Human Services has elevated an important challenge that can accompany intimate partner violence: substance use coercion. Substance use coercion occurs "when perpetrators of intimate partner violence undermine and control their partners through substance-use related tactics and actively keep them from meeting treatment and recovery goals". Abusers who carry out substance use coercion may force or pressure their partner to use drugs, for instance, or sabotage recovery efforts. A survey of callers to the US National Domestic Violence Hotline found that at least four out of ten respondents had experienced some form of substance use coercion: a partner pressuring them to use substances, a partner threatening to report their substance use to the authorities, or the victim/survivor's fear of calling the police because of their substance use (ibid).

Health care services are an important consideration in cases of substance use coercion by abusers. In addition to the potential physical and mental health consequences of substance abuse for the user, coercive substance abuse can also limit victims/survivors' ability to engage with health services and treatment. In addition to the direct health-related impacts, substance use coercion can prevent victims/survivors from retaining custody of their children and becoming economically self-sufficient. These compounding issues heighten the importance of an integrated, holistic service delivery response.

Source: (HHS Family and Youth Services Bureau, 2020[6]; Warshaw et al., 2020[7]).

3.2. Tools for detecting IPV should join up with a system of referrals in health

A major challenge to ending IPV is that much of the violence takes place in private. Although women experiencing IPV access health services more frequently than non-abused women, they may not be forthcoming about disclosing abuse (for more on barriers to disclosure, see Chapter 2). This greatly complicates the process of identifying and treating victims/survivors of IPV.

Health care professionals are well-placed to screen their clients for IPV. There is an ongoing debate about the benefits of two different approaches: *universal screening* versus *routine enquiry* for IPV among patients entering health services. Routine enquiry seeks to identify IPV through routine wellness questions, whereas universal screening entails an official and typically standardised screening tool[1].

It has been argued that universal screening should be implemented particularly in settings that both perpetrators and victims/survivors come into contact with, such as family and couples therapy and nurse-midwives (Todahl and Walters, 2011[8]; Paterno and Draughon, 2016[9]). For instance, at the first prenatal check-up appointment for pregnant women in Chile, women are screened using the abbreviated psychosocial risk scale (EPsA) (OECD QISD-GBV, 2022, see Annex A). The WHO recommends the routine enquiry approach, but a recent survey of country policies finds that only about one-quarter of countries regularly apply this approach in their health care systems. Around 10% of countries apply universal screening, while the rest do not have a standard approach to identifying IPV (World Health Organization, 2021[10]).

Although both methods of screening can be effective in increasing identification of women experiencing IPV, studies are inconclusive as to whether they substantively improve health outcomes following

identification by health care practitioners. This is due, at least in part, to a dearth of measured outcomes, post-screening follow-up and programme evaluation. Currently, *rates of referral* act as the primary measurable outcome of screening in research studies, as opposed to whether or not referrals are successful in securing *safety* for help-seeking women (Sprague et al., 2016[11]; World Health Organization, 2013[12]).

As a minimum standard, the WHO highlights the need for a standardised operating procedure to ensure first-line support for women who do disclose violence. In addition to an official protocol, first-line support through health services should include training for health professionals to learn how to ask about and discern IPV, with particular emphasis on being able to do so in a private setting that ensures confidentiality (World Health Organization, 2013[12]). The WHO highlights the importance of effective responses when IPV is revealed, otherwise women may find repeated enquiry difficult, particularly if no action is taken (World Health Organization, 2013[12]).

Screening is most fruitful when support services can be offered after the disclosure of violence. Good ways of establishing channels of communication regarding IPV cases include cross-agency partnering, set referral pathways, and co-location. However, a recent literature review of studies evaluating screening processes found that out only a minority of those screened who had experienced IPV were referred to follow-up psycho-social services. According to the review, part of the issue is that a lack of referral services undermines the effectiveness of screening processes in obtaining positive outcomes in health care, notably due to insufficient cross-sectoral collaborations with IPV-service advocates (Miller et al., 2021[13]). Simply put, providers had few places to send women who revealed abuse and needed support outside of the immediate health care environment.

More evaluations will be helpful to determine how best to implement screening tools, and how other services, referral pathways and training can be joined-up to provide immediate support for those who disclose. Future research could focus on measuring different outcomes, and especially longer-term results.

Some countries have prioritised strengthening health systems' capacity to respond to IPV through the national health care system. For example, Spain has published national guidelines aimed at healthcare practitioners to help them actively look out for warning signs of IPV, confirm suspected cases, and when detected, to determine their nature and severity (Escribá Agüir et al., 2009[14]). Similarly, in the United Kingdom, national-level guidance has been issued on how the National Health Service (NHS) can respond to violence against women and children (Taskforce on the Health Aspects of Violence Against Women and Children, 2010[15]; Department of Health, 2017[16]). This has included official guidance to support health care professionals following disclosures of IPV. It notes the importance of risk assessments and referring women to related health professionals or external resources like multi-agency risk assessment conferences known as "MARACs" (Chapter 2) (Department of Health, 2017[16]). The United Kingdom also provides a so-called "Quality Standard" to help improve the quality of care for services related to domestic violence and abuse (National Institute for Healthcare Excellence, 2016[17]; Macdonald, 2021[18]). Of course, these kinds of national guidelines are most useful when accompanied with the necessary funding to ensure that providers can in fact act upon the guidelines.

Strategic planning for IPV responses in health care settings have also been observed at the subnational level. For example, in New South Wales, Australia, the recent strategy (2021-26) for preventing and responding to domestic violence also outlines six *strategic directions* including improving identification protocols to enhance early interventions and providing integrated responses for people experiencing domestic violence (NSW Health, 2021[19]).

3.3. Developing integrated responses to IPV via health systems

Health care offers governments a significant opportunity to form policy recommendations and delineate minimum services to respond to IPV. Indeed, the World Health Organization has encouraged policy makers to strengthen health systems in promoting a multi-sectoral response to violence against women since 2009. In 2014, a resolution was put forward calling on countries to integrate GBV-specific responses better within the health care system, including through standardised procedures for the identification and referral of GBV cases (World Health Organization, 2014[20]).

In light of the relatively frequent contact between health care professionals and women experiencing IPV, the sector has in many ways been more advanced, historically, than other sectors in integrating targeted service delivery. Indeed, in a 2021 review, the WHO found that 81% of countries have multi-sectoral policies that aim to prevent and/or respond to violence against women. The health sector is most frequently involved in multi-sectoral policies: out of surveyed countries with multi-sectoral policies to address violence against women, 86% include the health sector, while only 61% include the police (World Health Organization, 2021[10]).

3.3.1. Integrated service delivery in health care settings can take a variety of forms

There is a variety of definitions of how integrated service delivery takes shape in the health care sector. One literature review on the definitions identified over 150 overlapping definitions of integrated care (Armitage et al., 2009[21]). Variation in definitions and mechanisms hampers the comparability of integrated care initiatives across countries and its expected outcomes. Terms such as integrated care, co-ordination of care, continuing care, care pathway and seamless care are used interchangeably, while different views are reflected in these definitions, including those from patients, providers and policy makers.

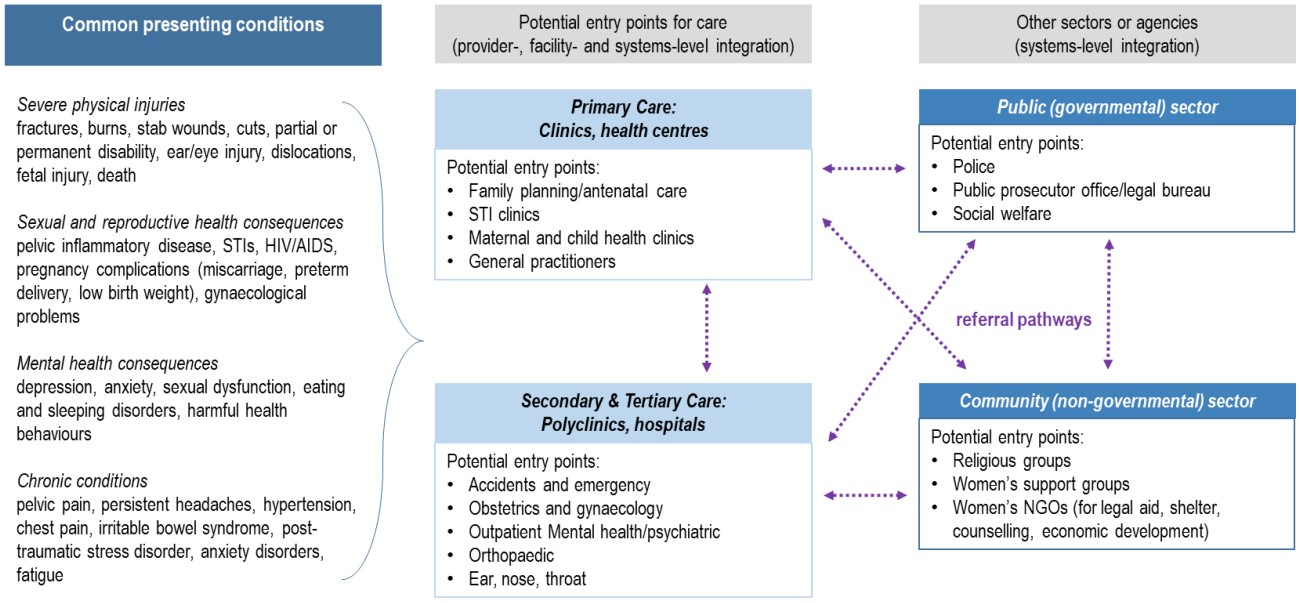
The literature often refers to some broad considerations when conceptualising common models of service delivery. First, it is valuable to note the breadth of services available, ranging from offering a package of preventive health interventions, acute crisis response and post-crisis continuity of care. Second, models of integration will be characterised by the time-span of the continuity of care, since integration can be oriented towards a specific episode of care (e.g. postnatal follow-up), stages in a person's life cycle (e.g. maternity) or adopting a life-course approach. Third, the intensity of integration is relevant, and range from partial integration, with non-binding linkages or ties between two sectors, to full integration, involving process of integrating health and social sectors into a new organisational model (Barrenho et al., 2022[22]).

This chapter considers three common models of service delivery are common to facilitate integrated responses to IPV against women through an entry point in the health care secto (Colombini, Mayhew and Watts, 2008[23]):

- **Provider integrated**: The same provider offers several services during the one single consultation. For example, "a nurse in accident and emergency is trained and resourced to screen for domestic violence, treat her client's injury, provide counselling and refer her to external sources of legal advice".
- **Facility integrated (co-located)**: All services are available in one facility, though are not delivered by a sole provider. For example, "a nurse in accident and emergency may be able to treat a woman's injury, but may not be able to counsel a woman who discloses domestic violence, and may need instead to refer the woman to the hospital medical social worker for counselling." This is in line with the "co-located delivery" model discussed in Chapter 1.
- **Systems-level integrated (referral pathways)**: A coherent referral system exists between facilities in different locations. For example, "a family-planning client who discloses violence can be referred to a different facility (possibly at a different level) for counselling and treatment".

Systems-level integrated service delivery to treat IPV in health care settings is often based on case management, MARACs, or referrals (Chapter 2). Figure 3.1. illustrates how a woman with physical or mental-health care needs brought about by experiences of IPV could present herself at a primary care doctor, clinic, or hospital and then be referred to resources in the social and justice sectors – or vice versa. Alternatively, a woman could be introduced to a case manager who helps her navigate this system. Where case-relevant information can be shared along with a referral or by the case manager, support might be more efficiently provided (see Chapters 1 and 6 for more).

Figure 3.1. Example of a GBV referral network in health care



Source: Adapted from original model in Colombini, Mayhew and Watts (2008, p. 639[23]), "Health-sector responses to intimate partner violence in low- and middle-income settings: a review of current models, challenges and opportunities", https://doi.org/10.2471/BLT.07.045906.

3.3.2. Lack of training can hamper responses by health care providers

Time and resource constraints, especially where health services are overstretched, limit the capacity to respond effectively to disclosures of violence (World Health Organization, 2013[12]). Inadequate funding, in particular, is a commonly-cited challenge across government and non-government providers (Chapter 6). Reliable and adequate funding for everyone involved is crucial to allow different agencies to build relationships and referral pathways.

Lack of implementation guidance and training have also been cited as hindering integration of IPV and health care services. Article 15 of the Istanbul Convention suggests that parties provide or strengthen training initiatives across sectors for relevant professionals dealing with victims/survivors of GBV. This includes training on issues such as gender equality and mutual respect, as well as co-ordinated multi-agency co-operation (Council of Europe, 2022[24]). For example, in a recent cross-national review of IPV-specific support services, GREVIO – the monitoring arm of the Istanbul Convention – highlights the introduction of graduate programmes dedicated to studying violence against women in Spain, as well as the introduction of men's violence against women as a compulsory subject for university students in Sweden (Council of Europe, 2022[24]).

While the obligation to provide training around IPV is crucially important for the health sector, in particular, countries have not always managed to implement this successfully. In 2017, a survey of 24 of the UK's 34 medical schools showed that 21 institutions delivered some education around domestic violence.

However, 15 of these schools providing some training still felt the training was inadequate, and 11 of the schools providing some training reported that their contact hours on the topic were two hours or less over the five-year course (Potter and Feder, 2018[25]).

One potentially promising approach is to embed IPV experts from community organisations or other sectors within existing health care institutions. This was the strategy used in the successful Themis and Pathfinder pilots carried out in the United Kingdom (Box 3.2). Since these efforts often target victims/survivors in relatively severe situations, it should be noted that such initiatives should be combined with preventative strategies and provisions for early intervention, as discussed in Chapter 2.

Box 3.2. Piloting Independent Domestic Violence Advisors (IDVA) throughout the UK health sector

On the ground, a series of promising pilots in England appointed Independent Domestic Violence Advisers (IDVAs) across National Health Service sites to act as case managers for women experiencing IPV. Since the pilots ended in 2020, IDVAs have remained co-located in some sites, and have even emerged in hospitals not originally included in the pilots. Importantly, Pathfinder is one of the few ISD initiatives for which academics have carried out impact analyses. Studies of the Pathfinder Project find that self-reported well-being improved among users who had gone through the programme – users who may not have been identified at all, had the programme not been deployed (Chapter 1). The model was since adopted as a best practice, and a toolkit was developed to support health leaders in delivering the model, though it is unclear how much progress has been made since 2020 given that its implementation does not appear to be mandatory.

Themis pilot, 2012-15

In collaboration with SafeLives, a national charity whose mission is to end domestic violence, the UK Government launched *Themis*, a pilot project which co-located IDVAs in select hospital emergency and maternity wards. The role of IDVAs was multidimensional:

1. provide training to health care workers to better identify cases of GBV;
2. provide immediate support to survivors in the form of safety planning;
3. provide in-hospital referrals, for example, to mental health practitioners;
4. provide off-site referrals, for example to emergency housing, substance use counselling, social workers and police.

Service uptake increased annually throughout the pilot, which delivered services to cis-gendered women and men, as well as to the LGBTI+ community.

Pathfinder pilot, 2017-20

With the help of a Consortium of non-governmental partners, the Pathfinder Project also saw the co-location of IDVAs at eight other hospital sites between 2017 and 2020. Over the course of three years, 633 individuals took up domestic abuse services after referral from health care under the Pathfinder project, including some who might otherwise have gone unassisted. According to the technical report conducted by Melendez-Torres and colleagues for SafeLives on the outcomes of the pilot, Health Pathfinder sites had an average quarter-on-quarter increase in referrals of around 10% in each quarter.

With Pathfinder, IDVAs also participated in weekly multi-agency risk assessment conferences (MARACs) held at the local police station prior to the COVID-19 pandemic, moving to daily remote (telephone) meetings during lockdowns. Survey evidence from 2019-20 published by the Consortium

indicate that self-reported well-being had increased for users exiting services, with 91% reporting *feeling safer* and 95% reporting *improved well-being.* Respondents also report that the abuse was reduced or stopped in many cases, especially when the abuse was physical.

Source: (OECD QISD-GBV, 2022); (Dheensa et al., 2020[26]; SafeLives, 2020[27]; Halliwell et al., 2019[28]; Melendez-Torres et al., 2021[29]; IRISi, 2020[30]; Elvey, Mason and Whittaker, 2022[31]; SafeLives, 2016[32])

3.4. Hospitals are important sites for an integrated policy response

Medical practitioners in a variety of settings are well-placed to assist individuals experiencing IPV. Alongside efforts to promote early identification and support, health care providers play a critical role in providing physical and mental health support related to experiences of IPV, and hospitals are often a victim/survivor's first stop in the wake of a violent crisis. Assistance can also be provided during unrelated or routine visits to medical practitioners. This was especially true during COVID-19, when social-distancing rules limited the number of people allowed to accompany a help-seeking individual in waiting and consultation rooms – thereby increasing women's privacy during medical appointments.

3.4.1. Member countries have successfully integrated IPV-related services in hospitals

Within wider health care systems, hospitals have been shown to be one important hub for ISD, particularly related to support for victims/survivors of severe violence. There are a few reasons for this. First, hospitals play a critical role in providing acute crisis support; second, they can conduct comprehensive assessments of health and social needs, and develop a plan of interventions and services required to meet needs; and finally, they can sign-post and co-ordinate access to the services and specialists needed. Countries with publicly-funded health care systems are also well-placed to co-ordinate responses nationally to implement integrated GBV supports, integrating hospital care with care in other parts of the health care system.

Co-located case management and referral models to support victims/survivors are reported throughout the OECD (Table 3.1) and play an important role over time: they help respond to crises in the immediate aftermath of violence, while also providing infrastructure for certain longer-term health resources. The joined-up service provision can help ensure that resources are used appropriately, with each actor playing a specialised role in a larger system of care, support and prevention.

In Austria, for example, hospitals are legally obliged to establish multidisciplinary protection groups to support adults who disclose instances of domestic violence. In Korea, more care is provided within hospitals, which often provide multidisciplinary centres that offer medical support in addition to psychotherapy and legal counselling for both the immediate victims and their family members.

In Italy, a national directive applied at the subnational level seeks to ensure timely and integrated support for women who disclose violence through a standardised assessment deployed in the health care sector. In the United Kingdom, Independent Domestic Violence Advisers at NHS sites refer clients to related services, though these services are not usually co-located (Box 3.2). And in France, the co-located service provision site Maison des Femmes, in the suburbs of Paris, was founded by a women's health provider; this model is now being rolled out in new physical sites throughout France (Chapter 6).

Table 3.1. Integrated, hospital-based responses to GBV

Country	Nature of Integration	Description of services delivered
Austria	Referral pathways	Through the federal hospital act in Austria, all hospitals are obliged by law to establish "victim protection groups for adult victims of domestic violence" since 2011. The Groups are responsible for facilitating early detection and prevention of domestic violence through awareness raising among hospital colleagues. More importantly, out of recognition that domestic violence requires solutions borne of inter-institutional and inter-disciplinary co-operation, the main goal of the Group is to establish a network of cross-sectoral actors, including police, shelters, social workers and helpline operators which can then be mobilised to support help-seeking individuals. The Group aims to identify individuals experiencing domestic violence among hospital clients, and to refer them to the nearest "violence protection facility", or to network contacts (or both), where they can receive a broad spectrum of support. Relatedly, the Groups are responsible for collecting and reporting administrative data on domestic violence according to a specialised scheme.
Finland	Co-located	In 2017, the Seri Support Centre was established in the Helsinki Women's Hospital Department of Obstetrics and Gynaecology with the support of the National Institute for Health and Welfare. The Centre is accessible 24-hour per day for individuals of any gender aged 16 and older to seek assistance related to experiences of sexual violence occurring less than one month from their visit, without necessarily having to make a police report. The Centre offers crisis care and support, forensic medical examinations, access to psychologists and social workers, medications, vaccinations or emergency contraception, treatment follow-up plans and a referral service to psychiatrists and third sector or municipal officials. The Centre can also make referrals where help-seeking individuals are under the age of 16 or have experienced sexual violence more than one month prior to their visit. There are now 21 SERI Support Centres in Finland, and three more are planned to be established by the end of 2023.
Ireland	Provider-integrated	Via the Department of Health, the Health Service Executive directly provides 83 specialised staff in hospitals to respond to GBV cases that are flagged.
Italy	Referral pathways	In 2017, the "Pathways for women subjected to violence" was adopted into the National Guidelines for Health Authorities via Prime Ministerial Decree. The programme, which is left to regional authorities to implement, seeks to ensure timely and integrated support for women through the health sector. The Pathway is initiated following an emergency code assessment for which health professionals are trained to deploy. Consenting women are then referred to dedicated regional supports, such as local anti-violence centres, to develop safety planning, access advocates and other resources. The most recent National Strategic Plan on Male Violence Against Women (2021-23) prioritises improving the effectiveness of the Pathways initiative, including developing monitoring mechanisms in conjunction with the National Statistical Institute of Italy (ISTAT).
Korea	Co-located	In 2004, MOGEF began to establish "Sunflower Centres" across the country to provide rapid, inter-disciplinary responses in cases of sexual assault, domestic violence or sex trafficking; over 30 exist nation-wide, many of which are located in hospitals. Twelve of these Centres deploy a "one-stop service centre" (OSC) model, where all services are available in one location. The one-stop Centres employ a permanent, multidisciplinary team of 25 specialists to provide medical treatment for injuries, including forensic examinations, as well as counselling and psychotherapy for both the immediate victim and their family members; legal counselling, advice and case-building support. Support staff is also available to facilitate travel to and from Sunflower Centres.
Norway	Co-located	Operating in existing health care settings, such as clinics and hospitals, 23 sexual assault reception centres offer medical care and counselling to help-seeking individuals. Of the 23 centres, six (26%) also accept individuals experiencing domestic violence.
United Kingdom	Co-located	The Secretary of State for Health, via the National Health Service (NHS) England, commissions 47 sexual assault referral centres (SARCs) which provide acute health care and psychosocial support, as well as direct access or referral to an Independent Sexual Violence Adviser (ISVA) who acts as a case manager. Though not yet nationally streamlined, Independent Domestic Violence Advisers (IDVAs) are similarly available in hospital settings (see Box 3.2).

Note: This table presents a non-exhaustive list of ISD practices in health care settings for survivors of violence in the OECD. MOGEF in Korea had recently been abolished and the funding resolution is uncertain.
Source: OECD QISD-GBV 2022 (Annex A); (UNDP, 2019[33]; Austrian Ministry of Social Affairs, 2022[34]).

Hospitals are well-placed to co-ordinate responses to IPV where there is a need for very acute or crisis care, but that does not necessarily mean they should be hubs for all forms of co-ordination. It is important to note that hospital care is relatively costly, so to use existing resources most effectively, other settings

within the health care system (e.g. those equipped with screening tools (Section 3.2)) might be better placed to support victims/survivors who are not in need of acute physical care. For instance, care can and ought to be co-ordinated and integrated across settings to maximise the potential of primary health care and mental health services. Indeed, such co-ordination can help ensure better outcomes for people in vulnerable circumstances, including people with chronic diseases and mental health issues, both of which are common among victims/survivors of IPV (OECD, 2021[35]; OECD, 2020[36]). Where the aim of services is to prevent violence and provide non-acute support for victims/survivors to live lives free of violence, community-based care (Chapter 6) could also serve as good hubs of co-ordination.

For instance, community-based care is recognised as the preferred approach for most mental health care (discussed in the next section). All OECD countries either already deliver the majority of mental health services outside of hospitals or have prioritised the transition to community-based care models. Community-based care has the potential to deliver care that is less costly than inpatient care, more in line with service users' preferences, and better integrated with other public services. This could be reflected in ISD responses to broader health needs related to IPV in coming years (OECD, 2021[35]).

3.5. Mental health care support is a critical part of an integrated response to violence

Experiencing physical or psychological violence of any kind can have negative and long-term consequences on a person's mental health and well-being. These consequences can be exacerbated in situations where violence is perpetrated by a known, trusted or loved individual.

The Lancet Psychiatry Commission lists a range of mental health disorders that are more common among people who have experienced IPV than those who have not, including "anxiety, depression, substance use disorder, post-traumatic stress disorder (PTSD), personality disorders, psychosis, self-harm, and suicidality" (Oram et al., 2022[5]). The Commission also underscores the cyclical and intergenerational relationship between violence and mental ill-health: "Exposure to IPV in childhood or adulthood increases the likelihood of developing a range of mental health problems, suicidal ideation, and attempting suicide. The presence of mental health problems also makes individuals more vulnerable to experiencing IPV. Children who are exposed to IPV […] greatly increase the risk of both experiencing and perpetrating IPV as an adult" (Oram et al., 2022[5])

Countries are working to extend access to dedicated mental health support for victims/survivors of IPV. Responses to OECD QISD-GBV 2022 illustrate policies which integrate mental health support and social support. At the local level in Denmark, for example, since 2020, municipal governments are obligated to offer up to ten hours of free, psychological counselling to women who are staying – or who have stayed – at a shelter as a result of domestic violence. Municipalities are also obligated to offer at least four, and up to ten, hours of psychological support to children accompanying women in this context. Sessions can be used both during and after shelter stays (OECD QISD-GBV, 2022).

Other OECD countries have integrated mental health with other support through multidisciplinary counselling centres co-ordinated at the national level (Table 3.2). In Costa Rica, for example, the National Institute of Women operates regional units which provide multidisciplinary supports, including psychosocial support, to women experiencing IPV. Similarly, in Greece, the Ministry of Labour and Social Affairs funds a number of dedicated counselling centres which provide targeted mental health services for women experiencing IPV. And in Japan, the national and subnational governments jointly fund and operate several spousal violence counselling and support centres which respond to women's mental health needs and accompany them to related medical appointments.

Table 3.2. Some counselling centres link mental health care with other social and health services

Country	Description of services delivered
Austria	The central and regional governments jointly fund a constellation of over 350 multidisciplinary women's counselling centres, including specialised branches to support women affected by female genital mutilation and forced marriage. Specialised centres also exist which provide family counselling, and men's counselling, including perpetrator counselling.
Costa Rica	The National Institute of Women (INAMU) operates 5 Regional Units, as well as the Women's Delegation in the capital, which provide psychological care to women experiencing violence. Both also provide access to specialised social workers and legal experts.
Greece	Via the Ministry of Labour & Social Affairs, the Research Centre for Gender Equality (KETHI, https://www.kethi.gr/en/counseling-centers) operates 14 counselling centres which provide mental health services to women suffering from violence or multiple discriminations through multidisciplinary teams that include psychologists, social workers and legal advisors.
Japan	The Cabinet Office and Prefectures jointly fund and operate over 100 Spousal Violence Counselling and Support Centres (https://www.gender.go.jp/policy/no_violence/e-vaw/soudankikan/01.html) which provide mental health services, as well as referral and accompaniment to medical appointments.
Korea	As of early 2022, the Ministry of Gender Equality and Family (MOGEF) jointly funded and operated, with municipal governments, counselling centres for sexual violence and domestic violence cases
Mexico	External Care Centres provide psychological services to women and their children. In 2021, nearly 62 000 women received mental health services from External Care Centres

Note: This table presents a non-exhaustive list of ISD practices related to mental health for survivors of violence in the OECD. At the time of this reports publication, MOGEF in Korea had recently been abolished and the funding resolution is uncertain.
Source: OECD QISD-GBV 2022 (Annex A).

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Notes

[1] For examples, see those listed in (Gerberding et al., 2007[37]).

4 Integrated housing, income, and child-related supports: Addressing acute needs while preparing for a future free from violence

Women experiencing IPV face a range of long-term challenges to living a life free from violence, including securing affordable housing, ensuring their economic security, and supporting their children's needs. OECD governments therefore need to provide a continuum of supports, over time, across a range of sectors to help those experiencing violence. This chapter explores how OECD countries have integrated service delivery for victims/survivors of intimate partner violence (IPV) in the following domains: emergency, transitional and longer-term housing; temporary income supports; and child-related services like counselling and out-of-school care. The supply of most of these services falls short of demand, and better integration is needed in most countries.

Key findings of this chapter

While many resources are devoted to addressing emergency and acute needs, a sustainable, integrated, and victim/survivor-centred response to intimate partner violence (IPV) must incorporate an additional critical dimension: time. Governments must integrate medium- and long-term considerations to support victims/survivors in building independent lives free from violence. This chapter discusses how OECD countries have integrated service delivery for IPV survivors in the following domains: emergency, transitional and longer-term housing; temporary income support; and child-related supports like child counselling.

- Women often remain in abusive relationships because they do not have a safer place to live. Related to this, IPV is a leading cause of homelessness among women cross-nationally. To reduce housing insecurity caused by IPV, national governments in the OECD generally focus on funding and providing women with emergency shelter, often administered by subnational governments or non-governmental service providers. This is an important first step, but in most countries the number of available beds is not sufficient to meet demand.
- Fewer efforts are made to support victims/survivors transitioning to longer-term affordable housing. A handful of OECD governments offer rent subsidies or priority access to social/public housing to women who have experienced violence, often those exiting emergency shelters. While these policies show good potential to promote long-term safety and independence from an abuser, in practice few victims/survivors benefit from these provisions because there is an inadequate supply of social housing in most countries.
- In light of the known costs associated with both violent victimisation and leaving a violent relationship, OECD countries have implemented a number of income support provisions for women experiencing IPV. These include crisis payments, housing subsidies, health care reimbursements and adapted tests for various benefit payments. Some income subsidies are facilitated/accessed through case workers (e.g. advocates in shelters help women navigate financial assistance). In other cases, the GBV-lens is integrated across general sectors and services (e.g. refunds for health care expenses due to IPV).
- In cases of family violence, child welfare service providers and providers of IPV-related services do not always align strategies. This can complicate the treatment of different family members' needs. Nevertheless, several OECD countries report dedicated policies or programmes aimed at making the help-seeking process more supportive of children while helping to alleviate the needs of victims/survivors who are mothers. These most commonly come in the form of counselling for child witnesses of violence. There are also occasionally education-related supports like out-of-school care helping children with homework, or transport to and from school. These services are often delivered through women's shelters, meaning that essential child-related supports may be interrupted when families exit emergency shelters.

4.1. Housing as a foundation for building a life free from violence

It can take months or years for a victim/survivor to escape intimate partner violence (IPV). Abusers often deploy coercive strategies that make it harder for women to leave, for example by becoming more violent or threatening, or by becoming temporarily remorseful and apologetic. In many cases, IPV also includes acts of economic violence, financial coercion or forced debt, leaving few resources for women to re-build a life free from their violent partner. Where poverty and violence co-occur, women may lack the financial, informational and social resources to escape a violent relationship, instead being forced to choose between

continued violence and, for example, homelessness. In a recent review of policies offered by Istanbul Convention signatories, GREVIO finds that both public housing and financial assistance are the two least accessible services for women escaping violence (Council of Europe, 2022[1]).

Most women fleeing violence do not only need support during emergencies but must also consider whether and how to build a new life free from the perpetrator (Chapter 2). For many women, this means completely redefining "home". Often they must find ways to ensure the well-being of their children, secure reliable income that enables them to live independently of their abuser, and afford to maintain their current home or establish a new one. More often than not, victims/survivors bear the costs of leaving a relationship.

A vertically- and horizontally-integrated service delivery response (Chapter 1) to support women experiencing IPV must therefore consider an additional critical dimension: time. A sustainable, trauma-informed response to VAW must incorporate medium- and long-term supports to mitigate the risk of continued harm for women experiencing violence; to re-assert their safety and independence in a timely manner; and to curb the repeated use of limited and costly emergency services.

This chapter explores how OECD countries have integrated service delivery for IPV survivors in the following domains: emergency, transitional and longer-term housing; temporary income supports; and child-related supports, like assistance with school and child counselling.

4.2. A continuum of support: Emergency, transitional, and longer-term housing for women escaping IPV

Women experiencing IPV may remain in violent relationships as a result of economic co-dependence, limited housing alternatives, and/or complications and liabilities related to home co-ownership, joint leases and rental arrears (potentially caused by economic abuse). Women with children bear these challenges all the more.

Domestic violence has been found to impact negatively a woman's ability to remain in a formerly-shared dwelling (if the abuser has left) or to secure alternate housing. Landlords may discriminate against survivors for fear of police interventions, damaged property or unpaid rent. In some cases, subnational governments may develop eviction policies that may not align with – or may actually undo – national-level action plans to mitigate GBV (see Box 4.1).

Box 4.1. Policy incongruence between national and subnational governments in the United States

Local nuisance property laws in some US municipalities conflict with national goals to address GBV

> *"Amy was getting fed up with the abuse from her long-term boyfriend. His violence was getting worse, her children were getting old enough to start asking questions about it, and she was thinking seriously about ending their relationship. She had called the police for protection five times in the last two years, and their usual response had been to tell him to leave the house for a few hours. After her last 911 call, though, they took a very different approach: the police told her that if she called them again, both she and her boyfriend would be charged with violating the city's nuisance property ordinance, arrested, and their children taken into custody by the state's child protective services. In addition, they would report Amy's repeated 911 calls to her landlord and she would be evicted from her home." (Arnold, 2019[2]).*

Increasingly, municipalities across the United States are implementing nuisance property laws in an effort to curb criminal activity in rental properties, and to recuperate policing costs by fining or evicting people who repeatedly call for emergency police services. For example, in East Rochester (New York),

the nuisance law requires landlords to evict a tenant after a third call to emergency services within a 12-month period; moreover, where a landlord fails to evict a tenant, the municipality can revoke their permit to lease their apartment at all.

Studies from municipalities in Missouri and New York show that these laws are often enforced against women experiencing IPV or family violence, as with the anecdote above, and have been found to disproportionately affect women of colour and low-income households. Such local-level laws can be particularly harmful when applied to cases of IPV – which are already known to be underreported – by portraying a potential victim of violence as complicit in a new crime, while also notably increasing an abuser's power.

More importantly, nuisance property laws also compromise access to immediate and future housing for people seeking help to escape violence, which runs counter to national-level housing protections in the US Violence Against Women Act (1994), as well as other housing-related financing provisions that seek to boost access to shelter.

Source: (Arnold, 2019[3]; Arnold, 2019[2]; Cais, 2008[4]).

Violence is a leading cause of homelessness and housing instability for women and their children (Yakubovich et al., 2022[5]).[1] This holds across countries. The numbers are striking: a recent survey of homeless populations in Germany found that nearly eight out of ten (79%) of women experiencing homelessness without shelter had experienced some kind of violence (Brüchmann et al., 2022[6]).[2] In Ireland, where homelessness rates among women are among the highest in Europe, two- thirds of homeless women report experiencing IPV (Mayock and Bretherton, 2016[7]). In Australia, 50% of adult women clients accessing Australia's Specialist Homelessness Services in 2021-22 had experienced family and domestic violence (AIHW, 2022[8]).

Some government frameworks acknowledge IPV is a strong determinant of homelessness. For example, Australia's National Housing and Homelessness Agreement considers "women and children affected by family and domestic violence" to be a priority homelessness cohort for which subnational governments are required to report investments (Australian Institute of Health and Welfare, 2019[9]). Australia's "Keeping Women Safe in their Homes" (KWSITH) programme is therefore an important and complementary initiative which allocates central funding to state and territorial governments, and select NGOs, to help women *remain* in their homes rather than uproot their lives in the wake of IPV (see Box 4.2). The initiative focusses, instead, on holding perpetrators of violence accountable for their actions by shifting the onus of rehoming on the abuser.[3]

Similarly, the Domestic Violence Housing First Model in the United States recognises that domestic violence is a leading cause of homelessness and has combined housing-related advocacy with flexible financial assistance to those who need them, with successful results (see Box 4.2).

While emergency shelters can provide essential temporary housing support, the importance of longer-term solutions in the form of transitional shelter and affordable housing cannot be overstated (Mantler and Wolfe, 2016[10]). Emergency shelters, though critical to crisis response infrastructure, do not constitute viable, long-term housing solutions for women who may otherwise be faced with homelessness if they want to leave a violent relationship.

Box 4.2. National initiatives promoting stable housing for victims/survivors

Keeping Women Safe in their Homes (KWSITH) in Australia

Women who are forced to leave their home to flee violence suffer additional hardships. Aside from the time, energy and other resources required to change locations – sometimes with children – a move can compromise proximity to employment, to children's school or day care, and access to support networks.

KWSITH was deployed in 2015-16 as part of the *National Plan to Reduce Violence against Women and their Children, 2010-22.* The Australian Government funds state and territory governments, along with select service providers, to deploy the programme according to an operational framework. Principle supports include assessing whether a woman and her children can safely remain in her home by way of risk assessments, safety planning, case management and home security audits. The programme also finances home security upgrades, such as installing or changing locks and security screen doors, installing alarm systems and security cameras, and for women at higher risk, providing technology such as monitored personal safety devices, surveillance cameras, dashboard cameras, and electronic sweeping and de-bugging of homes and cars.

Since its start in 2015-16, KWSITH has assisted 13 838 women and their children nationally. KWSITH aligns with related national planning for perpetrator accountability and interventions.

In October 2022, the Australian Government committed USD 51.9 million to continue funding the KWSITH programme and ensure continued and consistent service delivery. Implementation will be monitored via the Department of Social Services Data Exchange.

Domestic Violence Housing First (DVHF) Model in the United States

Recognising that domestic violence is a leading cause of homelessness and unstable housing, the DVHF Model in the United States aims to support women who leave an abusive home to achieve safe and stable housing. The Model works with victims/survivors experiencing unstable housing by, first and foremost, getting them into stable housing and then working to support them in other ways. This concept is based on the longstanding "Housing First" model used for other vulnerable populations with complex needs, such as mental illness.

A quasi-experimental, longitudinal evaluation study of DVHF followed women over two years after they sought services from one of five participating Domestic Violence agencies in the state of Washington. The evaluation considered the effectiveness of two pillars of the model: mobile housing-related advocacy and flexible funding. The evidence indicates that after 24 months, the DVHF model is more effective than services as usual in helping survivors achieve housing stability, safety, and improved mental health. Positive results were visible immediately after the initial six months, and then persisted over the two full years.

Source: (Australian Department of Social Services, 2022[11]; Breckenridge, 2021[12]; Chen and Sullivan, 2022[13]; OECD, 2015[14]).

4.2.1. Emergency shelters are common, but there are still not enough beds

To address IPV, national governments in the OECD have historically focused on funding and providing women with emergency shelter, with fewer efforts made to provide transitional shelter (from emergency to long-term housing) or access to longer-term affordable housing. This may be linked to the phrasing of the Istanbul Convention, which stresses the need for emergency shelters. Yet despite this focus on emergency housing, a recent review by the monitoring body of the Istanbul Convention, GREVIO, finds emergency

accommodation sorely lacking among signatories, including in the OECD. Austria is the only OECD country to have achieved the Istanbul Convention target of *one family place in shelter per 10 000 population* (Council of Europe, 2022[1]). This comes in the context of a broader environment of not enough space in emergency shelters for people in need (OECD, 2020[15]).

Shelters are infrequently managed by the national government. The national governments of Costa Rica, Greece and Türkiye do report operating some – or most – of the women's shelters in their countries, all of which offer multidisciplinary support services. Until recently this was also the case in Mexico, though shelter services are now co-ordinated by the National Commission to Prevent and Eradicate Violence against Women (CONAVIM), a decentralised administrative body of the Ministry of the Interior that works alongside local-level organisations. In Türkiye, the national government in 2022 mandated all 81 Provincial Governorships and municipalities with a population of over 100 000 to open women's shelters, with guidance from specialists from the General Directorate on the Status of Women.

Shelter services are otherwise generally provided at the national and subnational levels through policy and funding commitments and are delivered by a network of organisations at the local level who then often compete for government resources (Chapter 6). For example, in Korea, women's shelters are funded by both national government and subnational governments and operated by non-governmental organisations. In Japan, too, national government funds are used by non-governmental service providers. In Canada, some of these efforts consider intersectional needs: the Indigenous Shelter and Transitional Housing Initiative earmarks funds to create at least 50 transitional homes and 38 shelters for Indigenous women, children and 2SLGBTQQIA+[4] people escaping gender-based violence. The funds are allocated to service providers who submit service delivery proposals through an open call, and who are selected according to pre-determined evaluation criteria.[5] Canada's "Reaching Home" Homelessness Strategy[6] also fosters housing support for populations such as victims/survivors of GBV.

Central funding rules may also be adapted to ensure central funds are effectively allocated at the subnational level. In the United States, at least 70% of the funding issued by the Department of Health and Human Services through the Administration for Children and Families awarded to sub-grantees working in the field of domestic violence must be used for the primary purpose of providing immediate shelter and supportive services in respective states.

On the ground, dedicated funding for emergency (and transitional) shelter often comes with jurisdictional limitations which can restrict a woman's ability to re-locate to a shelter in a municipality other than the one of her registered addresses. Despite re-location being a common short-term safety strategy, one service provider explains, "further barriers arise when, for example, women escape to a women's shelter in [more distant] municipality for reasons of safety. These women will often be rejected there, since the compensation of costs among municipalities is complicated" (OECD Consultation, 2022) (see Chapter 1, Box 1.5).

The private sector can take on useful roles as providers of emergency housing, too. For instance, building on their initiative during the COVID-19 pandemic to provider emergency shelter at cost price, the hospitality company Accor has put in place a new platform. The platform "Emergency Shelter" aims to provide temporary accommodation to women and children leaving abusive partners. Between March and October 2022, 148 women and children benefited from the programme (Falstaff, 2022[16]; Accor, 2022[17]).

4.2.2. Transitional shelters are infrequently used

Women experiencing IPV often need time and support when moving from emergency shelters to long-term housing, which may imply high upfront costs and organisational resources. Shelters therefore often provide both emergency beds and transitional apartments, though the latter is markedly less common. The recent OECD Consultation with 27 non-governmental service providers (Chapter 1) revealed that respondents were more than twice as likely to offer emergency shelter as transitional shelter (56% to 22%).

Hungary offers a novel example of transitional housing for victims/survivors. Transitional housing services in Hungary are designed to provide longer-term housing for victims/survivors leaving abusive relationships. Women can move to these houses following crisis situations. By law, transitional houses can be operated in conjunction with crisis centres as well as secret shelters. In practice, transitional housing services are self-contained flats close to sheltered accommodations, for which there is no rent and the utilities are only gradually, over time, taken over by the victim/survivor. The services of the transitional home are available for five years, and in addition to housing, the survivor receives free psychological and legal counselling, as well as the guidance of a social worker who helps with reintegration into society. Hungary reports that "the period spent in a transitional house is about rebuilding a life; the survivor starts working, becoming more independent in their day-to-day life, which oftentimes includes taking care of their children. Survivors typically leave the care system after 2 years. Following time spent in such a transitional house, survivors can become so empowered, that there are virtually no examples of someone going back to their abuser." (OECD QISD-GBV, 2022).

4.2.3. Access to long-term, affordable housing remains a challenge

Awareness of – and access to – stable and affordable housing is a key determinant of help-seeking and restitution of personal safety for women experiencing IPV. Unfortunately, women fleeing violence do so in the broader context of a widespread housing affordability shortage in OECD countries, which leads many lower-income households to be overburdened by housing costs and/or live in poor-quality dwellings that are ill-suited to their needs (OECD, 2022[18]).

To support women and mothers in accessing long-term, affordable housing solutions, national governments most commonly offer rent subsidies or priority access to social housing. These benefits and programmes are often linked – either administratively or in terms of priority access – to emergency shelters as a way to support women leaving shelters.

Rent subsidies for women experiencing violence

Some countries offer rent subsidies to women escaping violence. The Chilean Ministry of Housing and Urbanism, in co-ordination with the Ministry of Women and Gender Equality and the National Service for Women and Gender Equality (SERNAMEG), provides women experiencing GBV with a subsidy to access rented or owned housing (OECD ISD-GBV, 2022). In the United Kingdom, recent amendments give housing support to people who have experienced domestic violence to claim a higher level of support as of 1 October 2022. The additional provision is available for people who already live independently, and who have written attestation of violence by either a health care professional, police officer, registered social worker, their employer, or a GBV-specific service provider. Notably, there is no time limit to claim this additional benefit; for example, a person who experienced abuse at age 20 can still appeal for the benefit at age 30, so long as they can provide evidence.

Greece offers an example of rent subsidies integrated with other services. The "Housing and Work Project" aims to rehouse individuals and families experiencing homelessness through an integrated approach and considers women living in domestic violence shelters to be one of its three priority groups. The programme provides some women with a two-year rent subsidy; a subsidy to cover costs of household goods and other functional needs; psychosocial support services; referral to other social benefits and services; and training services and support accessing work (OECD QISD-GBV, 2022); (Hellenic Republic, 2022[19]).

Priority access to social housing for women experiencing violence

Several countries have special provisions within existing social housing schemes which prioritise access to victims/survivors who are exiting emergency shelters. These include Belgium, Ireland, Japan, the Netherlands, Portugal, and Spain (see Table 4.1).

Importantly, while *de jure* priority access to social housing may be promised to women escaping situations of violence, such provisions face challenges in implementation. GREVIO has found in reviews of Belgium, Finland, France, Italy, the Netherlands, Portugal, and Türkiye that public housing and financial assistance are usually the two types of services that victims find more difficult to access even where the law foresees helpful measures (Council of Europe, 2022[1]). The Netherlands, for example, has a law mandating priority access for victims/survivors in social housing, but in practice many women are not placed as there are not enough spaces in the affordable housing stock (ibid). In general, there is a shortage of social housing supply in OECD countries, relative to demand (OECD, 2020[20]).

Australia offers a noteworthy approach. The underlying concept in recurring national plans is to empower women and their children to *remain* in their home if possible, and when it is safe to do so (Box 4.2). In effect, this places the onus of re-establishing a home on the person who committed violence.

Table 4.1. Examples of policies facilitating victims/survivors' access to social housing

Country	Description of services delivered
Belgium	Municipalities are legally obliged to grant priority consideration for social housing to women who have experienced violence and who are exiting shelter services.
Ireland	In 2017, the Department of Housing, Local Government and Heritage issued guidance to housing authorities highlighting the role they can play in assisting women impacted by domestic violence. The guidance makes a number of recommendations, including that local housing authorities provide short-term emergency housing to women exiting emergency shelters, but who are unable to return home due to safety concerns, without having to assess their eligibility for social housing support or include them on the authority's waiting list for housing supports. Importantly, this hinges on availability of housing. Where a woman is party to a joint tenancy agreement with the perpetrator of violence, she may return to the family home if the justice system has ensured the expulsion of the perpetrator. The housing authority can also install reinforced doors and bolts, lighting and a communications point to be funded via housing authorities' standard improvement works programmes.
Japan	Public housing occupants are usually selected through a public lottery system. However, low-income people with especially serious housing problems, including related to spousal violence, can be housed on a preferential basis, at the discretion of housing providers and depending on circumstances in the locality.
Netherlands	The housing law legally obliges municipalities to offer housing, with priority, to women who have experienced GBV and are exiting shelter services.
Portugal	Since 2012, the "Municipalities in Solidarity with Domestic Violence Victims" lays the legal framework wherein municipalities grant priority access to social housing for women leaving shelter services. To date, 42% of municipalities in Portugal have adhered to the programme.
Spain	Organic Law 1/2004 and 10/2022 regulates the priority access of victims/survivors of GBV to housing. Housing assistance programmes such as the "Programa de ayudas a las víctimas de violencia de género, personas objeto de deshaucio de su vivienda habitual, personas sin hogar y otras personas especialmente vulnerables" seek to provide an immediate housing solution for GBV victims and vulnerable people. Recipients can access financial aid of up to EUR 600 per month, which can support up to 100% of the rent.

Note: This table presents a non-exhaustive list of policies in OECD countries intended to link victims/survivors with social housing, typically as they exit emergency shelters. Additional comments were incorporated following OECD members' review.
Source: OECD QISD-GBV 2022 (Annex A); (Council of Europe, 2022[1]); Government of Ireland (Department of Housing, Planning, Community and Local Government, 2017[21]); Government of Spain (Ministry for transport, 2022[22]).

4.3. Income support can offer some financial security to women fleeing violence

Research from throughout the OECD has highlighted the significant link between poverty and intimate partner violence.[7] Domestic violence is not only more prevalent among people living in poverty, it is often more frequent and more severe. At the same time, women earn less and are less likely to be in the labour market than their male partners, on average across the OECD (OECD, 2022[23]). This often leaves women experiencing violence at an economic disadvantage when and if they want to leave a violent relationship. Against this backdrop, racial and ethnic minority women – who tend to earn less than white women – face particularly high risks (Gillum, 2019[24]).

Even for women with gainful employment and financially security, the personal economic cost of IPV is significant. IPV can compromise wages, employment continuity, or the prospect of career advancement. Though dated, the National Center for Injury Prevention and Control estimated in 2003 that, across the United States, people experiencing IPV lost "nearly 8.0 million days of paid work –the equivalent of more than 32 000 full-time jobs –and nearly 5.6 million days of household productivity as a result of the violence" (CDC, 2003[25]). A more recent study in the United States., based on the 2012 National Intimate Partner and Sexual Violence Survey to estimate "a population economic burden of nearly USD 3.6 trillion (2014 USD) over victims' lifetimes, based on 43 million US adults with victimisation history" (Peterson et al., 2018[26]).

Economic control and financial coercion are also often part of a perpetrator's strategy of abuse and are nearly invisible facets of IPV which directly impact a person's ability to leave an abusive relationship. Economic abuse can take many forms, including restricting access to (and use of) personal finances); restricting or blocking access to employment or job training; non-consensual use of another's personal finances; and forcing debt upon someone (Breckenridge, 2020[27]; Postmus et al., 2020[28]). Even when an abusive relationship has ended, the consequences of economic abuse can have long-term impacts on affected victims/survivors, for example in the form of debt or tarnished credit.

When leaving a violent relationship, a person may struggle to adapt to new financial dynamics as a single earner at the same time as they face the costs associated with re-establishing themselves. A single earner with children is even more exposed to poverty risks.

In light of the common co-occurrence of poverty and IPV, and the known costs associated with violent victimisation on the one hand and leaving a violent relationship on the other, OECD countries have put in place a number of income support provisions for women experiencing IPV (see Table 4.2). These include crisis payments, additional housing subsidies, health care reimbursement and adapted tests for various benefit payments.

4.3.1. Income support provided by government

The degree of integration of cash benefits varies, however. Some income subsidies are facilitated/accessed through case workers formally (e.g. in Anti-Violence Centres in Italy) or informally (e.g. advocates in shelters help women navigate financial assistance). In other cases, the GBV-lens is integrated across general sectors and services (e.g. refunds for health care expenses due to IPV, or payments in the wake of crises which include domestic violence).

Table 4.2. Targeted income/cost support provisions in cases of domestic violence in the OECD

Country	Targeted income support measure
Australia	Additional Child Care Subsidy (ACCS) (temporary financial hardship) is designed to provide support to qualifying families who are experiencing significant financial stress due to circumstances beyond their control, such as: • a person having to leave their home, and not being able to return due to an extreme circumstance such as domestic violence; • a person still living at home after being subjected to domestic violence by a family member who has left or been removed; Special exemptions also exist for people who are experiencing, or have experienced domestic violence, including with respect to parental leave and child benefit eligibility tests; A one-off crisis payment is available to existing income support recipients who changed their living arrangement due to domestic violence. In 2020-21, 25,575 Crisis Payments were granted to support customers affected by family and domestic violence. In 2021-22, more than 26,000 Crisis Payments were granted to support customers affected by family and domestic violence.
Costa Rica	The Mixed Institute of Social Assistance (IMAS) offers a temporary subsidy for women in situations of violence, including women at risk of violence. In 2021, 1 274 women benefitted from the provision.
Estonia	Women affected by violence are eligible to receive partial reimbursement for necessary mental health expenses related to treatment in the aftermath of violence.

Greece	Since 2021, special provisions for women experiencing violence have been incorporated into the guaranteed minimum income (GMI) scheme, including extended support for women exiting shelters.
Italy	In 2020, a number of new subsidies were enshrined in law for women who have severed ties with their abusers, as validated by case workers at regional Anti-Violence Centres: • The "Income of Freedom" subsidy is equivalent to EUR 400 per month for 12 months, paid by the National Institute of Social Security by way of a one-time payment. Women can apply via municipal social service offices by presenting a certificate issued by their anti-violence centre case workers; • The "Micro-Credit of Freedom" subsidy, which is articulated into two instruments: o The business microcredit, designated for women who intend to start a business. Women are referred by Anti-Violence Centres to the National Microcredit Board, where they are followed by entrepreneurial mentors. The aim of the credit is to offset the interest rate on loans granted for entrepreneurial activity. o The social microcredit, designated to support personal expenses, including rent and school supplies for children. Both subsidies are compatible with other benefits (e.g. citizenship income, inclusion income, etc).[8]
Korea	• MOGEF provides a one-time self-reliance benefit for individuals experiencing domestic or sexual violence, and are exiting shelter services. The benefit is automatically paid when they leave the shelter. • Women and their immediate family members are eligible to receive subsidies to cover mental health expenses in the wake of violence. Benefit applications, along with supporting documents, are processed through relevant support agencies, such as counselling centres or integrated support centres. This subsidy is not means tested.
Latvia	Municipalities are, by law, required to offer social assistance in the form of a crisis payment, including to women and girls in situations of violence. Municipalities determine the amount through their local laws. The benefit is not means tested and is paid out as a one-time sum. In 2021, the crisis payment was received by 1 417 girls (0 – 18 years old) and 7 388 adult women, though administrative data is not disaggregated by nature of the crisis, making it difficult to distinguish between payments disbursed as a result of human trafficking versus IPV, for example.
Portugal	The "Family Restructuring License and Subsidy" initiative was established in 2020 to support unemployed women who are forced to leave their residence due to a crime, such as domestic violence. Applications are processed through the Social Security Institute, and can be accumulated with other social benefits payments, with the exception of unemployment allowance.
Slovenia	In cases of proven IPV, the perpetrator's income is not considered in the means test related to household income when the plaintiff applies for social assistance. In cases where migrant women experiencing domestic violence have been issued temporary residence permits and lack means of subsistence, they are granted access to social assistance payments like the general public.
Spain	The Government Delegation against GBV within the Ministry of Equality funds a one-time special aid benefit for qualifying women (means-tested) experiencing consequences of GBV. Law 3/2019 aims to improve the situation of orphans who have lost their mother due to gender-based violence and other forms of violence against women, by establishing an "orphanhood provision" for the children whose mother had not previously contributed the sufficient amount to generate the right to an orphanhood pension.
Switzerland	Women affected by violence are eligible to receive additional subsidies to cover necessary physical and mental health expenses related to treatment in the aftermath of violence.

Note: This table presents a non-exhaustive list of income support policies for victims/survivors of violence in OECD countries. In some countries, transfers also come in the form of subsidies for private or social housing rentals (see Table 2.1). Additional comments were incorporated following OECD members' review.
Source: OECD QISD-GBV 2022 (Annex A); (La Moncloa, 2019[29]).

4.3.2. Workplace protections to keep victims/survivors in paid employment

Of course, while such subsidies and payments are helpful in the short term, women experiencing domestic violence require more sustainable, long-term solutions that help them preserve, or gain, paid employment. In 2019, the International Labour Organization (ILO) adopted the "Violence and Harassment Convention" (C-190), which seeks to eliminate violence in the world of work, but also highlights the shared responsibility of employers in mitigating the workplace effects of violence occurring at home (International Labor Organization, 2019[30]).[9] The accompanying recommendation suggests countries adopt special job-protected leave or temporary protection against dismissal for people experiencing domestic violence (International Labor Organization, 2019[30]).

Some countries, like Australia, Canada, Italy, Spain and the United States, have adopted provisions which guarantee time off for women to recover from violence without jeopardising their current jobs – though the leave is not always paid. In Canada, for example, the Canadian Labour Code entitles employees of federally-regulated workplaces (e.g. air transportation, federal public service, postal and courier services,

radio and television broadcasting) to ten days of leave per calendar year, out of which five days are paid, if the employee is the victim of family violence or is the parent of a child who is the victim of family violence. Employees of other workplaces are subject to provincial and territorial labour codes, all of which have some form of domestic/family violence leave provisions. The United States' Executive Office of the President also recently published the "Memorandum on Supporting Access to Leave for Federal Employees," which calls for job-protected leave for federal workers experiencing domestic violence, dating violence, sexual assault, or stalking.[10]

In Australia, the National Employment Standards entitle all employees, including part-time employees and casual workers, to 10 days' paid family and domestic violence leave in a 12-month period for employees experiencing family and domestic violence to deal with the impact. The National Employment Standards provide the minimum entitlements for employees in Australia, which means other kinds of employment arrangements such as enterprise agreements and individual arrangements cannot provide lesser conditions. The paid leave entitlement takes effect on 1 February 2023 for employees of businesses other than small business employers (fewer than 15 employees) and on 1 August 2023 for employees of small business.

In Spain, victims/survivors of GBV have extensive rights in the workplace. They are guaranteed reduced or reorganised work hours, geographical mobility, change of workplace, support needed for reinstatement and reserved job in case of temporary leave. Workers are reimbursed via social services when they are absent from work due to GBV, including for reasons including mental or physical recovery (Jefatura del Estado, 2004[31]).

France seeks to ensure that people who need to relocate and resign their job due to domestic violence are not excluded from unemployment benefits. However, the administrative burden to "prove" the job resignation was caused by domestic violence may be too high for some victims/survivors to claim the benefit. To be eligible, victims/survivors must show some, or all, of the following: a complaint filed with the public prosecutor, direct citations before the police or correctional court, a complaint with civil action before the investigation judge, a complaint with a police station or a gendarmerie, and proof of address of the old and new place of residence (Pole Emploi, 2022[32]). This requires time, effort and self-efficacy that a victim/survivor may not possess when escaping a violent situation.

Community-based organisations also play an important role in supplying women with related, non-monetary supports, such as clothing and footwear, food, or transit fares, in addition to financial counselling, job training and re-skilling opportunities. The consultation shows that 15 out of 26 responding organisations provide in-kind support such as food clothing, while 4 provided this by co-location and 6 by referral to off-site providers.

4.4. Integration with child-related services is necessary to streamline support

Given that intimate partner violence often occurs in the family home, if children are present, they are likely to bear close witness. Mothers require additional supports to respond to childcare needs, which can be a practical challenge when navigating the help-seeking process and working to rebuild their lives. For example, mothers may need support transporting her children to and from school from a new location, such as a shelter, or they may require childcare support in order to continue working. In addition, by-standing children may themselves require counselling or social support after witnessing violence.

Moreover, child abuse and IPV against women often happen simultaneously, though service delivery is inconsistently integrated (Langenderfer-Magruder et al., 2019[33]). Failure to holistically integrate IPV and child welfare services contributes to the marginalisation of help-seeking adults in contexts where IPV and child abuse are overlapping (Nikolova et al., 2020[34]; Langenderfer-Magruder et al., 2019[33]). Opportunities exist to integrate service delivery in this context, particularly where the number of agencies

involved in help-seeking, safety planning and resolution are often multiplied as a result of the presence of children (Olszowy et al., 2020[35]).

4.4.1. Integrating child-related supports for help-seeking mothers

Some IPV-oriented service providers, such as specialised police stations (Chapter 5), anticipate the likelihood of children being present during help-seeking. But supportive services which alleviate the needs of mothers seem to be more commonly integrated within housing services (OECD QISD-GBV, 2022). Indeed, state-operated women's shelters in Costa Rica, Greece, Israel and Türkiye report serving as many, if not more, children than they do women escaping domestic violence, offering supportive services to both (OECD QISD-GBV, 2022).

Importantly, when services for children are delivered through state-funded women's shelters, many essential child-related supports are interrupted when women exit emergency or transitional shelters (Council of Europe, 2022[1]).

To note, the child services reported in this chapter come from the perspective of *service providers addressing IPV;* OECD GBV-ISD (2022) generally did not capture IPV-related services reported from the perspective of child service providers.

Child services most commonly appear in the form of counselling for children affected by violence, including in Austria, Finland, Latvia, Mexico, New Zealand and Norway. There are also practical, education-related supports like out-of-school care, such as helping children with homework or transporting them to and from school, as in Costa Rica and Japan.

Table 4.3. Child-related services to support mothers experiencing IPV

Country	Description of services delivered
Austria	The Federal Chancellery funds Family Counselling Centres, 25 of which offer special child well-being support in the context of DV.
Costa Rica	The INAMU temporary shelters for women at high risk of femicide (CEAAM) employ child psychologists to attend to accompanying children aged over four years. In addition, a formal agreement with the Ministry of Public Education provides a teacher in each CEAAM to ensure educational continuity for accompanying children.
Finland	All state-funded shelters include child-centred crisis support for children whose parent experienced DV.
Israel	The Inter-Ministerial Committee via the Ministry of Welfare is responsible for allocating fixed job positions and delineating standards for social workers specialised in working with child witnesses of DV.
Japan	Women's Protection Facilities and other state-operated shelters offer accompaniment services to ensure children staying at the facilities continue to attend school.
Latvia	The Ministry of Welfare provides social rehabilitation services for children (and their mothers) when children and/or mothers have been affected by domestic violence. Children receive either a maximum of 10 psychologist consultations, or through specialised care at local crisis centres over the course of 60 days if criminal proceedings have been initiated for the offence committed against the child, or 30 days if there was no offence against the child. The municipality is able to grant additional aid, if it is determined necessary.
Mexico	In 2021, nearly 38 000 children received specialised counselling through External Care Centres, in addition to over 27 000 children who received social work, psychology and law services through PAIMEF. This is in addition to over 660 000 child-related services delivered to children attending shelters alongside their mothers.
New Zealand	The Ministry of Social Development is funding nine pilot sites via women's refuges which have adopted a *tamariki* [child] focussed family violence integrated safety response. Tamariki-centred services are provided for accompanying children ranging from 5–12 years old.
Norway	The Directorate for Children, Youth and Family Affairs manages 42 Family Counselling Services, which are increasingly adopting an integrated approach to domestic violence so as to better support the entire family unit, including children.
United States	The Justice for Families Program provides supervised visitation and safe exchange of children and youth by and between parents in situations involving IPV and DV.

Note: This table presents a non-exhaustive list of services for children that are integrated in government responses to intimate partner violence in the OECD.
Source: OECD QISD-GBV 2022 (Annex A).

4.4.2. Child welfare services and IPV services are infrequently integrated

Children in households where IPV takes place are often close witnesses to violent physical and sexual assault and psychological abuse. In some cases, they may themselves also be direct victims of violence. This means that children in households with IPV are vulnerable to lower well-being and may struggle later in life to achieve their potential. Indeed, exposure to IPV is considered a form of child maltreatment in many OECD countries – whether the children are direct victims, witnesses or simply living in a household where it takes place – which means that child protection services might be expected to intervene to assess harm to children in cases of IPV (OECD, 2019[36]).

While there may be benefits to including forms and cases of IPV in child maltreatment assessments, it often means that women are held to account for their partner's violence, and the children's exposure to that violence. Thus, abused women may see child welfare interventions as punitive, traumatising and re-victimising (Nixon et al., 2007[37]). Indeed, perpetrators may also use the threat of taking children away as a form of psychological abuse and warning against help-seeking (Chapter 2). At the same time, child protection services do not always help improve outcomes for children, but in some cases may add to their burden of physical and psychological harm (Nixon et al., 2007[37]).

Internationally, processes and procedures are generally lacking in cases where IPV and child maltreatment are co-occurring. Child protection services are often delivered directly by the government, whereas services for victims/survivors of violence are provided by an amalgam of different institutions – often non-governmental (see Chapter 6 for more on the role of non-governmental provision). This creates an administrative barrier to the successful integration of these two, multifaceted services.

Caseworkers and other related practitioners may also be isolated in professional silos which may fundamentally differ in terms of funding, guiding principles, paradigms and language. Child-welfare caseworkers may lack the necessary training to assess IPV both in relation to women and in relation to child maltreatment. For example, one study of foster care caseworkers in the United States found that many lacked any IPV-related training (Cheng and Lo, 2019[38]).

Co-location of industry-specific professionals can create the conditions for cross-training. The co-location of a family violence liaison within child welfare agencies has been shown to improve inter-organisational relationships which have historically borne tensions (Johnson et al., 2019[39]). At the same time, co-location may be complicated where service providers are already spread too thin. Co-locating adult services in the child welfare milieu also calls into question who the "primary client" is and how the service delivery approach should change to encompass both without compromising the well-being of either client group (Cheng and Lo, 2019[38]; Cleaver et al., 2019[40]; Langenderfer-Magruder et al., 2019[33]).

Despite these challenges, examples exist where child welfare services have been integrated with adult IPV services (see Box 4.3). The Child Protections Investigations (CPI) Project operating in the United States, which sees IPV as a component of child maltreatment rather than an addition to an existing case, successfully introduces a survivor-centred, trauma-informed approach that lays the organisational framework for inter-agency co-operation and collaboration, as well as client inclusion.

Box 4.3. Joining up support services for children and adults in the wake of GBV

Child Protection Investigations Project, Florida, United States

In 2009, the Florida Coalition Against Domestic Violence (FCADV), in partnership with the Florida Department of Children and Families and the Office of the Attorney General, launched the Child Protections Investigations Project (CPI) as a pilot in seven locations.

Their IPV-informed child welfare approach seeks to partner with protective parents to reduce child removals, increase client self-determination and hold offending parents accountable. It is their belief that witnessing IPV constitutes a major threat to child health and safety, and therefore prioritises responses to IPV rather than treating it as a separate, overlapping or burdensome issue.

The CPI Project works collaboratively with government, community-based organisations and other child welfare professionals to provide a co-ordinated response through the co-location of CPI units within certified domestic violence centres. By 2017, 42 certified domestic violence centres across all 67 Florida counties featured co-located CPI units which operate 24/7; some centres also provide linguistically and culturally specific services.

In 2016-17, the CPI Project cumulatively assisted over 14 000 women, children and men seeking emergency shelter; provided nearly 350 000 hours of counselling and advocacy; completed nearly 150 000 safety plans; and performed outreach and training for nearly 130 000 participants of various ages.

Operation Encompass, United Kingdom

Operation Encompass was set in in 2011 to help support children affected by violence at home by encouraging the sharing of sharing information between the police and schools. Schools are important because many children first disclose their experience of violence to their teachers, who may be some of the only approachable adults for some children. Having knowledge of pupils' situations at home, teachers can offer special support for children, including accompanying them to class or the playground and have one-on-one conversations with the child as needed.

Information flows from the police to schools. Whenever police officers attend a case of domestic abuse where children live in the household, they report the incident to a trained Key Adult in the child's school. Currently, 43 police force areas across England and Wales have adopted this practice.

Teachers are trained to make the most of the information. Operation Encompass also provides resources for teachers to help them adopt a safeguarding role towards their pupils. Teachers can access a free helpline, including support form clinical psychologists, as well as online training, provided by Operation Encompass. Over 10 000 teaching staff have accessed the online training, according to Operation Encompass.

Practitioners have been supportive of the programme, but stress that the success of the programme will hinge on schools being able to support the children, including by having specialist staff to care for children.

Source: (Langenderfer-Magruder et al., 2019[33]; NCJFCJ, 2019[41]; Centre for Social Justice, 2022[42]).

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Notes

[1] While violence is a cause of homelessness, it is also a *consequence* of homelessness. Women fleeing GBV may be sleeping rough or accessing homelessness services that predominantly serve men and are not equipped to provide safety, security and privacy for women. These challenges are compounded when women suffer from mental health issues or substance abuse, as many facilities are not equipped to offer integrated services to address complex needs (FEANTSA, 2019[43]).

[2] While this estimate refers to *all* forms of violence, and not only IPV, it is worth noting the valuable data source – a novel survey of people experiencing homelessness in Germany. The Society for Innovative Social Research and Social Planning and Kantar Public interviewed a representative sample of homeless persons taken in three stages in 151 German cities and municipalities. These estimate the numbers of persons living rough in the streets or in makeshift shelters and of persons in concealed homelessness, staying with acquaintances or relatives. In addition, the study offers insights into the socio-demographic composition of both groups of homeless and on important aspects of their life situation – including experiences of violence (Brüchmann et al., 2022[6]).

[3] For more on perpetrator interventions, see Chapter 2.

[4] 2SLGTBQIA+ is an acronym for Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, Asexual. The plus reflects the countless affirmative ways in which people choose to self-identify (Middlebury Institute of International Studies, 2023[47]).

[5] An overview of the evaluation criteria in order to receive grants is available at (CMHC, 2022[45]).

[6] For more details see https://www.infrastructure.gc.ca/homelessness-sans-abri/index-eng.html.

[7] See, for example, (Gillum, 2019[24]; Slabbert, 2017[44]; Fahmy, Williamson and Pantazis, 2016[46]).

[8] In 2020, high interest and uptake saw the entire EUR 3 million budgetary allocation paid out. In 2021-22, allocation was increased to triple the number of applications accepted to the programmes.

[9] OECD countries who have ratified C-190 include Greece, Italy, Mexico, Spain, and the United Kingdom.

[10] The Memorandum calls for greater access to paid leave and encourages agencies to expand employee access to unpaid leave, including for those experiencing violence. Available at: https://www.whitehouse.gov/briefing-room/presidential-actions/2023/02/02/memorandum-on-supporting-access-to-leave-for-federal-employees/.

5 Integrating the justice system in the service delivery response to intimate partner violence

The justice sector plays a foundational role in enabling victims/survivors of intimate partner violence (IPV) to seek justice and safety in response to violence. Although the justice sector in general, and police officers in particular, can be involved from emergency situations to long-term recovery, victims/survivors have too often been underserved by victim-blaming and underestimated risk assessments. Integrated service delivery (ISD), including co-location/referrals to partners in other social sectors and legal advocacy, can help repair these gaps and promote victims/survivors' holistic recovery.

Key findings of this chapter

The justice sector plays an important role in combating gender-based violence (GVB) and intimate partner violence (IPV), not least since legal frameworks provide the foundation on which claims of wrongful action can be made. The police serve as an important gatekeeper to accessing justice, security and protection, and they can refer victims/survivors to related interventions and support.

- While access to justice, in theory, is readily available for those in need in most OECD countries, the justice system is often complex and difficult to navigate. It is therefore crucial that the justice sector is included in systems of integrated service provision (ISD) and becomes more people-centred, taking into account the legal and justice needs of victims/survivors.
- For too many victims/survivors, the police services do not do their best work in investigating and stopping GBV and IPV. Training, standardised danger and risk assessments, and more effective use of barring orders can help the police improve their services.
- Co-locating civil society organisations and other GBV specialists in police stations and ensuring that cross-sector referrals to alternative sites work well can open up cross-training opportunities, make services more effective and help victims/survivors access the right services at the right time.
- Countries have also worked to ensure that more victims/survivors are able to make use of the legal frameworks that exist to support them by creating and funding targeted justice services and legal advocacy supports.

5.1. Involving the justice system from crisis through recovery

The justice sector, and particularly services provided by the police, play a multi-dimensional role in responding to gender-based violence (GBV) and intimate partner violence (IPV) against women, both in crisis situations and in longer-term recovery. To start, legal frameworks are the foundation for justice sector responses to IPV (OECD, 2021[1]). The Istanbul Convention elaborates at length about minimum requirements of substantive law in order to best protect the rights of women exposed to domestic violence (see Chapter 1, Box 1.2, for more on the Istanbul Convention) (Council of Europe, 2011[2]). This predominantly takes the form of criminalising sexist and violent behaviours, including stalking, forced marriage, and physical, sexual and psychological violence.

For victims/survivors, police sometimes serve as gatekeepers to accessing justice and other important supports, as reporting a crime to the police is an entry point for access to important interventions and safety (Saxton, 2022[3]). The police will often be called to the scene of violence to deal with a domestic dispute, and together with the courts, the police may decide on and enforce protective measures such as restraining orders. The justice sector also plays a role in criminal investigations following reports of IPV: courts provide the arena for which civil or criminal appeals for justice are made, sometimes with the help of legal advocates. The Istanbul Convention outlines procedural standards, including for victim's compensation, legal aid, sanctions and protection orders which are jointly executed through court and police arms of the justice system (Council of Europe, 2011[2]), though OECD research suggests that these targets are rarely fully met – even in OECD countries (Box 5.1).

Similarly, legal and justice needs, issues, and criminal and/or civil procedures are often intrinsically tied with other social, economic, health, or employment issues (OECD, 2021[4]). Victims/survivors may need access to various public services in addition to several legal and justice services, often at the same time,

undergoing different processes to resolve several issues at once. A holistic response to GBV requires strong collaborations among organisations within the justice system and between the justice system and other sectors (OECD, 2021[5]).

At the same time, an integrated justice response to IPV includes multi-dimensional perpetrator responses in tandem with multi-sectoral responses for women to wholly address the problem of GBV. Whereas most interventions focus on supporting the victim/survivor, justice-sector actors are in a good position to mandate perpetrator treatment and hold perpetrators accountable for their violent behaviour (see Chapter 2 for more on perpetrator-focused interventions). This need not always take the form of incarceration, but will crucially involve other forms of justice such as monitoring/tracking perpetrators' movements, mandating the entry into perpetrator programmes to prevent recidivism, following solutions based on restorative justice, or other outcomes based on problem-solving approaches (OECD, 2016[6]).

Similar to health care systems, police are readily available to respond to crisis in most OECD countries. De jure, those who experience IPV can seek help through the police and hold their perpetrators accountable through the court systems when the laws against GBV have been broken. At the same time, de facto access to justice is harder to achieve. The legal and justice system can be hard to navigate for non-experts, and many victims/survivors have low trust in the police force being able or willing to support them. To an extent, such reluctance may be justified given historical cultures of victim-blaming and down-prioritisation of GBV cases in parts of the justice sector (see Chapter 2 for more on barriers to reporting abuse).

This chapter focuses on justice sector responses and the specific pathways for victims/survivors which integrate multisectoral, trauma-informed supports for women experiencing IPV, notably by way of multidisciplinary police teams and services rooted in advocacy and empowerment, including specialised domestic violence courts.

Box 5.1. Legal frameworks are the foundation for ending gender-based violence

Solid legal frameworks are the basis for victims/survivors' ability to make claims against their perpetrators. Despite this, according to the OECD Social Institutions and Gender Index's (SIGI) survey of legal institutions, there is no participating OECD member country that has a fully comprehensive legal framework against GBV (SIGI, 2023[7]). Indeed, such a legal framework would need to help to co-ordinate criminal and civil procedures to respond to the multidimensional nature of GBV.

According to the forthcoming Social Institutions and Gender Index (SIGI) data and report, all OECD countries have basic legislation against rape and sexual harassment, but there are legal loopholes. While all OECD member countries criminalise rape under their legal frameworks, only 32 countries cover sexual abuse in a domestic relationship as an offence and just 27 countries explicitly prohibit marital rape (SIGI, 2023[7]). Moreover, only 22 OECD countries have implemented the progressive form of legislation where rape is defined as a lack of consent, rather than based on the need to prove that non-consent was explicit and heard. Similarly, while the law prohibits sexual harassment in all OECD countries, the law only includes criminal penalties in 28 OECD member countries (ibid).

Of particular relevance to this report, not all OECD countries have legislated against domestic violence: to date, it is only considered a criminal offence in 31 out of 38 member countries, while seven countries do either not have legislation on domestic violence at all, or existing legislation does not extend to the entire territory or domestic violence is only covered in their civil legislation. Moreover, countries do not always include all forms of abuse: physical, sexual, psychological and economic. Indeed, only 24 OECD countries specifically cover economic abuse in their definitions (SIGI, 2023[7]).

Source: (OECD, 2023[8]; SIGI, 2023[7]).

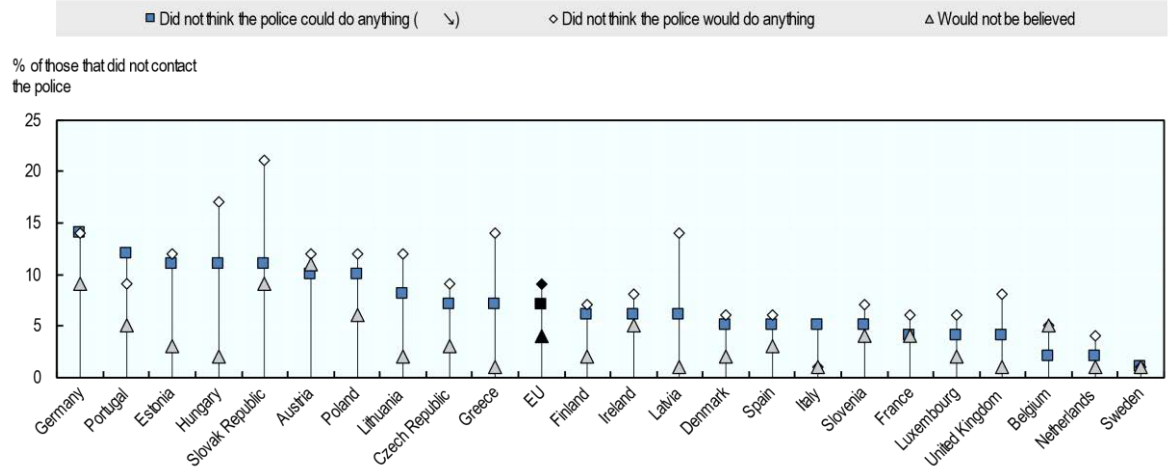
5.2. Countries are working to equip police forces to deal with partner violence

Even though the police often act as a gatekeeper for support, protection and other interventions, victims/survivors often hesitate to involve them. Many think that the police officers will not believe the help-seeker, that the police will not (or *cannot*) do anything, that their children might be taken out of the household, and/or that the perpetrator will retaliate against the help-seeker or her children if she reports to the police. Indeed, the latest EU Agency for Fundamental Rights (FRA) survey on violence against women illustrates that – on average across EU OECD countries – nearly one in ten (9% of) victim/survivor respondents failed to report their most serious incident of physical and/or sexual violence because they did not believe the police would do anything in response, and 7% did not believe the police *could* do anything (Figure 5.1).

These barriers to reporting mean that fewer women seek help, and only do so if their abuse is unbearable or if there are additional risk factors. For example, in Australia, a study of self-reported instances of IPV to police services suggests that women are more likely to engage with police only after multiple, repeated acts of violence, if the perpetrator is intoxicated, or if children are present (Voce and Boxall, 2018[9]).

Figure 5.1. The belief that the police could not or would not do anything is a common reason for not reporting serious incidents of partner violence

Share (%) of respondents reporting that they did not contact the police following the most serious incident of partner violence because they "did not think the police could do anything", they "did not think the police would do anything", or they "would not be believed", among women who report having been the victim of at least one serious incident of physical and/or sexual violence by a partner since the age of 15 and who say they did not contact the police about the most serious such incident, 2012



Note: When asked about the reasons for not contacting police following the most serious incident of physical and/or sexual violence by a partner since the age of 15, respondents could indicate one or more answer categories according to their experiences. Partners include persons with whom the respondents were, or had been, married, living together without being married, or involved in a relationship without living together.
Source: (European Union Agency for Fundamental Rights (FRA), 2012[10]), Survey on violence against women in EU, 2012, http://fra.europa.eu/en/publications-and-resources/data-and-maps/survey-data-explorer-violence-against-women-survey.

Research shows that some victims/survivors' fears about going to the police to report their perpetrators are justified. Police forces lack specialist understanding of IPV and have a history of undermining witness accounts, blaming the victims/survivors for the crime and underestimating the danger victims/survivors are in from IPV. For instance, a recent report from the United Kingdom points to a lack of specialist training on matters of GBV, an internal culture of victims/survivors-blaming, disproportionate investigative efforts to

establish the credibility of the victims/survivors (Stanko, 2022[11]). These are all obstacles to effective police intervention in GBV cases, impeding an individual's access to justice and contributing to an overall reluctance to report such incidences (Mundy and Seuffert, 2021[12]; Moylan, Lindhorst and Tajima, 2017[13]; Venema, 2014[14]; Glenn, 2021[15]; Sikder et al., 2021[16]; Langenderfer-Magruder et al., 2019[17]; Newberry et al., 2022[18]).

5.2.1. Unrealised potential for further victim/survivor support in police services

The Istanbul Convention stresses the need for regular, trauma-informed training initiatives for all professionals who may come in contact with women experiencing domestic violence (Council of Europe, 2011[2]). Without training, police officers risk misevaluating help-seekers.

The Australian Government reports recognising the importance of training and has committed to develop and deliver a national training package to enhance the effectiveness of police responses to family, domestic and sexual violence issues. To achieve this, the Government will work with state and territory law enforcement agencies and victims/survivors. This package will seek to train law enforcement on a series of complex family, domestic and sexual violence matters, including coercive control, sexual assault, technology-facilitated abuse, child safety, and detrimental attitudes and behaviours.

A recent study from the United States suggests that, when training is lacking, police officers may misinterpret manifestations of trauma, confounding these instead with low credibility or apathy (Franklin et al., 2019[19]). Women may also appear disoriented or confused as they attempt to recount violent events to police following strong blows to the head, further compromising their perceived credibility (Concussion Alliance, 2022[20]). It has also been documented that perpetrators often call their partners "crazy" and deliberately do things to make their partners feel that they are going crazy (HHS Family and Youth Services Bureau, 2020[21]; Warshaw et al., 2020[22]).

These factors may be exacerbated for victims/survivors experiencing substance use coercion – a situation whereby their abusive partners encourage or force them to take substances, or to take more than they initially wanted (Chapter 3, Box 3.1). These victims/survivors may also lose credibility among providers who are not trained to understand such effects, including non-expert police officers. This can be especially damaging where police officers resign from providing additional supportive services as a result of victim-blaming or a misinterpretation of risk.

More could be done to make effective and objective use of danger and risk assessments (overviewed in Chapter 2). Without specialist training or robust actuarial risk assessment frameworks, risk assessment may be subjective and underestimate risk. For example, one study uncovered discrepancies in the levels of risk attributed to fictional IPV cases by 38 experienced police officers working in the United Kingdom. When participating officers were reminded of national risk assessment guidelines, one-third changed their original designations (Kebbell, 2019[23]). Similarly, in the Canadian province of New Brunswick, a recent study shows officers being much more likely to arrest a perpetrator as part of a risk management strategy after having deployed an actuarial risk assessment tool (70.2%) than were officers who did not use the tool (26.8%) (Ballucci, Campbell and Gill, 2020[24]).

Related to this, barring orders, restraining orders or protection orders risk being underused if risk assessments are subjective or underestimate risk. The Istanbul Convention highlights the important role of emergency barring orders in de-escalating situations of domestic violence and prioritising the safety of women experiencing IPV, but these orders are not as widely used as they could be (Council of Europe, 2011[2]). The decision to restrain a perpetrator is often subject to police officers' interpretation of risk at the moment of reporting. Better training and clear risk assessment frameworks may therefore help ensure that restraining orders are more effectively used.

While many risk and danger assessments ask about the history of abuse and some ask about any knowledge of partners' criminal records, it may be useful to more systematically complement the

information provided by victims/survivors with information from police records. For instance, Turner, Brown and Medina-Ariza (2022[25]) build a model incorporating several observable factors to predict the occurrence of domestic violence against women. They find that the most influential variables in the model were related to criminal history, domestic abuse history, and time since the last incident.

5.2.2. Co-locating community-based service providers can make police services more accessible

In addition to specialised training, integrating providers from outside the police service has also been found to increase feelings of safety and security among help-seekers, as well to increase confidence in police services more generally. The co-location of service providers can help reduce administrative burden, both for service providers and for the women they are helping (Chapter 1), with the added benefit of freeing up resources to offer more training, integration and better support.

Recent studies in Australia, for example, have shown that the presence of community advocates in police stations has created opportunities for cross-training, in addition to increased police accountability and transparency when addressing cases of GBV (Mundy and Seuffert, 2021[12]; Newberry et al., 2022[18]; Morgan and Parkes, 2018[26]). Similar studies about specialised women's police stations have also shown positive outcomes, namely through increased uptake in GBV-related services driven by growing public confidence in countries as diverse as Portugal, India, Argentina and Brazil (see Box 5.2 for one example) (Machado et al., 2021[27]; Carrington et al., 2020[28]; Newberry et al., 2022[18]).

Box 5.2. Women's police stations in Buenos Aires, Argentina

131 of the 645 police stations in the province of Buenos Aires are so-called "women's police stations." This means that about one in five police stations in the province have a special mandate to respond to cases of sexual and gender-based violence against people of all genders, including members of the LGBTI+ community, as well as general services. Services are available 24/7, and stations have multiple consultation rooms and are designed to host children.

These specialised police stations house multidisciplinary teams, including social workers, police officers, lawyers and psychologists who may be male or female, and are led by a superintendent of gender policy. In addition to direct service provision, women's police stations also engage in community-based prevention activities on a monthly basis.

Most notably, they are also mandated to meet on a monthly basis to ensure service providers are aligned with internal mandates and geographically relevant needs. They participate on local boards (mesas locales), co-ordinate with other government organisations and collaborate with educational institutions, justice centres and courts on a regular basis to ensure coherent service delivery.

This does not mitigate the need for comprehensive gender mainstreaming in all police stations, so that all officers are equipped to receive and support victims/survivors – but it is a potentially useful step to a more effective response.

Source: (Newberry et al., 2022[18]; Ministerio de Seguridad, 2022[29]).

The composition of the police force matters, too. One study from the United States uncovers a significant correlation between female representation in police forces and the increased reporting of violent crimes against women, especially cases of IPV. The authors also find that increases in female officers are associated with declines in rates of intimate partner homicide and non-fatal domestic abuse (Miller and Segal, 2019[30]).

Throughout the OECD, integration and co-location initiatives in police stations have often started at the local level. These successful examples at the subnational level can be helpful to better shape policy recommendations from the top. In Porto, Portugal, the local public prosecutor's office operates a special victim support office from within the Bom Pastor police station. Although the office supports victims of a variety of crimes, it is a key stakeholder in stakeholder in the development and deployment of Porto's most recent action plan, the "Municipal Plan for Equality and for Combating Domestic Violence" (2018-21). In New South Wales (Australia), a non-governmental domestic violence intervention service has set up in the Nowra police station and works closely with police to deliver co-ordinated responses to help-seeking women (Box 5.3).

In some countries, police are also involved in so-called "MARACs," multi-agency risk-assessment conferences, or similar case conferences bearing slightly different names. These meetings bring together community police, health care workers, public prosecutors, social workers, child welfare providers and case managers, on a regular basis, to ensure the long-term safety and continuity of care for women who are particularly at-risk of present IPV. Such case conferences are reported to exist in Australia, Austria, the United Kingdom, Finland and New Zealand, though service delivery arrangements vary in different national and local contexts (Chapter 1).

Box 5.3. Local-level examples of integrated service delivery within police stations

Case Study 1: Victims' Support and Information Cabinet (GAIV), Porto, Portugal

In 2013, the Public Prosecutor's Office of the municipality of Porto initiated "PSP-Porto Victim's Support and Information Cabinet" (GAIV) – a permanent service desk working in parallel with the city's public security and police services to handle all local cases of domestic and family violence, in particular.

In line with stakeholder recommendations, GAIV operates from the new Bom Pastor Police Station, which was designed to be more welcoming than traditional police stations. The station features different rooms, such as learning and training rooms, spaces for children, and designated areas to keep victims and offenders separate when both are present at the station. Between 2013 and 2018, GAIV assisted nearly 11 000 cases, most of which were domestic violence (DV) calls made by women between the ages of 30 and 40.

The GAIV task force is comprised of 16 agents, headed by an officer in chief, who provide 24-hour services available seven days a week to residents of Porto. Service delivery is facilitated by inter-organisational co-operation between police, local NGOs, health services and public prosecutors, for which GAIV acts as a focal point and co-ordinating body in case management. It is also tasked with implementing court orders alongside clients, for example, by escorting them to collect personal belongings from their homes or accompanying them to legal proceedings. Finally, GAIV also manages tele-assistance devices which, if triggered, rapidly deploy police to engage in crisis intervention.

GAIV is also involved in the broader municipal response to GBV, acting as a key stakeholder in the development and deployment of Porto's most recent action plan, the "Municipal Plan for Equality and for Combating Domestic Violence" (2018-21).

Case Study 2: Domestic Violence Intervention Service (DVIS), New South Wales, Australia

The YWCA's Domestic Violence Intervention Service (DVIS) has been co-located at the Nowra Police Station in New South Wales (Australia) for over ten years. It is the only police-based co-location model of its kind in Australia, providing long-term support by co-ordinating service delivery between government agencies, legal and criminal justice institutions, and other community-based NGOs on a case-by-case basis.

Police and DVIS workers interact on a daily basis, creating an opportunity for cross-training, upskilling and the expansion of service delivery beyond the criminal justice lens. More importantly, it encouraged a relationship of trust between two very different providers, facilitating overall collaboration in service delivery.

A recent evaluation of the DVIS initiative suggested that the presence of community-based advocates increased police accountability and transparency when addressing cases of gender-based violence, specifically DV against women. The evaluation found that co-location of this type had an immediate and positive impact on such reporting barriers associated with police, such as victim-blaming and trivialisation of violence. The presence of community-based workers meant that individuals reporting cases of GBV were more likely met with emotional support, empathy and validation, and were guided through the web of resources and services involved throughout the help-seeking process.

Source: (Machado et al., 2021[27]; Mundy and Seuffert, 2021[12]; Porto, 2018[31]; YWCA, 2023[32]; Carrington et al., 2020[28]; Campanhã Parish Council, 2020[33]).

A few OECD countries' Ministries of Justice have developed co-location strategies at the national level. In Denmark and in Norway, for example, integrated service delivery models which were developed at the national level are being deployed locally (Box 5.4).

Box 5.4. Ministries of Justice can plan for co-location in police stations

Denmark: Civilian experts embedded in police stations to work on complex cases of violence

In 2021, each of the 12 police districts in Denmark established specialised inter-disciplinary teams to respond to GBV. The initiative was funded by the Ministry of Justice and required that each police district incorporated at least two civilian employees to support investigators working with vulnerable complex cases of violence, including sexual assault, stalking and domestic violence. Otherwise, individual police districts were at liberty to establish their multi-disciplinary teams as they deemed appropriate given their working contexts.

In general, the Teams consist of police officers, in addition to social workers, psychologists, and criminologists, who provide general support and legal guidance to help-seeking individuals in the wake of GBV. They are responsible for screening and identifying cases of GBV, and to provide initial case co-ordination, including referral of victims and perpetrators to relevant external collaborators. Specific duties include: appointing a contact person to offer guidance and information about rights, compensation, procedural rules related to court appearances, and preparation in connection with case progress; appointing a public lawyer for criminal cases; issuing restraining-, exclusion- and expulsion orders (emergency barring orders), including immediate restraining orders.

In addition, the Teams play an important role in educating their peers on trauma-informed practice, especially when addressing cases of IPV, rape, stalking, so-called "honour" crimes and hate crimes. In an effort to better address these cases wherein plaintiffs are especially vulnerable, the Danish Police has also established 30 specially designed interrogation rooms. Because the initiative is fairly recent, monitoring and evaluation has not yet been planned.

Norway: Project November

Project November was a multidisciplinary pilot deployed as part of the 2013 Ministry of Justice and Public Security Action Plan against Domestic Violence; and has since been adopted in the Oslo Police District. The Crisis Centre Act requires the municipality to provide comprehensive and co-ordinated

follow-up of women, men and children who are victims of domestic violence (DV). Recently, the Trøndelag police district started a pilot project based on the experiences gained from Project November.

Project November brought together different agencies in the Stovner police station in Oslo. The interdisciplinary group of police, psychologists and social workers which are divided into two teams: (i) a police team, comprised of specially-trained officers, who perform domestic violence risk analyses; and (ii) a psycho-social team, comprised of social workers and psychologists who support the police team in conducting risk assessments, in addition to providing support, counselling and advocacy related to accessing other, related agencies such as housing and social services.

Analyses of Project November identify a lack of co-location which has frustrated efforts to have police and other service providers meet with women experiencing DV in a common location. Scholars attribute this unintended outcome to four factors: (i) opting to create dedicated Project November psychologists and social workers rather than co-locating staff from existing services, as was originally intended; (ii) performing insufficient groundwork at the national level (ministry and directorate level) to ensure municipal level commitments; (iii) a lack of political will from the City of Oslo municipality to engage with Project November's mandate, which requires interaction between the police and the municipality; and (iv) an unfulfilled mandate by the City of Oslo municipality to take the lead on co-ordinating assistance for those experiencing violence, largely due to pre-existing challenges.

Source: OECD QISD-GBV, 2022 (Annex A); (Bredal and Stefansen, 2017[34]; Bredal, 2019[35]).

5.2.3. Police can refer victims/survivors to related service providers

As a minimum level of support, where co-location is not possible, police services can nonetheless provide an important entry point for women experiencing IPV to access integrated service delivery. Some OECD countries have created explicit, inter-sectoral linkages where police services initiate related, inter-disciplinary help-seeking services (see Table 5.1). In Austria, the Czech Republic, Luxembourg and the Slovak Republic, for example, police are required to contact support services and link them with the women experiencing violence. Australia frequently co-locates community-based service providers within existing police stations, while others have introduced specialised women's police stations (including Portugal, India, Argentina and Brazil).

Table 5.1. Examples of linked services initiated following police engagement

Country	Description of services delivered
Austria	When police issue barring orders, they are under legal obligation under the "Protection Against [Domestic] Violence" Act to notify one of nine Violence Protection Centres in Austria. The Violence Protection Centre proactively contacts and follows-up with the potentially endangered person in order to offer support in the form of safety planning, legal advice and referral to justice sector providers.
Belgium	The Houses of Justice, via Judicial Victim Support Services, actively contact victims and perpetrators in domestic violence cases, by telephone or video conference, to inquire about the situation and to ensure follow-up.
Czech Republic	Following the expulsion of a perpetrator of domestic violence from a home, police identify individuals in need of support to Intervention Centres.
Denmark	In 2021, each of the 12 police districts in Denmark established specialised inter-disciplinary teams to respond to GBV (see Box 5.4).
Luxembourg	Following the expulsion by police of a perpetrator of domestic violence from a shared dwelling, the *Support Service for Victims of Domestic Violence* (Service d'Assistance aux Victimes de Violence Domestique – SAVVD) proactively contacts victims to offer psycho-social support, psychological counselling, referral services, in addition to legal counselling and accompaniment to and from legal appointments, including court proceedings.
Norway	Police districts in Oslo, and more recently in Trøndelag, have adopted interdisciplinary teams to address GBV following a 2013 pilot project known as *Project November* (see Box 5.4).

Slovak Republic	After evicting a perpetrator of violence from a shared dwelling, police are obliged to signal, within 24hrs, the local intervention centre. In turn, the intervention centre proactively contacts the victim within 72hrs of the offense to offer a range support services.
Türkiye	A risk analysis form is filled in for victims of domestic violence who make contact with police services. The form is transmitted to the Violence Prevention and Monitoring Center (ŞÖNİM) through data integration. After this, ŞÖNİM begins to provide services for victims of violence.

Note: This table presents a non-exhaustive list of ISD practices in police services to support survivors of violence in the OECD. Additional comments were incorporated following OECD members' review.
Source: OECD QISD-GBV 2022 (Annex A); (Hae-yeon, 2021[36]; YNA, 2019[37]).

5.3. Integrating legal advocacy services to improve access to justice

Women experiencing IPV may need support navigating legal procedures, including criminal and civil matters related to enforcing protection or barring orders against their abusive partner; ensuring their legal entitlement to possessions or property; and securing legal custody of their children where applicable. Such processes can be intimidating in the best of circumstances and may be particularly overwhelming during crises linked to intimate partner violence.

In addition, justice services have been criticised by some scholars as prescriptive, framing criminal justice responses as being in the best interest of the victim rather than empowering help-seekers "to make choices that are less coerced by their circumstances" (Hoyle and Palmer, 2014[38]). Services may be able to offer better support and achieve longer-term solutions when they are flexible and victim/survivor focused, working with women to find solutions that address their needs and desires, rather than providing standardised services (Hoyle and Palmer, 2014[38]).

A recent study from the United States conducted personal interviews to better understand how "justice" and "accountability" were defined by women who had experienced IPV. The study found that, while approaches like incarceration offered accountability and (temporary) safety, such approaches remained limited in terms of addressing root causes of violence. Women participating in study expressed the need and preference for "restorative aspects of justice, including perpetrator's acknowledgment of harm, achieving physical safety and stability, and perpetrator rehabilitation through counselling" (Decker et al., 2022[39]).

Victims/survivors also navigate difficult trade-offs in their attempt to achieve security through the justice system. In interviews conducted with US women who experienced IPV in the past year, Decker (2022[39]) finds that some justice goals can at the same time encourage and discourage engagement for formal justice systems, and in some cases, women experienced that incarceration offered only temporary relief, was not effective in encouraging behavioural change, and could exacerbate underlying problems. The existence of such tensions, alone, may reduce willingness of women to engage with the justice sector in the wake of IPV (Decker et al., 2022[39]).

For these reasons, legal advocacy services can help empower women to seek justice on their own terms. To ensure that more victims/survivors are able to make use of the legal frameworks that exist to support them, targeted justice services have emerged alongside legal advocacy supports to better support women in the wake of IPV.

5.3.1. Empowering women through advocacy supports and tailored justice services

Legal advocacy services are designed to facilitate access to resources, either directly, or by providing information, guidance and advice to ensure help-seekers are as well informed as possible about their options across institutional settings (Hoyle and Palmer, 2014[38]). To access justice in the context of IPV, advocacy services are particularly supportive of women through different legal processes associated with civil or criminal hearings.

A number of targeted, national-level initiatives exist in the OECD to support women in accessing justice through *legal support*, including some policies which exemplify multidisciplinary or integrated approaches (see Table 5.2). In Austria and Portugal, for example, dedicated multidisciplinary counselling centres have been established which provide psycho-social counselling in addition to legal counselling and court navigation support to improve access to justice for women impacted by domestic violence. In Australia, legal support services have been embedded in health care settings to streamline access to justice for women who are already accessing health services (see Table 5.2).

These services attract many help-seekers. For example, in 2020, most of the contacts to Victim Support Finland (VSF) were related to domestic violence and sexual crimes (OECD QISD-GBV, 2022, see Annex A). In Latvia, domestic violence is the most common call category to the general legal aid hotline; and in Chile, 75% of people accessing the Centres for Attention to Victims of Violent Crime (CAVI) are women. The majority of them do so in the context of IPV (OECD QISD-GBV, 2022).

In addition, OECD countries have established specialised *domestic violence courts* and adapted proceedings to consider the complexity and potential for re-traumatisation in accessing justice. Costa Rica, New Zealand, Türkiye and the United Kingdom, for example, have established dedicated domestic violence courts which apply trauma-informed practices to empower women as they appeal for justice. Domestic violence courts apply specialised knowledge to better enforce orders, jointly delivered with police, that protect women.

Domestic violence courts can also play an important role in enforcing perpetrator accountability through offender intervention programs. In fact, a recent study from Alberta (Canada) showed that offender recidivism following a behavioural change intervention dropped from 41.2% to 8.2% after specialised domestic violence courts were established and involved in enforcing implementation (Tutty and Babins-Wagner, 2016[40]).

Table 5.2. Examples of multidisciplinary advocacy supports in the justice sector in the OECD

Country	Description of services delivered
Australia	Since 2012, the Government has funded *Health Justice Partnerships* (HJPs), which deliver legal support services in health care settings for women experiencing domestic violence. There are over 100 HJPs across the country, ranging in level of integration from outreach services, to co-location of legal professionals or non-governmental women's advocacy providers in hospitals or health centres.
Austria	The central and regional governments jointly fund a constellation of over 350 multidisciplinary women's counselling centres which provide psychological care, legal advice and, in come branches, family counselling at court.
Costa Rica	The National Institute of Women (INAMU) provides specialised legal care and assistance services, as well as legal representation, for women who are in proceedings related to domestic violence and other forms of violence against women and. This is provided through established, multidisciplinary Regional Units (2 lawyers for each of the 5 Units), as well as through the Care Units of the Women's Delegation in the capital (8 lawyers). The Judiciary also has specialised domestic violence courts with specialised Deputy Prosecutors for Gender Affairs. The Integrated Victim Assistance Platforms (PISAV) bring together and coordinates free psychological, legal, health and social services, as well other cross-sectoral services that provide access to justice, under a restorative justice approach. This platform co-locates the court of Domestic Violence, the Alimony Court, Prosecutor, Defense Public Department of Social Work and Psychology, as well as the Victim Care and Protection Office of Crime.
Mexico	In 2021, PAIMEF supported over 250 000 women by delivering over 690 000 legal services to facilitate access to justice in cases of GBV.
New Zealand	The judiciary operates eight Family Violence Courts and two Sexual Violence Courts which aim to expedite proceedings and ensure complainants are not re-traumatised by the court process.
Portugal	In 2019, the Ministry of Justice and the Attorney General of the Republic issued a joint protocol to establish special branches to address GBV within the existing cross-national network of multidisciplinary *Victim Support Offices* (Gabinete de Apoio à Vítima – GAV). The Offices offer emotional, legal, psychological and social support services through strategic partnerships. In 2021, additional offices were opened within existing National Support Centres for the Integration of Migrants (Centro Nacional de Apoio à Integração de Migrantes – CNAIM) to offer assistance to people affected by domestic violence and/or harmful traditional practices, namely victims of female genital mutilation and early or forced marriages.

Spain	Support is offered to the victims/survivors of violence by recognising their right to information and free legal counsel. In addition, the Organic Law 1/2004 created the Courts for Violence against Women as specialised courts with jurisdiction for criminal and civil cases on acts that constitute crimes of gender violence. In 2019, a total of 106 Courts dealing exclusively with cases of Violence against Women and 353 compatible courts had been created.
Türkiye	Specialised domestic violence courts have been established by the Ministry of Justice to ensure timely preventative and protective measures in cases of violence against women. The Ministry of Justice has also established Directorates of Judicial Support and Victim's Services in 161 courthouses across the country. Vulnerable groups including the victims of domestic violence are able to get information and psycho-social services during the proceedings.
United Kingdom	Over 120 Specialist Domestic Violence Courts (SDVCs) have been established across England and Wales.

Note: This table presents a non-exhaustive list of multidisciplinary legal advocacy practices for survivors of violence in the OECD. Additional comments were incorporated following OECD members' review.
Source: OECD QISD-GBV 2022 (Annex A); (Government of Spain, 2019[41]; Alonso and Valverde, 2017[42]).

5.3.2. Advocacy services can help victims/survivors navigate a challenging legal landscape

Justice sector specialised advocacy can be especially helpful when navigating ambiguous, changing or entirely new legal landscapes. This is especially true today, as certain forms of violence proliferate on the internet and remain difficult to report or prosecute (EIGE, 2022[43]). According to the Fundamental Rights Survey (2020[44]), 25% of 16-29 year-old women in EU countries report having experienced cyber-harassment in the past five years.

Digitally-facilitated stalking and harassment are becoming increasingly prevalent, as are digital sex crimes such as trading intimate personal photos or videos without permission (Jurasz and Barker, 2021[45]). In October 2021, GREVIO adopted a General Recommendation on the digital dimension of VAW. In it, they introduce a number of new obligations under the Istanbul Convention in relation to digitally-facilitated violence against women, including in the context of domestic violence (Council of Europe, 2022[46]; Coşkun and Güzel, 2021[47]).

In a horizontal review of parties to the Istanbul Convention, GREVIO highlights a general lack of specialist services available to women experiencing digitally-facilitated forms of violence (Council of Europe, 2022[46]). Some OECD countries have anticipated the emergence of this form of VAW. In Korea, the problem of digital violence had led the (now-abolished) Ministry of Gender Equality and Family (MOGEF) to open a central hub, with regional satellite offices, to assist people in seeking justice in the face of new and insidious forms of GBV taking root in the online world.

In Germany, the Government funds *Hate Aid*, a non-governmental organisation which offers counselling to victims of digital violence. Hate Aid also works closely with specialised law firms, and endeavours to cover legal costs where civil proceedings are pursued, though federal funding does not cover legal representation (HateAid, 2022[48]).

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6 Partnership in practice: Integrating non-governmental partners in the fight against IPV

Chapter 6 explores the role of non-governmental organisations (NGOs) and other actors in providing integrated service delivery (ISD) to victims/survivors of gender-based violence (GBV) and intimate partner violence (IPV). Governments and NGOs can usefully co-ordinate service provision for a victim/survivor-centred approach. Co-ordination often comes both in the form of co-location and referrals to established partners. At the same time, restricted flows of information across agencies and providers, together with unpredictable funding streams, risk harming NGOs' capacity to respond to needs and effectively co-ordinate services.

Key findings of this chapter

For a holistic, whole-of-state response to gender-based violence (GBV) against women, governments' direct service provision can be usefully complemented by that of non-government actors. Non-government organisations (NGOs) can play important roles in ensuring a victim/survivor-centred approach to fight IPV.

- Often operating locally or based on "by-and-for" services, non-governmental providers can be more nimble than larger government providers and supply specific technical expertise valuable in the local context, keeping victims/survivors at the heart of provision.
- Non-governmental providers can also offer a more informal route to help-seeking compared to official government-run services, especially when familiar actors in society are brought in as partners. In this sense, NGOs can both lower barriers to reporting abuse, and bring in actors to form a society-wide response to IPV.
- Co-locating services is one useful approach to co-ordinating services across non-governmental actors and government-run services. Where it is not possible to fully co-locate provision in one place – for instance when services target small populations or in rural areas – partial co-location with specialised services being available on certain days or by facilitated phone calls can be a good option.
- Information sharing is key to the effective provision of services but can be especially hard to achieve across government and non-government providers. Clear rules and legislation on how, when and which data can be shared can help to ensure the safety of victims/survivors while being able to share the necessary information to provide appropriate services and avoid re-victimisation.
- Non-government providers typically rely on state funding, but these funding streams are often unpredictable. Unpredictable funding means that NGOs cannot operate in the optimal way, so governments should consider making sure that funding is sufficient and sufficiently consistent to enable longer-term planning.

6.1. Governments need non-government partners to respond to IPV most effectively

Since intimate partner violence (IPV) affects people and their activities throughout all of society, governments do well to partner with civil-society and non-government actors to deliver a holistic response. A "whole-of-state" approach involves comprehensive legal frameworks, minimum standards for services, clearly outlined roles and responsibilities and buy-in across government (Chapter 1).

In addition to this, governments' direct service provision can usefully be complemented by non-government actors to achieve holistic, survivor-centred responses. Non-government actors, including charities, social enterprises, schools, employers and places of business – such as pharmacies, grocery stores and hairdressers – can each play a role in a society-wide response to IPV. This chapter considers the role of partnerships between government and non-government actors in delivering integrated services to support victims/survivors of GBV – and IPV in particular. It highlights perspectives of non-government providers in delivering services, describe key challenges they face and explores how effectiveness can be further improved.

The chapter builds on existing research in the area by evaluating the results from novel findings from the 2022 Consultation with Non-Governmental Service Providers serving Gender-Based Violence (GBV) Victims/Survivors (the OECD Consultation 2022, see Annex B) (Box 6.1).

This chapter first argues that non-government actors are well-placed to deliver technical victim/survivor-centred services. Second, it details experiences of partnerships and co-location from the OECD Consultation 2022 and suggests some ways to improve co-ordination. Finally, it discusses two main challenges faced by non-governmental providers: sharing information and managing funding streams.

Box 6.1. OECD 2022 Consultation with Non-Governmental Service Providers serving GBV Victims/Survivors

The OECD Consultation 2022 (see Annex B) collected responses from 27 non-governmental service providers working to support victims/survivors of GBV. Providers operated in 14 countries, including Belgium, Cameroon, Canada, Finland, France, Germany, Ireland, Latvia, Mauritius, Netherlands, Portugal, Slovak Republic, Türkiye, and the United Kingdom. All categorised themselves as "non-profit, non-governmental organisation/programme that directly delivers services" except for one provider that described themselves as a "for-profit organisation that directly delivers services". Given that nearly all respondents are non-profit, non-governmental organisations (NGOs), this chapter sometimes uses the term non-governmental organisation (NGO) in lieu of the more inclusive term non-governmental service provider.

The consulted providers include those who provide fully co-located services, a combination of integrated and co-located services and providing one primary service. The chapter also uses, albeit to a lesser extent, findings from the 2022 OECD Questionnaire on Integrated Service Delivery to Address Gender-Based Violence (OECD QISD-GBV, 2022, see Annex A) to which 35 out of 38 OECD member countries responded. (For more details about the OECD Consultation 2022 and the Questionnaire used in this report see Box 1.5 in Chapter 1, and Annex A and Annex B).

6.2. Non-government actors contribute to a victim/survivor-centred, society-wide service delivery approach

Non-government actors can help improve the coherence and coverage of service delivery by complementing public services. Smaller non-governmental providers operating locally can be more nimble than larger government providers and supply specific technical expertise valuable in the local context, keeping victims/survivors at the heart of provision. Non-governmental providers can also provide a less formal alternative to the state when seeking help, especially when familiar actors in society are brought in as partners. In doing so, non-governmental organisations play a key role in facilitating a "society-wide" response to GBV.

Non-governmental actors are often well-placed to offer victim/survivor-centred support in their community. Local circumstances can differ widely within the same country, and actors closer to the ground are often more tuned into specific circumstances relevant to their populations than national providers. Community needs can vary significantly between regions or even within cities, and geographic variation often compounds socio-economic differences and disadvantage.

For instance, there are significant regional divergences in the prevalence and experience of IPV across Canada, with rural areas facing some different challenges compared to urban areas, including geographical isolation, scarcity of resources and great difficulty keeping clients anonymous (Faller et al., 2018[1]; Beyer, Wallis and Hamberger, 2015[2]; Forsdick-Martz D., 2000[3]). Indeed, rural providers in Canada often improvise because they lack the specific capacities required to respond to a range of diverse needs (Chapter 1). In the United States, women in rural and isolated areas have to travel more than three times farther than women in urban and suburban areas, and over one-quarter of sampled IPV victims/survivors in rural and isolated areas have to travel more than 40 miles (64 km) to the nearest services (Peek-Asa C., 2011[4]). It is important that services are adapted to the localities they serve, and can respond nimbly, so they can mitigate context-specific challenges experienced by victims/survivors (Box 6.2).

Box 6.2. Complementing governments in providing victims/survivor-centred services

Non-government service provision to support victims/survivors of GBV is widely present in OECD countries. The Istanbul Convention, which many OECD countries have signed, ratified and/or implemented (for more see Chapter 1), emphasises that measures taken to combat domestic violence shall involve, where appropriate, all relevant actors, including civil society organisations. It goes on to mandate that non-governmental actors and civil society be recognised, encouraged and supported at all levels to help combat violence against women (Council of Europe, 2011[5]). This box presents a few examples of how governments work with non-governmental organisations, but the form of funding and support can take many different forms.

Lithuania works with non-governmental providers for specialised services

In Lithuania, non-governmental providers are funded to provide a specialised help services for victims/survivors of GBV through the Specialised Comprehensive Assistance Centres. For instance, they receive financial support from the state budget to provide complex services to children-victim of violence. Within the projects funded by state budget, non-governmental organisation provide services including psychological counselling, psychotherapy, legal services and informational campaigns. Preventive services include positive parenting services, psychological assistance and a Parent Hotline that focuses on psychological consultations provided for free.

Finland entrusts civil-society organisations with providing legal aid and support

The Finnish Ministry of Justice has entrusted Victim Support Finland with a public service obligation to provide and produce general support services for victims of crime under the Victims' Rights Directive from 2018 to 2027. In 2020, most of the contacts to VSF were related to domestic violence (24%) and sexual crimes (14%).

Ireland funds non-governmental providers to lead on provision of housing and refuges

The Irish Department of Housing, Local Government and Heritage's role is to support the work of local authorities and non-governmental organisation who provide accommodation support to victims of domestic, sexual and gender-based violence. This included capital funding support for the development of new refuges. Support for the provision of new refuges will continue under the capital assistance scheme "Housing for All".

Source: OECD QISD-GBV, 2022 (Annex A).

6.2.1. Local providers can address local service needs well

The intersection of social identity and various other forms of disadvantage and vulnerability, such as geographical and social isolation, poverty or lack of access to employment and minority status, can increase the risk of exposure to violence from an intimate partner (Faller et al., 2018[1]). Women facing intersectional disadvantages also often face higher barriers to reporting violence and accessing services than women with fewer disadvantages (Baker et al., 2015[6]; UN Women, 2019[7]). The ability to seek and access help can be influenced by for instance citizenship status, language fluency, financial means, employment status, overall physical and mental health and parental status (Marchbank, 2020[8]). In addition, marginalised populations, such as members of Black, Indigenous, or other ethnic minorities, as well as sex workers, members of the LGBTI+ community and homeless people might have negative past experiences or legacy tensions with formal institutions, and especially the police (Mundy and Seuffert, 2021[9]).

Specific local circumstances intersect with other sources of disadvantage for certain groups, which often increases the need for case-sensitive responses from service providers. For instance, interviews with providers in northern Canada show that many women who need to escape violent partners in the rural and northern regions face a situation where the nearest services are far away and ways of getting to them are limited (Pauktuutit, 2019[10]). In Paris, women's experiences are shaped by the neighbourhood they live in. A study using survey evidence from different family planning centres the metropolitan Paris area finds that experiences differ markedly across centres in different neighbourhoods within the same larger suburban area. Even after controlling for general instability and centre, women who were undocumented or temporarily documented, were out of work, and/or experiencing housing insecurity were most likely to report violence than their less-disadvantaged peers (Roland et al., 2022[11]).

The value of acknowledging intersectionalities is recognised in the UN Women's Handbook for National Action Plans on Violence Against Women (UN Women, 2012[12]) recognises that women's experiences of violence are shaped by social, economic, health and identity factors, and UN Women (2019[7]) highlights the value of specialist services run "by and for" the communities they aim to support. In response, Article 12 of the Istanbul Convention specifically calls on parties to "take into account and address the specific needs of persons made vulnerable by particular circumstances" (Council of Europe, 2011[5]).[1]

6.2.2. *"By-and-for" providers offer valuable expertise to address intersectional needs*

To address these intersectional needs, "by-and-for" service providers play an important role. "By-and-for" service provision refers to services that are run by people from the community they aim to serve (Domestic Abuse Commissioner, 2021[13]). Together with other non-governmental providers with specific technical expertise, "by-and-for" providers add value both due to their context-specific knowledge of how to address intersectionalities, and due to their roots in communities, which can help inspire confidence and feelings of safety that are essential to victims/survivors.

These providers can also add value in informing quality standards and the government approach to service provision (UN Women, 2020[14]; Htun and Weldon, 2018[15]). For instance, Jewish Women's Aid UK provides a secure refuge where Kashrut, Shabbat and festivals are fully observed, which can be an important asset for observant victims/survivors. At Asian Women's Resource Centre UK, victims/survivors do not need to speak in English if they have a different preferred language and they meet professionals who understand the cultural context of the abuse and perpetrator (Centre for Social Justice, 2022[16]). In the United Kingdom, front line workers identify a need for greater investment in "by-and-for" services, with the limited number of specialist refuges often oversubscribed (Safety4Sisters, 2020[17]). Respondents to the OECD QISD-GBV 2022 valued this specialised technical expertise of non-governmental providers and communicated a desire to protect the independence of these service providers (Box 6.2).

6.2.3. Familiar organisations can be easier to approach than formal government agencies

It is valuable to have diverse, non-governmental actors embedded throughout society who can respond to the needs of victims/survivors. Many women find it difficult to report or seek help for violence, for instance because they experience stigma, have a lack of support networks, or do not believe that they will be treated with respect by formal institutions (Chapter 2).

Barriers reporting and/or escaping IPV can be lowered when victims/survivors have the option to use points of contact in places that are more familiar and less formal than government (Sylaska and Edwards, 2014[18]; World Health Organization and Pan American Health Organization, 2012[19]). Charities, the private sector and other familiar non-government institutions are well-placed to act as points of contact and support that bring services closer to women and increase awareness of the right to a violence-free life (UN Women, 2020[14]; Council of Europe, 2022[20]). This broadening of opportunities to report and seek help contribute to governments achieving a whole-of-society approach to respond more effectively to IPV.

One way non-government organisations act as points of contact for women affected by IPV is by training workers in sectors that people often come into contact with, such as education systems, postal systems, and the health care system (Box 6.3; (OECD, 2020[21])). For instance, in the Czech Republic, postal workers received training from the NGO Rosa to recognise signs of domestic violence, communicate with victims about their situation, and offer support and referrals (UN Women, 2020[14]; PostEurop, 2020[22]). In the United Kingdom, the non-governmental organisation Women's Aid trained Jobcentre staff to support women experiencing domestic abuse in 2019 (Department for Work and Pensions, 2019[23]). Now each Jobcentre Plus has assigned points of contact who support those seeking help in situations of domestic violence (Home Office, 2022[24]).

There is scope for doing more in the area of training staff in service occupations with a high degree of client interface. For instance, a 2017 UK medical school survey showed that while 21 out of 25 surveyed institutions delivered *some* education around domestic violence, 15 of respondents felt training was inadequate. Eleven of the surveyed institutions reported providing fewer than two hours on the subject over a five-year course (Potter and Feder, 2017[25]) (Chapter 3).

Some actors in the private sector have taken initiative, too, both in the public sphere and for its own employees. The "One in Three Women" campaign, for example, has brought together 14 multinational

companies to develop best practice on supporting employees who are victims/survivors and promoting community outreach. And due to the heightened risk of violence during COVID-19, Vodafone launched an internal awareness-raising campaign and refocused its global policy on ensuring that employees can work safely from home. Their updated policy details comprehensive workplace support, including ten days of paid safe leave and security measures adapted to remote working from home (UN Women, 2020[14]).

Box 6.3. Pharmacies are well-placed as support hubs since they are regularly visited

Women in Canary Islands, Spain, can use code words to seek help

During the COVID-19 pandemic, many opportunities to move outside of the home were removed, which prompted the Institute for Equality of the Canary Islands to launch the Mascarilla-19 ("Mask 19") campaign. Since pharmacies were one of few essential businesses to remain open during the lockdowns imposed, these provided reliable places from which to provide assistance to victims/survivors of IPV. Woman seeking help could go to a local pharmacy and request a "Mask 19". The pharmacy staff would then note down contact details, notify the police and contact support workers (UN Women, 2020[14]).

Because of the campaign's success in Spain, similar initiatives were subsequently launched in Argentina, Belgium, France, Germany, Italy and Norway (UN Women, 2020[14]). The success of the programme has also meant that pharmacies continue to play a more important role in the Government's fight against GBV and IPV in Spain. In 2021, the Government Office against GBV signed an agreement with The General Pharmaceutical Council of Spain to conduct awareness campaigns via pharmacies (Ministry for Equality, 2021[26]).

UK's pharmacies partner with non-governmental providers to open up as GBV support hubs

During May 2020, pharmacies started providing Safe Spaces within their facilities to support victims/survivors of GBV. The initiative was launched by the UK Says No More campaign and worked with pharmacy chains including Boots, Superdrug, Morrisons, and independent pharmacies. The Safe Spaces offered victims/survivors the possibility to safely contact specialist services (Centre for Social Justice, 2022[16]). By October 2020, a report estimated that one-quarter of pharmacies across the United Kingdom facilitated a Safe Space in their consultation rooms. Since the launch of the scheme, there had been at least 3 700 visits to a Safe Space. (Hestia, 2020[27]).

6.3. Co-location helps non-governmental organisations provide effective services

One approach to integrated service delivery is the co-location of service provision (Chapter 1). This is approach is increasingly common among non-governmental providers: a large-scale mapping of shelters in North America, for example, shows that many offer a variety of services at the location of the shelter, as well as through referrals and transfers on an *ad hoc* basis. The most commonly provided services included crisis management, counselling and mental health support, but children's needs, education and legal advice were also common (Samardzic and Morton, 2020[28]). This co-located approach is also used by service providers connected to the European Family Justice Center Alliance (for more on this, see Box 1.4 in Chapter 1) and the growing network replicating the "Maison des Femmes" model in France (Box 6.4Box 6.4.). These co-located centres are usually financed privately and publicly.

Co-location of different non-governmental providers in one place can improve victims/survivors' access to different services and greater technical expertise to address specific needs. When services are co-located and/or operating under established partnerships, there is also potentially less of a need for case managers

to assist help-seekers navigate a complex system, thereby potentially improving efficiency and effectiveness.

6.3.1. Service providers report the benefits of co-located services

The OECD Consultation 2022 suggests that non-governmental provider see value in integration, co-location and partnerships to provide services. In response to the OECD Consultation 2022 question "What strategies have worked to improve the efficiency of services and trauma reduction?", one organisation reports that it helps to have "co-operation with medical institutions, [a] common understanding what the victim needs are, [and a] multidisciplinary approach". Similarly, another response finds that "Well-established structures of co-operation at [the] local level" are successful. The responding organisation goes on to specify: "this includes modelling the usual paths of clients, so that everyone knows what they can do themselves [and] when and to whom to guide to if [additional help is] needed". Box 6.4 offers an example of co-location in practice.

Box 6.4. *Maison des Femmes* in France co-locates cross-sector support

The *Maison des Femmes* (Women's House) in the suburbs of Paris is a structure that has been specifically dedicated to offering interdisciplinary support by co-locating health, social and judicial services. It is located on the grounds of a public hospital in a separate building and offers services including physical medical care (including contraception, abortion care, clitoral reconstruction surgeries), legal counsel, and psychological consultations (Roland et al., 2022[11]). The model is being rolled out in France and several similar structures have been opened in Bordeaux, Marseille and other cities.

A study compares the clients cared for in the Maison des Femmes with those cared for in two other more typical Family Planning centres women exposed to violence also tend to visit. It is found that despite the centres being geographically very close to each other, survey evidence from clients show that the proportion of women reporting IPV in Maison des Femmes was considerably higher than the proportion in the other two centres. This might suggest that many victims/survivors who seek help are aware of the ability to visit a dedicated centre with co-located specialist services (Roland et al., 2022[11]).

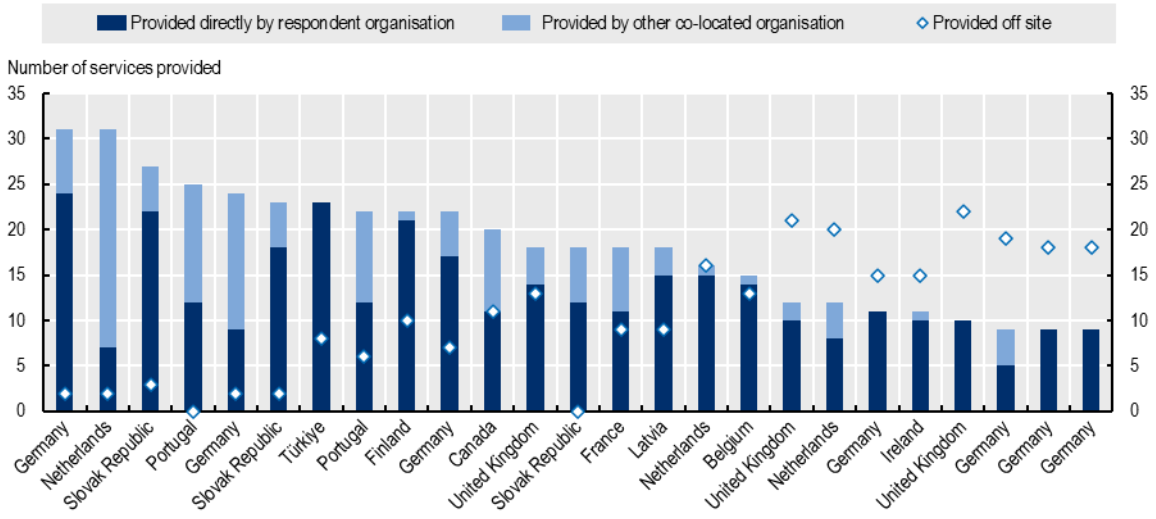
Source: Maison des Femmes (www.lamaisondesfemmes.fr).

The value of co-located services is reflected in the organisational structure of many of the providers who participated in the OECD Consultation 2022. Fifteen of the 27 organisations that responded to the OECD Consultation 2022 reported that they had established partnerships with other organisations working fully or partly in the same location. Eleven focused on providing *one* primary service, although they also have established partnerships with other local service providers and/or agencies with whom they co-operate on a regular basis. (One provider did not specify their level of co-ordination).

They survey also asked respondents about the nature of service provision. Respondents were asked which services are provided: "(a) directly by your staff; (b) directly by staff working through a co-location arrangement; (c) directly via referral to established partners who visit your organisation to meet with clients; (d) provided directly via referral to an affiliated or unaffiliated provider located off-site; or (e) not available in your area". The answers, illustrated in Figure 6.1, suggest that when more services are provided on-site, either by the respondent or by a partner provider who is wholly or partly co-located, there tends to be less of a need to refer help-seekers to off-site service providers.

Figure 6.1. Co-location can help increase service provision at one site

Number of services provided on site by respondent provider, co-located providers and off-site providers, by responding organisations' country location



Note: x-axis labels present the country name of the responding organisation; the y-axis value is therefore not a nationally-representative value for the listed country. This chart excludes three respondents: organisations from two non-OECD member countries and one due to lack of data.
Source: 2022 OECD Consultation with Non-Governmental Service Providers serving GBV Victims/Survivors (Chapter 1, Box 1.5).

6.3.2. Partner organisations play an important role in offering specific expertise

A single service provider is unlikely to have adequately skilled staff, resources and capacity to address all of the diverse needs of victims/survivors. The OECD Consultation 2022 suggests that some services requiring more technical or specific expertise were more frequently provided by co-located partners. These services are interpretation and translation (11 respondents report that this service is provided through a co-located provider), substance use and addiction counselling services (8), and job training, reskilling or adult education programs (8).

Full co-location may not be feasible for services that are not frequently needed. A solution to this is to partly co-locate services, for example by hosting regular site visits by, or facilitate virtual meetings with, professionals with specific technical expertise. This can be a practical solution in rural areas where full-time professionals may not be needed at every site. Respondents to the OECD Consultation 2022 reported that regular visits by different providers to the respondent's site was the most frequent co-location/co-ordination agreement for issues related to support for LGTBI+ victims/survivors, short-term and long-term housing, divorce or child custody related support, children's school liaisons.

The OECD Consultation 2022 also provides some initial indications that there may be scope for further co-location among some of the organisations that responded. This can be seen for organisations that have made little use of co-location yet refer many help-seekers to off-site providers (Figure 6.1). It was common to provide referrals to services located off site for services related to substance use and addiction counselling services (13 respondents report referring to off-site providers for this service) and job training, reskilling or adult education (11). Other services that were often provided by referral to organisations off-site included civil legal matters (11), legal counselling (11) and matters related to residency status, immigration and asylum (12) as well as second-stage/transitional housing (11) and long-term affordable housing (11).

6.4. Governments can strengthen safe information sharing routines across sectors

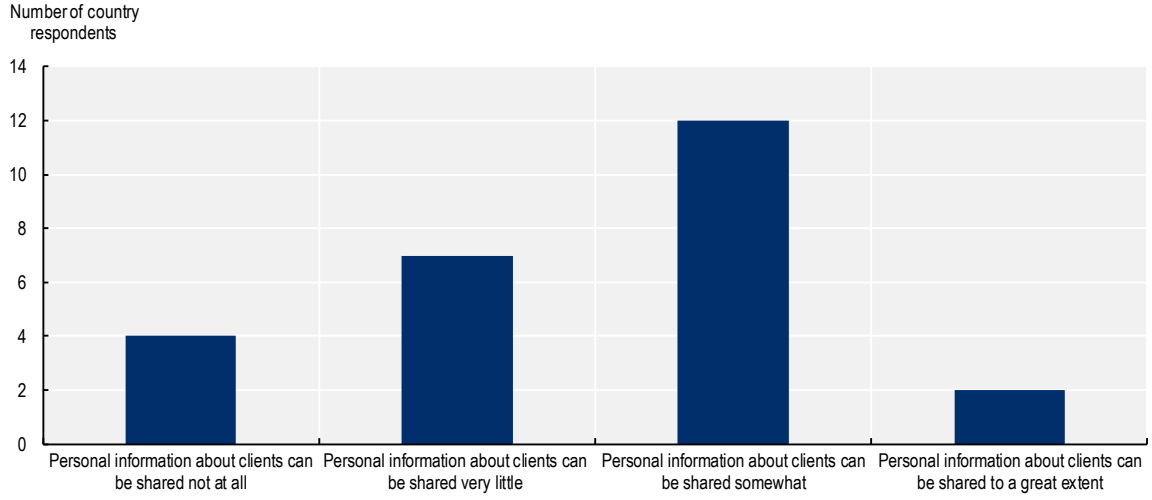
Secure and effective sharing of information is essential to providing integrated services, and this is a particular challenge for non-governmental organisations that are less likely to hold or be able to access relevant information about victims/survivors than the government. Effective sharing of information can prevent re-traumatisation from having to describe experiences of abuse several times and lead to a more efficient and timely public response when women experience violence. At the same time, data privacy is of utmost concern when it comes to victims/survivors of GBV and the risk of personal information leaking increases as more agencies have access to that information (see Chapter 1 for an extensive discussion on problems with data sharing). Several respondents to the OECD Consultation 2022 (see Annex B) suggested that better forms of information sharing – for example, via formal arrangements or an integrated database – are essential to improving outcomes for help-seeking individuals.

Yet data sharing goals face challenges in the field. Providers participating in the OECD Consultation 2022 were asked "How satisfied are you with existing co-ordination mechanisms between sectors and service providers in your area working to support people who have experienced GBV?". Only 12 report that they are satisfied or very satisfied, six neither/nor, and nine that they are dissatisfied or very dissatisfied.

Similar findings emerge from the OECD QISD-GBV 2022 sent to governments. Out of the 26 countries that responded to the question "To what degree can personal information about clients be shared, for example between government and non-governmental agencies or case or social workers and doctors to help reduce the administrative burden and costs for both clients and providers?", only two report that information could be shared "to a great extent"; twelve report "somewhat"; seven "very little"; and four "not at all" (Figure 6.2).

Figure 6.2. Few countries report that client data can be easily shared

Number of countries responding to each description of the degree to which client data are shared across agencies and providers, 2022

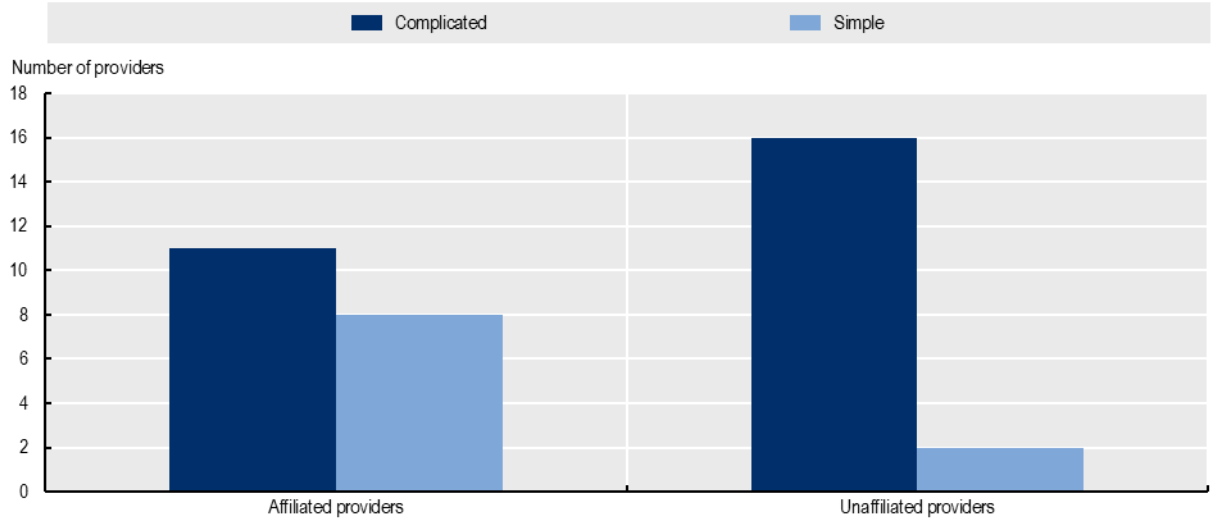


Note: Figure 6.2 presents the distribution of responses to the question, "To what degree can personal information about clients be shared (for example between government and non-governmental agencies, case workers, and doctors) to help reduce the administrative burden and costs for both clients and providers?" Two respondent organisations provided two answers. In those instances, the more conservative option was selected as the primary response. 10 respondents are excluded, one responded "don't know" and nine did not respond.
Source: OECD QISD-GBV 2022 (Annex A).

The OECD Consultation 2022 also suggests that partnerships and information sharing go together. Descriptively it appears easier to share case-related information between affiliated service providers where established partnerships exist, for example, in a situation of co-location. Eight respondents to the OECD Consultation 2022 say that sharing information with affiliated partners is simple or extremely simple, while only two report that information sharing is simple or extremely simple in cases where there are no established affiliation or partnership (Figure 6.3). Part of the reason may be that stakeholders often jointly develop co-ordinated information-sharing protocols and procedures in collaborative service delivery arrangements, so that they can collaborate to perform informed risk assessments and deliver effective solutions to help-seekers (CACP, 2016[29]). In the absence of such protocols, the norm of client privacy siloes prevails.

Figure 6.3. Partnerships and data sharing go hand in hand

Respondent organisations reporting how simple or complicated it is for service providers from their organisation to share case-related information with other service providers, if they are affiliated through established partnerships versus whether they are unaffiliated and/or work in a different sector



Note: Reports results from two questions; 1 "How simple is it for service providers from your organisation to share case-related information with other service providers who are affiliated with your organisation through established partnerships, but who are employed by different agencies; for example, in a situation of co-location?" and 2 "How simple is it for service providers from your organisation to share case-related information with other service providers who are unaffiliated and/or operating in a different sector?". One respondent is excluded due to lack of data. The figure does not report respondents who respond "Neither simple nor complicated", which are seven with regards to Affiliated partners and eight with regards to Unaffiliated partners.
Source: 2022 OECD Consultation with Non-Governmental Service Providers serving GBV Victims/Survivors (Chapter 1, Box 1.5).

6.5. Funding streams should be predictable to facilitate stable service provision

External funding for non-governmental providers is often fragmented, limited and short-sighted, making day-to-day operation difficult and meaning that organisations are not always able to provide services to as high a standard (or with as broad coverage) as they aim to. This also makes long-term partnerships, collaborative working and integration harder to achieve. Moreover, research from the social services sector finds that funding that directly targets the integration of service delivery also tends to be short-term in nature, as it often supports time-limited pilot schemes and trials (OECD, 2015[30]). More predictable funding streams – and funding specifically to achieve efficiency gains, partnerships and cross-sector collaboration

– could help provide better services to victims/survivors and help non-governmental providers settle more firmly into cross-sector partnerships and co-located facilities.

6.5.1. Insecure funding risks destabilising service delivery

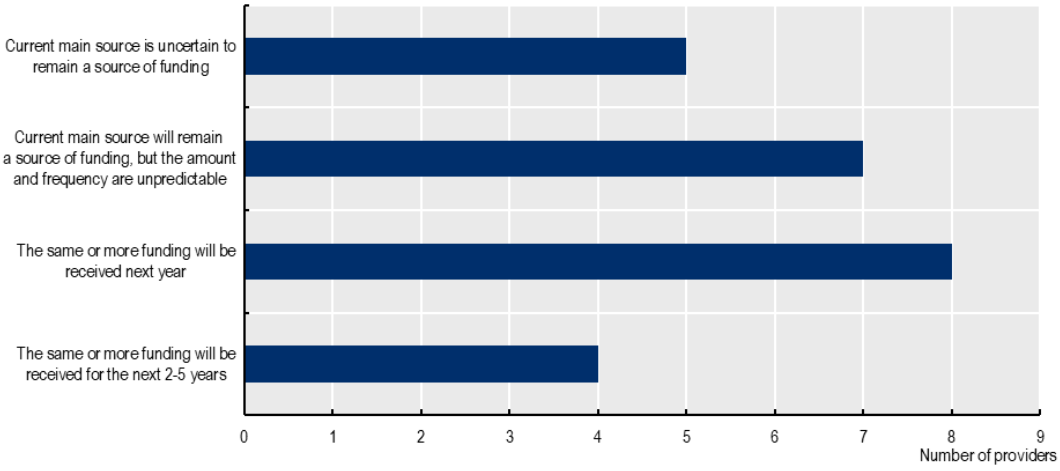
Non-government providers often flag that their lack of secure funding ends up limiting the services that they are able to operate. Resource shortages and funding delays can be an obstacle to implementation of time-sensitive action plans, such as in crisis-response intervention (Schreiber, Maercker and Renneberg, 2010[31]). Variable funding streams can also complicate the provision of ongoing services, through limiting the ability of providers to plan strategically for the future and hire and retain staff. This can create a heavy reliance on volunteers (Centre for Social Justice, 2022[16]; Baffsky et al., 2022[32]; Skinner and Rosenberg, 2006[33]). These findings are echoed by respondents to the OECD Consultation 2022. For instance, when asked to describe resources or procedural adjustments that would make a significant impact for clients in the way of streamlining services, one provider responds that "more advice would be possible if the institution were independent of donations."

Providers responding to the OECD Consultation 2022 report that their funding is often concentrated across few sources. Nine providers (out of 23 answering this question) report that they are receiving funding from three or fewer funding sources. Nine providers also report that 81-100% of their budget comes from one single funder, with some providers reporting that this large portion is combined with various smaller pots and some reporting few, if any, additional sources. This concentrated funding comes from national, regional or municipal government.

In most of the cases where funding is reported as predictable for at least one year into the future, the government is the primary provider of funds. Only four providers in the OECD Consultation 2022 report that their main source of funding is secure for the coming 2-5 years. In these cases, the main funder is the government. A further eight providers in the OECD Consultation 2022 are reassured by predictable funding from their main source for the following year (Figure 6.4). Conversely, in three out of the four cases where the main sources of funding came from outside of government (private/corporate funding, charitable trust or internal fundraising), that source of funding is uncertain.

Figure 6.4. Less than half of respondents report that their main source of funding is secure in the coming year(s)

Count of respondent organisation by degree of uncertainty in organisations' main sources of funding, 2022



Note: The share of each main funding source of the total budget ranged from 1-20% to 81-100%. Three respondents are excluded due to lack of data.
Source: 2022 OECD Consultation with Non-Governmental Service Providers serving GBV Victims/Survivors (Chapter 1, Box 1.5).

Governments can help by protecting funding for non-governmental organisations working to combat IPV. Budgets can be designed to support cross-sector co-ordination. Lessons can be drawn from the United Kingdom, for example, which recently implemented funding rules to boost investment in mental health services. The funding rules places conditions on re-financing by central or subnational governments and aims to better ensure continuity and coherence of planning from the top-down. Such provisions have the potential to be effective in the context of gender-based violence, too (Box 6.5).

Box 6.5. NHS England's mental health investment standard

The National Health Service (NHS) in England introduced a "mental health investment standard" (MHIS) in 2015-16, to encourage increased spending on mental health services, year-on-year. Since most local mental health funding is not ring-fenced each local NHS Clinical Commissioning Group (CCG) determines its own mental health budget from its overall funding allocation. To ensure that (at least nominal) funding for local mental health services increase year-on-year, the MHIS requires that all CCGs in England increase their planned spending on mental health services by a greater proportion than their overall increase in budget allocation that year.

Figures from NHS England's Mental Health Dashboard indicate that the measures have been able to show some successes. The Dashboard provides a national and local overview of spending on mental health services. It is promising that 2020-21 was the first year when all CCGs met the MHIS in 2020-21 (for instance, only 81% of CCGs achieved the Standard in 2015-16). In 2020-21, local CCGs spent GBP 12.1 billion on mental health, learning disability and dementia services in England, up from GBP 9.1 billion in 2015-16. In 2020-21, this was 14.8% of the total funding allocated to CCGs for health services, up from 13.1% in 2015-16.

The NHS has also included further spending commitments in its long-term plan. These include a ring-fenced investment fund worth at least GBP 2.3 billion a year by 2023-24.

Source: OECD QISD-GBV, 2022 (Annex A); (NHS England, 2022[34]; NHS North East London, 2021[35]).

6.5.2. Potential savings from integration require committed investment

Lack of predictable funding streams and the associated difficulty with strategic planning means that co-location, integrated delivery and collaborative strategy often requires targeted funding for that express purpose. Non-governmental providers have a lot to gain financially from co-ordination with other organisations – not only can co-ordination help improve the quality and quantity of service provision, it can also offer efficiency gains and cost saving.

For instance, multi-lease arrangements can be more affordable as a result of space-sharing, thereby making these service hubs less vulnerable to fluctuations in funding. Shared workspaces can allow for a redistribution of operational costs through shared infrastructure, such as conference rooms and office equipment, as well as resources, such as community partners and volunteers (Kurpa et al., 2021[36]; Skinner and Rosenberg, 2006[33]). Some countries, such as Denmark, have started initiatives with targeted funding that aims to encourage a move towards integration and co-location (Box 6.6), but there is scope for more strategic action by other countries in this area.

Box 6.6. Denmark invests in integrated service delivery with non-governmental providers

Denmark has funded a new model with integrated services aimed at prevention (Chapter 1, Box 1.3) and in 2020, Denmark allocated DKK 14.5 million (around EUR 1.95 million) to an intervention-model aimed at providing early and preventive contribution against violence in intimate relations. The model consists of a collaboration between the police, the municipality and a non-governmental organisation. When the police respond to calls of domestic disturbances or violence, they will attempt to motivate the persons involved into starting an ambulatory treatment programme at the NGO in collaboration with the municipality. An early evaluation showed that the model helped secure an earlier response to violence in intimate relations (OECD QISD-GBV, 2022).

Denmark will also provide further support to the non-governmental unit against violence, Lev Uden Vold (Live without Violence), to establish cross-sector partnerships. Lev Uden Vold is to use the new funding running until 2024 to establish partnerships with staff in other sectors, such as the police and health care workers, which interact with victims of violence in intimate relations or perpetrators of such violence (Chapter 1, Box 1.3). The goal is to give the staff in partner sectors relevant tools to identify and help victims of violence in intimate relations or perpetrators of such violence (OECD QISD-GBV, 2022).

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Notes

[1] The Explanatory Report defines those made vulnerable by particular circumstances as “pregnant women and women with young children, persons with disabilities, including those with mental or cognitive impairments, persons living in rural or remote areas, substance abusers, prostitutes, persons of national or ethnic minority background, migrants – including undocumented migrants and refugees, gay men, lesbian women, bi-sexual and transgender persons as well as HIV-positive persons, homeless persons, children and the elderly” (Council of Europe, 2011[5]).

Annex A. OECD Questionnaire on Integrated Service Delivery to Address Gender-Based Violence

Introduction

In addition to this survey, over the early part of 2022, the OECD will conduct three further surveys on GBV:

1. An additional survey on *Integrated Service Delivery to Address Gender-Based Violence* for Non-Government Organisation respondents.
2. *2022 OECD Survey on Strengthening Governance and Survivor/Victim centric Approaches to end GBV* (which will be distributed through the OECD Working Party on Gender Mainstreaming & Governance*).*
3. *Social Institutions and Gender Index (SIGI) Legal Survey* (which will be distributed to DEV member countries through its Governing Board).

The aim of the surveys is to identify member states' public governance and survivor-centred approaches to GBV including good practice examples as well as common challenges and requirements. This will help to promote cross-country learning and strengthen the evidence base about what works to support survivors of GBV.

For the purpose of the surveys, GBV refers to any type of violence directed at someone based on their factual or perceived sex, gender, gender identity or gender expression that results in, or is likely to result in, physical, sexual, psychological, or economic harm or suffering, including threats of such acts, coercion, or arbitrary deprivation of liberty. GBV can occur in public, private, and digital spaces. It is a phenomenon deeply rooted in gender inequality, power imbalances, and harmful gender norms. Accordingly, GBV disproportionately affects women and girls, although people of all genders can experience GBV.

This survey – *Questionnaire on Integrated Service Delivery to Address Gender-Based Violence (QISDS)* – focuses on the provision of integrated services. Your responses will inform OECD advice on how to improve and better integrate service delivery for people who have experienced GBV. It is a vitally important area. We know domestic violence has escalated during COVID-19, but even in pre-pandemic times, survivors faced a host of complex challenges when seeking support to escape and recover from violence. To support survivors, different policy and service delivery domains such as education, social protection, justice, health, employment, physical and financial security need to work together. Further, violence against women was the main priority indicated by the vast majority of countries who responded to the question about what areas of gender inequality should be dealt with most urgently in the OECD *Questionnaire on progress towards Gender Equality in the area of "Employment"* circulated to countries in May this year.

The Questionnaire is divided into three sections:

1. *Service Provision and Delivery*: this section presents tables dedicated to specific policy domains (physical health, mental health, housing, etc.). We kindly ask you and your colleagues to identify, as best as possible, which levels and offices of government are responsible for supporting survivors across these policy areas.
    a. The policy areas are presented in separate tables to facilitate your distribution of the questionnaire to relevant staff in different agencies/Ministries if necessary.
2. *Emergency Support during COVID-19*: this section asks about additional resources and tools that your government committed to support people experiencing gender-based violence (GBV) during the pandemic.
3. *Integrating Service Delivery across Domains*: this section explores the degree to which national, federal or central government is directly involved in integrating service delivery (ISD) across providers, and/or promotes ISD. While the section focuses on actions at the national level, information on any relevant actions at the sub-national level are also sought.

Please focus on programmes and resources that are specifically available to survivors of GBV. For example, below you will find a section on child-related services, while a country may offer sole-parent benefits, these benefits should not be included in the table unless the benefit is exclusively available to a parent who has experienced GBV. There is an opportunity in some of the questions to provide information on other services available to, but not *specifically* designed for GBV survivors, if you believe it is relevant.

Service Provision & Delivery

The following seven tables ask about *who* is responsible for the direct provision of *what* services for survivors of gender-based violence, hereafter referred to as “clients”. The tables also ask about the annual funding allocated to entities who are engaged in the *direct* provision and delivery of services for ‘clients’, including the source(s) of funding and the nature or type of services and volumes, that is, the number of clients served if known.

The tables cover the following groups of services:

1. physical health
2. mental health
3. access to justice services
4. housing
5. child-related services
6. income support, and
7. crisis intervention and case management.

In the tables, please only include those services specifically designed to respond to the needs of individuals who have experienced or are currently experiencing gender-based violence. There may be other services available that are not specifically designed for survivors of gender-based violence; these are asked about in the second part of each question.

Note: “Direct provision of services” includes any government operated or government funded front-line office(s) or point(s) of service through which members of the public can access support in the form of services or referrals to services, funded by a dedicated budget. “Direct provision of services” can also mean that government directly employs dedicated staff/service providers who are located in one or more offices operated by an affiliated partner.

Physical health services

How would you describe the role of the following actors when it comes to the direct provision and delivery of physical health services for clients? Please mark an X in the relevant cell where an actor has no responsibility. Where an actor does have responsibility, please include the names of the relevant Ministries, agencies, or departments involved and the specific role they play. Please include URLs where possible.

Please also specify the annual funding allocated to these different actors who are engaged in the *direct* provision and delivery of physical health services for "clients", including the source(s) of funding, the nature or type of services and volumes, that is, the number of clients served, if known.

Note: "physical health services" refers to a broad range of medical services or related referrals, such as dedicated clinics or offices within hospitals; specialised practitioners such as radiologists, physiotherapists or gynecologists who provide dedicated hours to clients; dedicated nurse-operated hotlines; etc. (Mental health services are covered in the next table.)

	Has no responsibility for directly providing dedicated physical health services to clients	Has little or some responsibility for directly providing dedicated physical health services to clients	Has high degree of responsibility for directly providing dedicated physical health services to clients	What is the annual budget for each of the services identified in this table?	What are the budget sources and what share of the budget does each funder contribute (eg federal government 50 per cent and provincial government 50 per cent)?	What is the nature or type of service(s) funded, including numbers of clients served if known, for each of the services identified in this table?
National, federal or central government		[For example: the Ministry of Health, www.health.xx **funds** NGOs to provide subsidised medical services for survivors of GBV.]	[For example: the Ministry of Health, www.health.xx **provides** specialised staff in hospitals to respond to survivors of GBV.]		[For example: national budget, line item ##.]	
Regional, state or provincial government					[For example: services are funded 100 per cent by Provincial government.]	[For example: Provincial government operates specialised units in medical centres for survivors, serving approx.. ## clients annually.]
Local government				[For example: the local health departments **provide** specialised staff in hospitals to respond to survivors of GBV.]		
Non-governmental Organisation		[For example: an NGO is funded to provide a specialised helpline for survivors of GBV.]			[For example: 80 per cent of funding is received from national/federal government and provincial funding covers 20 per cent.]	
Private Sector Organisation or Other		[For example: GPs **provide** medical services funded by government for survivors of GBV.]				

In the space provided below, please describe any additional details about the government's responsibilities related to direct provision of physical health services to clients. This can include (a) describing relevant information about modes of delivery (b) identifying programs not specifically designed for survivors of GBV, but that may still serve this population, or (c) naming Ministries, agencies or departments who collaborate on service provision, but are not directly responsible for delivering these to clients, etc.

Mental health services

How would you describe the role of the following actors when it comes to the direct provision and delivery of mental health services for clients? Please mark an X in the relevant cell where an actor has no responsibility. Where an actor does have responsibility, please include the name of the relevant Ministries, agencies, or departments involved and the specific role they play. Please include URLs where possible.

Please also specify the annual funding allocated to the different actors who are engaged in the *direct* provision and delivery of mental health services for "clients", including the source(s) of funding, the nature or type of services and volumes, that is, the number of clients served, if known.

Note: "mental health services" here refers to a broad range of direct medical services or related referrals such as, for example: short and long-term counselling or psychiatric assessment; dedicated mental health care professionals in hospitals or outpatient settings; specialised support for clients with pre-existing conditions, etc.

	Has no responsibility for directly providing dedicated mental health services to clients	Has little or some responsibility for directly providing dedicated mental health services to clients	Has high degree of responsibility for directly providing dedicated mental health services to clients	What is the annual budget for each of the mental health services identified in this table?	What are the budget sources and what share of the budget does each funder contribute (e.g. federal government 50 per cent and provincial government 50 per cent)?	What is the nature or type of service(s) funded, including numbers of clients served if known, for each of the services identified in this table?
National, federal or central government		[For example: the Ministry of Health, www.health.xx funds NGOs to provide specialist counselling services to survivors of GBV.]	[For example: the Ministry of Health, www.health.xx provides specialised mental health services in hospitals for clients.]		[For example: National budget, line item ##.]	
Regional, state or provincial government					[For example: services are funded 100 per cent by Provincial government.]	
Local government						
Non-governmental Organisation		[For example, NGOs provide specialist counselling services to survivors of GBV.]			[For example: 80 per cent of funding is received from federal government and provincial funding covers 20 per cent.]	
Private Sector Organisation or Other						

In the space provided below, please describe any additional details about the government's responsibilities related to direct provision of mental health services to clients. This can include (a) describing relevant information about modes of delivery (b) identifying programs not specifically designed for survivors of GBV, but that may still serve this population, or (c) naming Ministries, agencies or departments who collaborate on service provision, but are not directly responsible for delivering these to clients, etc.

Access to justice

How would you describe the role of the following actors when it comes to the direct provision and delivery of access to justice services for clients? Please mark an X in the relevant cell where an actor has no responsibility. Where an actor does have responsibility, please include the names of the relevant Ministries, agencies, or departments involved and the specific role they play. Please include URLs where possible.

Please also specify the annual funding allocated to the different actors who are engaged in the *direct* provision and delivery of access to justice services for 'clients', including the source(s) of funding, the nature or type of services and volumes, that is, the number of clients served, if known.

Note: "access to justice" here refers to services offering support in the form of legal advice, resources, representation or specialised courts related to navigating the criminal, civil and administrative branches of the justice system, including any ancillary services. This includes legal awareness resources and campaigns, available legal aid, specialised GBV courts and prosecution for GBV perpetrators, as well as special provisions related to victims and witnesses of GBV. It can also encompass the existence of integration/accumulation of proceedings that relate to the same GBV case despite the claims being of different nature (civil, criminal and administrative).

	Has no responsibility for directly providing dedicated support for access to justice to clients	Has little or some responsibility for directly providing dedicated support for access to justice to clients	Has high degree of responsibility for directly providing dedicated support for access to justice to clients	What is the annual budget for each of the services identified in this table?	What are the budget sources and what share of the budget does each funder contribute (e.g. federal government 50 per cent and provincial government 50 per cent)?	What is the nature or type of service(s) funded, including numbers of clients served if known, for each of the services identified in this table?
National, federal or central government		[For example: the Ministry of Justice funds lawyers to provide advice and/or representation to survivors of GBV.]	[For example. the government provides specialised courts for survivors-victims of GBV.]		[For example: National budget, line item ##.]	
Regional, state or provincial government					[For example: services are funded 100 per cent by Provincial government.]	
Local government						
Non-governmental Organisation		[For example, an NGO is funded to provide resources such as written materials or advice for survivors of GBV.]			[For example: 80 per cent of funding is received from federal government and provincial funding covers 20 per cent.]	
Private Sector Organisation or Other		[For example, lawyers are funded by government to provide advice and/or representation to survivors of GBV.]				

In the space provided below, please describe any additional details about the government's responsibilities related to direct provision of access to justice-related services for clients. This can include (a) describing relevant information about modes of delivery (b) identifying programs not specifically designed for survivors of GBV, but may still serve this population, or (c) naming Ministries, agencies or departments who collaborate on service provision, but are not directly responsible for delivering these to clients, etc. Due to the breadth of potential legal resources, we invite you to elaborate on the nature of legal support (e.g. related to child custody; tenant laws; immigration; insurance claims; etc.).

Housing support

How would you describe the role of the following actors when it comes to the direct provision and delivery of housing support for clients? Please mark an X in the relevant cell where an actor has no responsibility. Where an actor does have responsibility, please include the names of the relevant Ministries, agencies, or departments involved and the specific role they play. Please include URLs where possible.

Please also specify the annual funding allocated to the different actors who are engaged in the *direct* provision and delivery of housing support for "clients", including the source(s) of funding, the nature or type of services and volumes, that is, the number of clients served, if known.

Note: "housing support services" here refers to rental or housing assistance including, for example, emergency (including sheltered housing), temporary or long-term transitional housing infrastructure, support for clients accessing social housing or cash support for housing.

	Has no responsibility for directly providing dedicated housing services to clients	Has little or some responsibility for directly providing dedicated housing services to clients	Has high degree of responsibility for directly providing dedicated housing services to clients	What is the annual budget for each of the services identified in this table?	What are the budget sources and what share of the budget does each funder contribute (e.g. federal government 50 per cent and provincial government 50 per cent)?	What is the nature or type of service(s) funded, including numbers of clients served if known, for each of the services identified in this table?
National, federal or central government		[For example: a federal government agency funds NGOs to provide emergency housing for clients.]	[For example: federal government provides an accommodation supplement to clients who require social housing.]		[For example: National budget, line item ##.]	
Regional, state or provincial government					[For example: services are funded 100 per cent by Provincial government.]	
Local government						
Non-governmental Organisation		[For example: NGOs provide emergency housing for clients.]			[For example: 80 per cent of funding is received from federal government and provincial funding covers 20 per cent.]	
Private Sector Organisation or Other						

In the space provided below, please describe any additional details about the federal government's responsibilities related to direct provision of housing support services for clients. This can include (a) describing relevant information about modes of delivery (b) identifying programs that are not specifically designed for survivors of GBV, but may still serve this demographic, or (c) naming Ministries, agencies or departments who collaborate on service provision, but are not directly responsible for delivering these to clients, etc.

Child-related services

How would you describe the role of the following actors when it comes to the direct provision and delivery of child-related services for clients? Please mark an X in the relevant cell where an actor has no responsibility. Where an actor does have responsibility, please include the names of the relevant Ministries, agencies, or departments involved and the specific role they play. Please include URLs where possible.

Please also specify the annual funding allocated to the different actors who are engaged in the *direct* provision and delivery of child-related services for "clients", including the source(s) of funding, the nature or type of services and volumes, that is, the number of clients served, if known.

Note: "Child-related services" here refers to childcare supports, and child welfare and well-being supports, such as specially trained paediatricians, day care services, parental counselling, child-friendly shelters, counsellors or social and/or workers in schools, etc.

	Has no responsibility for directly providing dedicated child-related services to clients	Has little or some responsibility for directly providing dedicated child-related services to clients	Has high degree of responsibility for directly providing dedicated child-related services to clients	What is the annual budget for each of the services identified in this table?	What are the budget sources and what share of the budget does each funder contribute (eg federal government 50 per cent and provincial government 50 per cent)?	What is the nature or type of service(s) funded, including numbers of clients served if known, for each of the services identified in this table?
National, federal or central government		[For example, provides targeted information campaigns in school settings.]	[For example, offers direct financial support to GBV survivors to support children.]		[For example: National budget, line item ##.]	
Regional, state or provincial government					[For example: services are funded 100 per cent by Provincial government.]	
Local government						
Non-governmental Organisation		[For example, NGOs provide specialist counselling services for children of survivors of GBV.]			[For example: 80 per cent of funding is received from federal government and provincial funding covers 20 per cent.]	
Private Sector Organisation or Other						

In the space provided below, please describe any additional details about the federal government's responsibilities related to direct provision of child-related services for clients. This can include (a) describing relevant information about modes of delivery (b) identifying programs that are not specifically designed for survivors of GBV, but may still serve this demographic, or (c) naming Ministries, agencies or departments who collaborate on service provision, but are not directly responsible for delivering these to clients, etc.

Income support

How would you describe the role of the following actors when it comes to the direct provision and delivery of income support for clients? Please mark an X in the relevant cell where an actor has no responsibility. Where an actor does have responsibility, please include the names of the relevant Ministries, agencies, or departments involved and the specific role they play. Please include URLs where possible.

Please also specify the annual funding allocated to the different actors who are engaged in the *direct* provision and delivery of income support for "clients", including the source(s) of funding, the nature or type of services and volumes, that is, the number of clients served, if known.

Note: "income support" here refers to interventions such as direct cash transfers, general or targeted allowances whose eligibility criteria direct funds to these clients. While it does not include general social assistance that targets a wider population, it could include any specific assistance that helps a client access general social assistance.

	Has no responsibility for directly providing income support services to clients	Has little or some responsibility for directly providing income support services to clients	Has high degree of responsibility for directly providing income support services to clients	What is the annual budget for each of the services identified in this table?	What are the budget sources and what share of the budget does each funder contribute (e.g. federal government 50 per cent and provincial government 50 per cent)?	What is the nature of or type of service(s) funded, including numbers of clients served if known, for each of the services identified in this table?
National, federal or central government		[For example, government funded information campaigns in targeted settings to raise awareness about available resources.]	[For example: the relevant Ministry offers direct cash transfers to GBV survivors.]		[For example: National budget, line item ##.]	
Regional, state or provincial government			[For example: the relevant Office offers direct cash transfers to GBV survivors.]		[For example: services are funded 100 per cent by Provincial government.]	
Local government						
Non-governmental Organisation					[For example: 80 per cent of funding is received from federal government and provincial funding covers 20 per cent.]	
Private Sector Organisation or Other						

In the space provided below, please describe any additional details about the federal government's responsibilities related to direct provision and delivery of income support for clients. This can include (a) describing relevant information about modes of delivery (b) identifying programs that are not specifically designed for survivors of GBV, but may still serve this demographic, or (c) naming Ministries, agencies or departments who collaborate on service provision, but are not directly responsible for delivering these to clients, etc.

Crisis intervention or case management

How would you describe the role of the following actors when it comes to the direct provision and delivery of crisis intervention or case management services for clients? Please mark an X in the relevant cell where an actor has no responsibility. Where an actor does have responsibility, please include the names of the relevant Ministries, agencies, or departments involved and the specific role they play. Please include URLs where possible.

Please also specify the annual funding allocated to the different actors who are engaged in the *direct* provision and delivery of crisis intervention or case management services for "clients", including the source(s) of funding, the nature or type of services and volumes, that is, the number of clients served, if known.

Note: "crisis intervention or management services" here refers to the cross-cutting personnel and infrastructure in place to mitigate physical, emotional, and/or psychological harm in sudden emergency situations. This can include, for example, specialised units among first-responders, dedicated emergency hotlines for reporting developing incidents of violence, dedicated reporting checkpoints in public places (such as pharmacies or schools, for example) and related communication campaigns about reporting mechanisms, such as official "code words". Due to the breadth of this question, the space below may be used to contextualize the nature of such services.

	Has no responsibility for directly providing dedicated crisis intervention or case management to clients	Has little or some responsibility for directly providing dedicated crisis intervention or case management to clients	Has high degree of responsibility for directly providing dedicated crisis intervention or case management to clients	What is the annual budget for each of the services identified in this table?	What are the budget sources and what share of the budget does each funder contribute (e.g. federal government 50 per cent and provincial government 50 per cent)?	What is the nature or type of service(s) funded, including numbers of clients served if known, for each of the services identified in this table?
National, federal or central government		[For example: federal or national government funds provincial or state government to provide a dedicated emergency hotline for reporting developing incidents of violence.]			[For example: National budget, line item ##]	
Regional, state or provincial government			[For example: provision a dedicated emergency hotline for reporting developing incidents of violence.]		[For example: services are funded 100 per cent by Provincial government]	
Local government						
Non-governmental Organisation			[For example: NGOs provide communication campaigns about reporting mechanisms.]		[For example: 80 per cent of funding is received from federal government and provincial funding covers 20 per cent.]	
Private Sector Organisation or Other			[For example: pharmacies provide a dedicated reporting checkpoint for survivors of GBV.]			

In the space provided below, please describe any additional details about the federal government's responsibilities related to direct crisis intervention or management services for clients. This can include (a) describing relevant information about modes of delivery (b) identifying programs not specifically designed for survivors of GBV, but may still serve this population (c) naming Ministries, agencies or departments who collaborate on service provision, but are not directly responsible for delivering these to clients, or (d) specially trained staff who work specifically with clients in the provision of universal services, etc. Where applicable, please specify the nature of the crisis intervention or management service(s) provided by the aforementioned Ministries, agencies, departments or other actors.

Emergency support during COVID-19

The following questions are about any emergency funding allocated to support the *direct,* cross-sectoral provision and delivery of services for "clients".

In the wake of the COVID-19 pandemic, service providers have had to adapt to physically distanced service delivery while at the same time, the incidence of some forms of gender-based violence is estimated to have increased as a result of COVID-19 related confinement measures.

Have additional/emergency funds been allocated or reprioritised by the government (this could be national/federal/central, regional/state/provincial or local government) to support direct service provision and delivery for clients (i.e. above and beyond existing, pre-pandemic budgetary provisions)?

Note: Please consider funds that support the direct delivery of services across sectors (i.e. services directly provided by national, sub-national, non-governmental, or private-sector entities)

1. Yes, the government has released additional funds or reprioritised funds to support direct service delivery to survivor/victims of gender-based violence in the wake of the COVID-19 outbreak;
2. No additional funding has been released to support direct service delivery to survivor/victims of gender-based violence in the wake of the COVID-19 outbreak;
3. Don't know.

If yes, considering the additional/emergency funds allocated to support the direct provision and delivery of services for clients across sectors in the wake of the COVID-19 pandemic, please indicate in the space below the: (a) name of beneficiaries (i.e. the actor(s) who receive funding to deliver services) (b) source of funding or benefactor (i.e. the name of the Ministry, agency, department of office who allocates the funds to the service provider) (c) sum of funding, and (d) the nature/frequency of funding.

Name(s) of Beneficiaries (include URLs where possible)	Name of Benefactor (source of funding)	Sum of Emergency Funding (national currency)	Nature of Funding: One-time emergency relief Recurring sum with determined end-date Recurring sum with undetermined end-date

In the space provided below, please describe any additional details about the provision of services to clients through the COVID-19 pandemic. For example, were services provided differently to meet the needs of clients during COVID-19?

Integrating Service Delivery across domains

The following questions are about *integrated* service delivery for "clients". Clients often require support from more than one service provider, for example, they may require medical attention, financial aid, support with housing, child-care support, counselling and legal support simultaneously. Clients may also have to

submit the same basic information repeatedly to apply to different services, rather than Ministries or offices safely sharing this data directly. Integrated or co-located points of service can provide clients with a "one-stop" experience.

Note:

"Integrated points of service" are those where a multidisciplinary team of specialised service providers from different sectors are directly employed by one entity.

"Co-located points of service" are those where a multidisciplinary team of specialised service providers from different sectors work together in a communal space – all or some of the time – while remaining employed by their respective agencies.

Does the national/federal/central government directly operate integrated or co-located point(s) of service?

1. Yes;
2. No;
3. Don't know.

If yes: in the space provided, please list the point(s) of service directly operated by the government, specifying whether they are integrated, co-located, or a hybrid of both. Please include URLs where possible:

If yes: thinking about the integrated service(s) provided, in whole or in part, by the government, please describe the measures and/or practices to ensure cohesive integration and/or effective co-operation.

For example, co-ordination may be facilitated through permanent coordinating bodies; external/independent boards; focal points; etc.

If yes: thinking about the integrated and/or co-located service(s) provided, in whole or in part, by the government, please describe how is funding coordinated between service areas.

For example, budgets may be pooled and independently distributed by the organisation through which service providers are employed; budgets may be allocated to individual service sectors or specific providers, such as mental health or legal services; budgets may be allocated to providers working with specific population groups, such as youth, people with disabilities, migrants, etc.

To what degree does the national/federal/central government actively promote the integration or co-location of services at the subnational and/or non-governmental level, or via private service providers?

1. To a great extent;
2. Somewhat;
3. Very little;
4. Not at all;
5. Don't know.

If the government does promote integration: please provide details about how the government promotes cross-sectoral integration or co-location of services for clients at the sub-national and/or non-governmental levels or via the private sector by selecting all the options that apply. For each selection where possible, please provide relevant URLs in the spaces provided.

1. Through dedicated funding for points of service to transition to an integrated or co-located model of service delivery, including human-resource subsidies or cash transfers for infrastructural/technological renewal;

2. Through dedicated funding to support the improvement or expansion of service delivery in points of service already operating through an integrated or co-located delivery model. This can include funds for additional service coverage, as well as larger demographic coverage;

3. By providing specialised government-employed staff to work in non-governmental points of service;

4. By establishing or supporting existing resource centre(s), training initiatives, directories or knowledge hubs for practitioners;

5. By creating or supporting existing federal task force(s), board(s) or focal point(s) who play co-ordinating roles;

6. Other: please specify other ways in which the government promotes cross-sectoral integration of services for survivor/victims of gender-based violence in the space provided. Please include relevant URLs where applicable.

While this question focuses on the actions of the national/federal/central government, cross-sectoral integration or co-location of services for clients may also occur at the sub-national level i.e. regional/state/provincial or local government levels. Where this is the case please provide information in the space below with relevant URLs where applicable.

Information-sharing

To what degree can personal information about clients be shared, for example between government and non-governmental agencies or case or social workers and doctors to help reduce the administrative burden and costs for both clients and providers?

1. To a great extent;
2. Somewhat;
3. Very little;
4. Not at all;
5. Don’t know.

If the answer is (a), (b) or (c) please provide details about how the government ensures personal information is shared safely, securely and ethically. Please provide relevant URLs if possible.

Communicating with Clients & Other Stakeholders

The following questions are about engagement, participation and communication with relevant stakeholders, including survivors of gender-based violence.

Does national/federal/central government produce and manage a directory of available points of service for GBV survivors across levels of government, through non-governmental organisations and/or private actors?

1. Yes, it is updated regularly (monthly or quarterly)
2. Yes, it is updated semi-regularly (annually)
3. Yes, it is updated on an *ad hoc* basis
4. No, though planning is underway to develop and/or deploy one in the future;
5. No, and there are not yet plans to develop one in the future.

If yes: When was the last time the government took stock of or mapped available points of service for GBV survivors across levels of government and through non-governmental organisations? Please provide a date

If yes: Please provide details on how this information is disseminated, including URLs, community centres or phone service through which it is accessible.

Thinking about the services provided and delivered directly by the national/federal/central government, how are the voices of relevant stakeholders represented and integrated into the process of selecting the types of services offered, and the mechanisms through which they are delivered? Select all that apply:

1. Regular in-person or virtual meetings with clients (e.g. conferences, roundtables, workshops, focus groups etc.);
2. *Ad hoc* in-person or virtual meetings with clients (e.g. conferences, roundtables, workshops, focus groups etc.);
3. Regular in-person or virtual meetings with service providers, practitioners, experts and/or professionals (e.g. conferences, roundtables, workshops, focus groups etc.);
4. *Ad hoc* in-person or virtual meetings with service providers, practitioners, experts and/or professionals (e.g. conferences, roundtables, workshops, focus groups etc.);
5. Regular surveys for clients and service-users;
6. *Ad hoc* surveys for clients and service-users;
7. Regular surveys for service-providers;
8. *Ad hoc* surveys for service-providers;
9. Regular requests for comments by clients and service-users;
10. *Ad hoc* requests for comments by clients and service-users;

11. Regular requests for comments by service-providers
12. *Ad hoc* requests for comments by service-providers;
13. A permanent consultation body, board, or group of experts including both clients and service providers;
14. Other, please specify:

Does an independent body exist at the national/federal/central level to receive complaints from clients accessing services in any sector (national, sub-national, non-governmental, private)?

1. Yes; Please indicate the name of the body in the space provided
2. No
3. Don't know

Does an independent body exist at the national/federal/central level to receive complaints from service providers working in any sector (national, sub-national, non-governmental, private)?

1. Yes; Please indicate the name of the body in the space provided
2. No
3. Don't know

Looking to the Future of Integrated Service Delivery

Has any government agency undertaken or commissioned research (for example, cost-benefit analyses) to compare the benefits of direct, unidimensional service delivery versus integrated and/or co-located service delivery?

1. Yes;
2. No, though are plans to do so;
3. No, and there are no plans to do so;
4. Don't know

Note, if yes, please attach relevant documentation when returning this questionnaire to the OECD if you can.

In the space below, please provide examples of good or promising practices related to integrated or co-located service delivery for GBV survivors in your country. These could be examples from the subnational level. Please include relevant URLs, where possible.

What are the current challenges, obstacles or barriers to streamlining service delivery through integrated or co-located points of service?

Annex B. 2022 OECD Consultation with Non-Governmental Service Providers serving GBV Victims/Survivors

1. Please specify the country in which your organisation operates:

2. Do you consider your organisation to be a:

1. Non-profit, non-governmental organisation/programme that directly delivers services
2. For-profit organisation that directly delivers services
3. Advocacy or lobby group that does not directly deliver services
4. Other:

3. How long has your organisation been in operation?

4. People who experience gender-based violence often require assistance with multiple services at the same time, such as housing, employment supports, medical care, and access to legal representation. The integration and/or co-location of services is important.

Would you classify your organisation as providing (if other, please specify):

1. Integrated services: Services offered directly by specialised providers from different sectors of expertise, where your organisation directly employs a multidisciplinary team to meet the cross-sectoral needs of people who experience GBV. Case-file sharing between providers is streamlined. These may be at the same location or at different locations.
2. Co-located services: Services offered directly by specialised providers from different sectors of expertise, working together in a communal space all or some of the time, while remaining employed by their own respective agencies. Case-file sharing between providers is facilitated, but not necessarily streamlined.
3. A combination of integrated and co-located services
4. A sole/primary service, though we have established partnerships with other local service providers and/or agencies with whom we co-operate on a regular basis
5. None of the above, please specify:

Below is a list of services often accessed by people experiencing, or who have experienced, GBV. These can be services accessed in-person or virtually/by telephone.

Please select which services are provided: (a) directly by your staff; (b) directly by staff working through a co-location arrangement; (c) directly via referral to established partners who visit your organisation to meet with clients; (d) provided directly via referral to an affiliated or unaffiliated provider located off-site; or (e) not available in your area.

Services Offered:	Provided directly by your staff	Provided directly by staff from other organisations, working at one site (a co-location arrangement)	Provided directly via referral to established partners who visit your organisation to meet with clients	Provided directly via referral to an affiliated or unaffiliated provider located off-site	Not Available in the Area	Don't Know
Emergency Shelter						
Second-Stage Housing (incl. Transitional Shelter)						
Long-Term/Affordable Housing						
Transportation or Transport Vouchers						
General Helpline/Infoline (incl. text or online chat)						
24H Crisis Line (i.e.: hotline, text or online chat)						
Crisis Counselling						
Long-term Counselling						
In-Kind Support (e.g.: food; clothing; etc.)						
Economic/Income Support (e.g.: cash; gift cards; vouchers)						
Child/Youth/Teen Services or Programming (e.g., child care; youth counselling; after-school program; summer camp; etc.)						
Access to Physical or Mental health practitioners						
Substance Use/Addiction Counselling						
Survivor (peer) support groups						
Other Leisure or Alternative Therapy Programming (e.g.: craft circles; yoga; etc.)						
Job Training, Reskilling or Adult Education Programs						
Financial Skills or Budget Counselling						
Interpretation/translation services						
Perpetrator-specific rehabilitation and/or prevention programs						

Below is a list of additional support and advocacy services commonly offered to people who have experienced GBV.

Please select which services are provided: (a) directly by your staff; (b) directly by staff working through a co-location arrangement; (c) directly via referral to established partners who visit your organisation to meet with clients; (d) provided directly via referral to an affiliated or unaffiliated provider located off-site; or (e) not available in your area.

Advocacy/Support Related to:	Provided directly by your staff	Provided directly by staff working through a co-location arrangement	Provided directly via referral to established partners who visit your organisation to meet with clients	provided directly via referral to an affiliated or unaffiliated provider located off-site	Not Available in the Area	Don't Know
Residency status or other immigration or asylum-related matters						
Criminal legal matters (e.g., Procuring protective or restraining orders, arrest or court related support)						
Divorce or child custody related support						
Other civil legal matters						
Other legal counselling/advice, including legal aid						
Safe/Supervised Visitation						
Navigating child welfare, protective services						
Housing related support (e.g., landlord or housing authority)						
Benefit procurement (incl. immigration benefits, welfare, childcare subsidies, disability, etc.)						
Children's school liaison						
Animal care or placement						
Support for LGBTQ2I+ populations (tailored programming, support groups, specialised healthcare services, etc.)						
Support for Indigenous populations (tailored resources, support groups, claims or benefits, etc.)						
Support for cis-gendered male survivor-victims of domestic violence						

6. From the above-mentioned services and advocacy supports, would you consider one of these to be your *primary* area of service delivery? If so, please indicate the primary focus or activity of your organisation in the space below:

7. The following questions assess how service delivery has changed as a result of the COVID-19 outbreak:

Thinking about <u>in-person assistance</u>, please select the situation that best describes your organisation:

1. In 2020-21, my organisation assisted more people in-person than it did in 2018-19
2. In 2020-21, my organisation assisted the same number of people in-person than it did in 2018-19
3. In 2020-21, my organisation assisted fewer people in-person during the pandemic than it did in 2018-19.

Thinking about assistance over the phone, please select the situation that best describes your organisation:

1. In 2020-21, my organisation assisted more people over the phone during the pandemic than it did in 2018-19.
2. In 2020-21, my organisation assisted the same number of people over the phone during the pandemic than it did in 2018-19.
3. In 2020-21, my organisation assisted fewer people over the phone during the pandemic than it did in 2018-19.

Thinking about online assistance, please select the situation that best describes your organisation:

1. In 2020-21, my organisation assisted more people online during the pandemic than it did in 2018-19.
2. In 2020-21, my organisation assisted the same number of people online during the pandemic than it did in 2018-19.
3. In 2020-21, my organisation assisted fewer people online during the pandemic than it did in 2018-19.

8. The following questions relate to the sharing of case-related information between service providers and across sectors.

How satisfied are you with existing co-ordination mechanisms between sectors and service providers in your area working to support people who have experienced GBV?

1. Very satisfied
2. Satisfied
3. Neither satisfied, nor dissatisfied
4. Dissatisfied
5. Very dissatisfied
6. Not applicable
7. Don't know

How simple is it for service providers from your organisation to share case-related information with other service providers who are affiliated with your organisation through established partnerships, but who are employed by different agencies; for example, in a situation of co-location?

1. Extremely simple
2. Simple
3. Neither simple, nor complicated
4. Somewhat complicated
5. Extremely complicated
6. Don't know

How simple is it for service providers from your organisation to share case-related information with other service providers who are unaffiliated and/or operating in a different sector?

1. Extremely simple
2. Simple
3. Neither simple, nor complicated
4. Somewhat complicated
5. Extremely complicated
6. Don't know

If applicable, please describe the barriers and obstacles that exist in terms of cross-sectoral coordination or sharing of case-related information between service providers. These can be, for example, due to legal or privacy concerns, technological obstacles, time constraints, internal policies, etc.

Please describe strategies that have worked to the benefit of clients, in terms of efficiency of service procurement and trauma reduction. Feel free to provide examples of integrated service delivery that worked particularly well in your organisation.

Please describe resources or procedural adjustments that would make a significant impact for your clients in the way of streamlining services.

9. The following questions are about direct funding and financing of your organisation. Please indicate the percentage of your annual budget that the following sources of funding account for; including the stability of the source of funding in the space provided:

Thinking about Federal/National Ministry, agency, programme(s) or grant(s):

1. 0%
2. 1-20%
3. 21-40%
4. 41-60%
5. 61-80%
6. 81-100%

Please indicate the stability of the source of funding going forward, according to the options provided:

a. The same of more funding will be received next year
b. The same or more funding will be received for the next 2-5 years
c. This will certainly remain a source of funding in the future, though the amount and frequency is not predictable
d. This is uncertain to remain a source of funding in the future
e. Not applicable

Thinking about Sub-national (state, provincial, regional) government agency, programme(s) or grant(s):

1. 0%

2. 1-20%
3. 21-40%
4. 41-60%
5. 61-80%
6. 81-100%

Please indicate the stability of the source of funding going forward, according to the options provided:

a. The same of more funding will be received next year
b. The same or more funding will be received for the next 2-5 years
c. This will certainly remain a source of funding in the future, though the amount and frequency is not predictable
d. This is uncertain to remain a source of funding in the future
e. Not applicable

Thinking about local/municipal government, programme(s) or grant(s):

1. 0%
2. 1-20%
3. 21-40%
4. 41-60%
5. 61-80%
6. 81-100%

Please indicate the stability of the source of funding going forward, according to the options provided:

a. The same of more funding will be received next year
b. The same or more funding will be received for the next 2-5 years
c. This will certainly remain a source of funding in the future, though the amount and frequency is not predictable
d. This is uncertain to remain a source of funding in the future
e. Not applicable

Thinking about private or corporate funding/sponsorship:

1. 0%
2. 1-20%
3. 21-40%
4. 41-60%
5. 61-80%
6. 81-100%

Please indicate the stability of the source of funding going forward, according to the options provided:

a. The same of more funding will be received next year
b. The same or more funding will be received for the next 2-5 years

c. This will certainly remain a source of funding in the future, though the amount and frequency is not predictable
d. This is uncertain to remain a source of funding in the future
e. Not applicable

Thinking about non-profit sources of funding (non-profit foundation, religious organisation or charitable trust):

1. 0%
2. 1-20%
3. 21-40%
4. 41-60%
5. 61-80%
6. 81-100%

Please indicate the stability of the source of funding going forward, according to the options provided:

a. The same of more funding will be received next year
b. The same or more funding will be received for the next 2-5 years
c. This will certainly remain a source of funding in the future, though the amount and frequency is not predictable
d. This is uncertain to remain a source of funding in the future
e. Not applicable

Thinking about internal fundraising or individual donations:

1. 0%
2. 1-20%
3. 21-40%
4. 41-60%
5. 61-80%
6. 81-100%

Please indicate the stability of the source of funding going forward, according to the options provided:

a. The same of more funding will be received next year
b. The same or more funding will be received for the next 2-5 years
c. This will certainly remain a source of funding in the future, though the amount and frequency is not predictable
d. This is uncertain to remain a source of funding in the future
e. Not applicable

Thinking about profit from service users:

1. 0%
2. 1-20%
3. 21-40%
4. 41-60%

5. 61-80%
6. 81-100%

Please indicate the stability of the source of funding going forward, according to the options provided:

a. The same of more funding will be received next year
b. The same or more funding will be received for the next 2-5 years
c. This will certainly remain a source of funding in the future, though the amount and frequency is not predictable
d. This is uncertain to remain a source of funding in the future
e. Not applicable

Since the outbreak of the COVID-19 pandemic (Q1 2020), has your organisation received additional/emergency funding?

1. Yes
2. No
3. Don't know

Is/was this funding:

1. A one-time sum
2. A regularly occurring sum, distributed over a fixed time frame
3. A regularly occurring sum, distributed indefinitely or until further notice
4. Not applicable
5. Don't know

10. The following questions are about indirect funding and other non-monetary supports for your organisation.

Thinking about indirect funding and/or non-monetary supports provided by the government, which of the following does your organisation already benefit from? (Select all that apply)

1. Capacity-building in the form of training
2. Capacity-building in the form of informational resources
3. Capacity-building in the form of networking and communication fora
4. Infrastructural resources that facilitate collaboration and/or cooperation with other service providers (e.g., a database; intranet; etc.)
5. Physical infrastructure, such as office spaces, clinics, hospital wards, etc.
6. Human resources, such as government employees who perform dedicated work in and/or for your organisation
7. Other; please specify:

Thinking about the indirect funding and/or non-monetary supports listed above, which would your organisation benefit from receiving (where it does not already)? (Select all that apply)

1. Capacity-building in the form of training
2. Capacity-building in the form of informational resources

3. Capacity-building in the form of networking and communication fora
4. Infrastructural resources that facilitate collaboration and/or co-operation with other service providers (e.g. a database; network; etc.)
5. Physical infrastructure, such as office spaces, clinics, hospital wards, etc.
6. Human resources, such as government employees who perform dedicated work in and/or for your organisation
7. Other; please specify:

Annex C. Glossary

Table A C.1. Key terms and definitions used in this report

Term	Definition
Domestic violence (DV)	"All acts of physical, sexual, psychological or economic harm that occurs within the family or domestic unit, or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the person experiencing violence" (Council of Europe, 2011[1]). In lay terms, domestic violence is broader than intimate partner violence as it may involve non-partner offenders and victims (e.g. fathers, uncles, brothers).
Gender-based violence (GBV)	"Any type of harm that is perpetrated against a person or group of people because of their factual or perceived sex, gender, sexual orientation and/or gender identity" (Council of Europe, 2022[2]). Statistically, gender-based violence is most commonly carried out by self-identified men against self-identified women.
Intimate partner violence (IPV)	"Any act of physical, sexual, psychological or economic violence that occurs between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim." (EIGE, 2022[3])
Istanbul Convention	Shorthand name for the landmark 2011 Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (CETS No. 210). This enabled the creation of a legal framework at the pan-European level to protect women against all forms of violence, and prevent, prosecute and eliminate violence against women and domestic violence.
Multi-agency Risk Assessment Conference (MARAC)	Regular meetings which bring together professionals and service providers from different sectors (e.g. police, health care, child services) to discuss individual-high risk cases of IPV. Also known as case conferences.
Victim/survivor	The terms survivor and victim are often used interchangeable to refer to a person (typically a woman) who has experienced violence. "Victim" is the more conventionally-used term, especially in the immediate aftermath of violence, while "survivor" is increasingly used by advocates to reframe women's agency during the recovery process (see for example www.rainn.org and www.efjca.eu). To be more inclusive of these diverse perspectives, both terms are used in this report.

Supporting Lives Free from Intimate Partner Violence

TOWARDS BETTER INTEGRATION OF SERVICES FOR VICTIMS/SURVIVORS

Many OECD governments regularly identify violence against women as the top gender equality issue their country faces. Yet in all countries, addressing this multifaceted issue presents serious governance and implementation challenges as victims/survivors have complex needs both during and after experiences of violence. Different service delivery providers such as health, justice, housing and social protection must work together seamlessly – across governmental and non-governmental providers – to provide an effective response. This report presents a stocktaking of OECD governments' efforts to integrate service delivery to address the most prevalent form of gender-based violence against women: intimate partner violence. It presents an overview of different strategies for coordinating key services commonly offered in OECD countries: healthcare, justice, housing, child services, income support, and preventative programmes to stop the reoccurrence of violence. Based on extensive feedback from 35 out of 38 OECD countries and a consultation with non-governmental service providers, this report identifies best practices and investigates the barriers to resolving one of the most pressing human rights issues in OECD countries today.

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