Navigating the System: A Gender - Based Violence Perspective

2025

Final Report for the CEVAW Referral Pathways Mapping Project

The Coalition to END VIOLENCE AGAINST WOMEN C.E.V.A.W

COMMUNITY POTENTIAL

Navigating the System: A Gender-Based Violence Perspective

CEVAW Referral Pathways Mapping Project - Final Report

September 2025

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on behalf of Community Potential

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CEVAW Referral Pathways Mapping Project
Final Report

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Glossary of Terms

2SLGBTQI+ - Two-Spirit, Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and others
CCR - Coordinated Community Response
CEVAW - Coalition to End Violence Against Women
CMHA - Canadian Mental Health Association
CP - Community Potential
DV – Domestic Violence
FACS - Family and Children's Services
GBV - Gender-Based Violence
HCV - Hepatitis C Virus
HIV - Human Immunodeficiency Virus
IPV - Intimate Partner Violence
SADV – Sexual Assault Domestic Violence
STBBIs - Sexually Transmitted and Blood-Borne Infections
UNDP – United Nations Development Programme
UNFPA – United Nations Population Fund
UNODC – United Nations Office on Drugs and Crime
VAN - Victim Assistance Network
VSN – Victim Services Niagara
VWAP - Victim/Witness Assistance Program
WHO – World Health Organization

Executive Summary

This project provides a detailed analysis of the work completed by Community Potential in collaboration with the Coalition to End Violence Against Women (CEVAW) in Niagara. CEVAW is a diverse collective voice of organizations from the Niagara region that is working toward ending gender-based violence against all women, and their children, by raising public awareness, educating, sharing information, networking, and identifying and breaking down systemic barriers that perpetuate violence. CEVAW is funded by the Ontario Government, through the Ministry of Children, Community and Social Services.

This report offers a comprehensive assessment of gender-based violence (GBV) support systems, the identification of systemic challenges, and the development of strategic recommendations aimed at improving the referral pathways and the overall coordination of services. Commissioned by CEVAW, this three-year project not only evaluates the capacity and effectiveness of GBV-specific services but also addresses areas where GBV survivors, especially those with complex needs, interact with the mainstream system. The report aims to illuminate opportunities for system improvement, while providing a fulsome resource to enhance the referral accuracy and knowledge of service providers that may interact with the GBV sector.

Through the environmental scan, network mapping, focus groups, and mock situation tables, the report identifies common challenges in both mainstream and GBV-specific services, including inconsistent intake processes between services, challenges related to shelter and housing access, limited capacity to serve individuals with complex needs, and barriers faced by marginalized populations such as non-binary individuals, newcomers, and those dealing with substance use and mental health challenges. The report highlights the collective effort across sectors to navigate these challenges and continue supporting those in need. These efforts are often limited by resource constraints, but organizations are committed to improving their systems and service coordination.

The report offers strategic recommendations aimed at enhancing service delivery for all individuals, particularly those with complex needs, by fostering a more collaborative, integrated, and trauma-informed approach across all services and sectors. By improving referral pathways, streamlining communication, and encouraging cross-agency collaboration, the goal is to create a more responsive and accessible network of services for GBV survivors. Through the creation of a knowledge toolkit and a series of network maps, CEVAW is well-positioned to support organizational efforts to streamline communication, improve service accessibility, and create a more unified approach to supporting survivors of GBV. These resources will serve as a foundation for improved service delivery, strategic guidance as CEVAW works to strengthen their position as a leader in collective impact and provide CEVAW member agencies with the tools they need to respond effectively to the needs of survivors.

Introduction

CEVAW is committed to improving the safety and well-being of individuals affected by GBV across the Niagara region. As the only local collaborative working to end GBV, CEVAW recognizes the complexities and barriers that survivors face when attempting to access services and navigate the service system more broadly. With the increasing demands for support services and the growing diversity, complexity, and acuity of individuals affected by GBV, it is essential to understand where the strengths, gaps, and opportunities to improve the current support systems are.

In response to these challenges, CEVAW partnered with Community Potential (CP) to conduct a comprehensive assessment of the GBV sector in Niagara. This three-year project aimed to:

1. Examine and identify current community supports and referral pathways for individuals accessing GBV services.
2. Create a system map to visually represent the network of services, enabling a clearer understanding of how organizations collaborate and interact.
3. Develop a knowledge toolkit that will enhance the ability of CEVAW member agencies to provide accurate and timely referrals to survivors.

The project was approached in a phased process, beginning with an environmental scan of existing models, followed by network mapping, focus group consultations, and the creation of resources aimed at improving referral accuracy. These steps were designed to capture the complexity of the existing system, highlight key challenges, and provide strategic recommendations for enhancing service delivery and the

collective impact of the collaborative. This report synthesizes the findings and presents an actionable framework for CEVAW and its partners to adopt in addressing the needs of GBV survivors in Niagara.

Project Overview

The Coalition to End Violence Against Women (CEVAW) contracted Community Potential (CP)[1] to complete a three-year project that:

- Examines and identifies current community supports and referral pathways for those accessing gender-based violence services within the CEVAW organization;
- Create a system map to present to CEVAW agencies; and
- Assist in developing a resource for CEVAW member agencies that will improve knowledge and referral accuracy when provided to those seeking support.

To achieve the deliverables highlighted above, CP broke the project down into a sequential process that included:

- Environmental Scan
  - Review relevant models for systems mapping
  - Identify consistencies, best practices, desirable aspects
  - Identify building blocks for CEVAW map
  - Review existing data/information assets to inform mapping
- Network Map
  - Build CEVAW Network Map to identify existing and potential connections for strengthening referral pathways
- Focus Groups
  - Conduct focus groups/interviews with CEVAW members to inform mapping
- Resource Development
  - Prepare knowledge toolkit to improve CEVAW members' knowledge and referral accuracy in assisting individuals seeking support
- Engagement
  - Present final report to CEVAW membership & engage member agencies' community partners in opportunities for action, which are illuminated by this project.

Section 1: Environmental Scan

A comprehensive review of previous system mapping exercises was completed, as well as an analysis of what other mapping exercises have been carried out and researched at an international level.

Different Niagara service sectors have been mapped before. In 2015, CMHA Niagara mapped mental Health Crisis Services in the Niagara region in an effort to improve integration and system coordination.[2]

[1] Community Potential is a new organization that incorporated during this project and assumed the work of Niagara Connects, formerly housed under InCommunities Niagara, in January 2024. While the organizational entity changed during the life of this project, the staff responsible for this project remained the same.

[2] Jodoin, Ernest. "Mapping Mental Health Crisis Services in the Niagara Region: Towards Improved Integration and Coordination of Services" Canadian Mental Health Association, Niagara, June 2015. Access link:

This work drew upon previous efforts completed in Peel Region in 2014 and importantly noted that system mapping "provides a visual representation of different parts of the system in order to analyze common practices: where the system is working well, and where it is breaking down. System maps are an important first step in identifying system gaps and barriers, and opportunities for improved integration, coordination and access."[3] The methodology for Mental Health Mapping included a series of focus groups and interviews with key informants; a review of program descriptions found in community information databases, websites, brochures and protocols; frameworks/standards where available; system mapping; and a literature review of relevant models.[4]

Similarly, in 2018, Niagara Connects, in partnership with Age-Friendly Niagara, completed a network analysis to better understand connectivity among people and organizations involved with Age-Friendly work in Niagara and beyond. This analysis included surveying 25 people to build out a web of over 135 individuals and 84 organizations involved in age-friendly work in Niagara. These maps were used to understand the structure and sustainability of the age-friendly work as it currently stood, as well as opportunities and direction for increased engagement of members in a coordinated effort.

For a specific Gender-Based Violence (GBV) perspective, End VAW Now (an initiative by UN Women), provides multiple resources related to service mapping. This project looked to work completed in 2011 by the Department of Health in the United Kingdom, "Response to Sexual Violence Needs Assessment Toolkit."[5] This work noted the importance of: becoming aware of main uses or services, and whether there are any groups not being reached and why; what GBV services cover, and whether they are geographically concentrated in specific areas.[6] This is an essential lens for our own local work to consider with the unique urban/rural mix that makes up Niagara.

In an effort to provide global support for accessing services for victims of gender-based violence, the United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence developed an essential services package of seven modules guiding the coordination of essential services, service delivery guidelines, and governance coordination processes and mechanisms. As this document is geared to an international audience, not all aspects of the module are as relevant to the Canadian experience; however, service descriptions and standards in *Module 4: Essential social services* and *Module 5: Essential actions for coordination and governance of coordination* provide excellent basic guidelines related to this project. See pages 8-11 for a selection of relevant material.

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https://www.niagaraknowledgeexchange.com/wp-content/uploads/sites/2/2015/08/Mapping-Mental-Health-Crisis-Services-in-Niagara-Region-21July2015-FINAL.pdf

[3] Ibid, pg. 6.

[4] Age-Friendly Niagara, "Summary of Age-Friendly Community Needs Assessment Research compiled in Municipalities across Niagara as of December 2020." Access link: https://niagaraknowledgeexchange.com/wp-content/uploads/sites/2/2021/01/Age-Friendly-Needs-Assessment-Research-in-Niagara-Municipalities_December-2020_FINAL.pdf

[5] Response to Sexual Violence Needs Assessment Toolkit (Department of Health, England, 2011), London: Department of Health.

[6] UN Women, Virtual Knowledge Centre to End Violence against Women and Girls. "Conduct a service mapping exercise" (February 21, 2019).

Module 4:[7]

REFERRAL	
Description	**Standards**
Referral pathways assist women and girls to receive timely and appropriate support services. Referral processes must incorporate standards for informed consent	• Services have protocols and agreements about the referral process with relevant social, health and justice services, including clear responsibilities of each service • Procedures between services for information sharing and referral are consistent, known by agency staff, and communicated clearly to women and girls • Services have mechanisms for coordinating and monitoring the effectiveness of referrals processes • Services refer to child specific services as required and appropriate

SYSTEM COORDINATION AND ACCOUNTABILITY	
Description	**Standards**
An integrated, multisectoral or systems approach to service delivery brings together a range of services and organizations who have a common set of goals to provide more coordinated responses to violence against women and child protection. Social services must work with and alongside health and justice services to deliver quality responses for women and girls. Social services have a responsibility to, and are accountable to this broader service system.	• Services operate in a collaborative and supportive manner with and alongside other social services, health, police and justice services • Services develop and regularly review protocols, memorandums of understanding, and agreements that clearly document the roles and responsibilities of each agency • Services seek the engagement of other social services, and health and justice agencies in workforce development and training, and monitoring and evaluation activities • Services document and advocate for women and girls rights and systemic improvements and accountability

[7] United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence (UN Women, UNFPA, WHO, UNDP, and UNODC partnership). Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines. 2015. Module 4: Essential social services.

Module 5:[8]

3.2
GUIDELINES FOR LOCAL LEVEL COORDINATION AND GOVERNANCE OF COORDINATION OF ESSENTIAL SERVICES

ESSENTIAL ACTION: 1. CREATION OF FORMAL STRUCTURE FOR LOCAL COORDINATION AND GOVERNANCE OF COORDINATION	
Formal structures for local coordination and governance of coordination support the participation of local institutions and organizations and enable robust mechanisms that can be understood by, and are accountable to the stakeholders and the community.	
CORE ELEMENTS	**GUIDELINES**
1.1 Standards for coordination	Formal structures must ensure they include standards which: • Are consistent with international human rights standards. • Take a victim/survivor-centered approach grounded in women and girls' human right to be free from violence. • Include perpetrator accountability.

ESSENTIAL ACTION: 2. IMPLEMENTATION OF COORDINATION AND GOVERNANCE OF COORDINATION	
Effective implementation of local level coordination and governance of coordination should be guided by an action plan that is aligned with national level strategy and developed via consultative processes. Agreements and standard operating procedures that are shared amongst participating organizations and accessible to communities will support the effective functioning of local coordination effort.	
CORE ELEMENTS	**GUIDELINES**
2.1 Action plan	Local level action plans should: • Comply with laws and policies and align with national strategy and standards on coordination and governance of coordination. • Identify local needs and gaps. • Be developed using consultative process in which key stakeholders, especially victims/survivors and their representatives. • Identify priorities. • Define specific activities to be carried out – including timelines, individual agency responsibilities, necessary resources, and indicators for measuring progress. • Identify possible resources and undertake efforts to obtain them. • Create linkages to other local responses to violence against women and girls. • Inform all relevant stakeholders that have not been involved in the development of the action plan.

[8] United Nations Joint Global Programme on Essential Services for Women and Girls Subject to Violence (UN Women, UNFPA, WHO, UNDP, and UNODC partnership). Essential Services Package for Women and Girls Subject to Violence: Core Elements and Quality Guidelines. 2015. Module 5: Essential actions for coordination and governance of coordination.

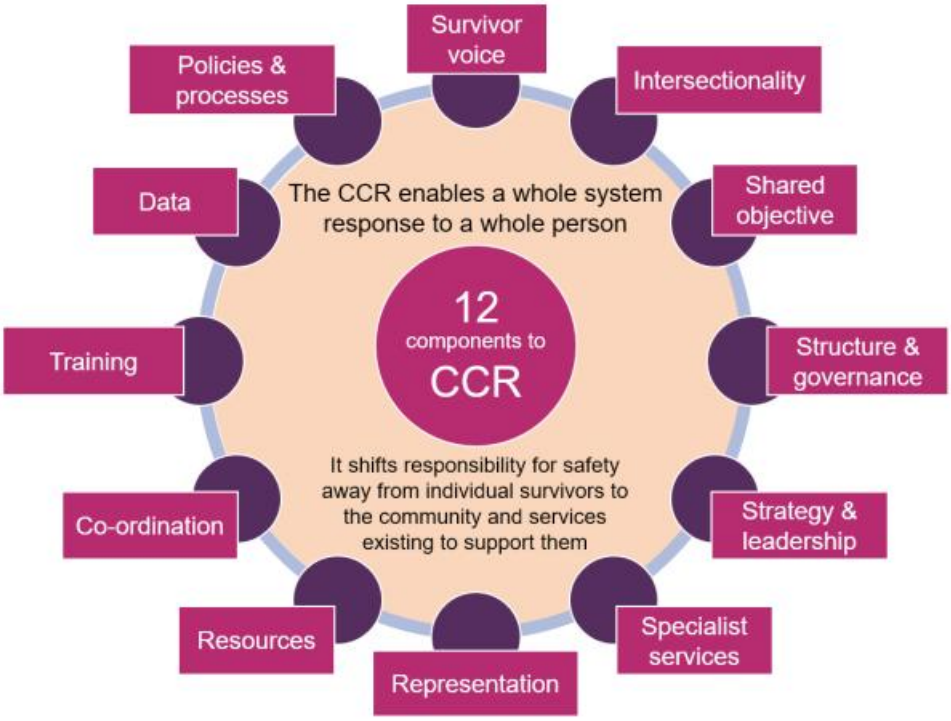
2.2 Agreements for agency membership and participation in coordination mechanisms	• Develop mission and vision of the coordination mechanism on common understanding of violence against women and girls. • Identify composition of the coordination mechanism (including representatives of justice, social services and health care sectors and civil society including marginalized groups and other relevant parties). • Require that agency representatives have decision making authority for their agencies. • Define roles and responsibilities of representatives. • Define chairing arrangements and terms of office. • Establish meeting schedule. • Create decision making process. • Adopt accountability and complaint resolution process. • Create review process for functioning of the coordination mechanism, including timeframes for completion of work. • Create group rules (for example, confidentiality). • Commit to share information with specifically identified relevant stakeholders.
2.3 Case management/ case review process	• Prioritize victim/survivor safety over preservation of the family or other goals. • Empower victim and survivor participation through informed choices (for example, right to decide what services to access, whether to participate in justice process). • Provide accessible services to victims/survivors taking into account geographic accessibility, affordability, availability of providers, understandable information, etc. • Ensure ongoing risk assessment and safety planning. • Agree on response to heightened risk. • Ensure the creation of processes that recognize the needs of children who are victims of violence, directly or as a result of violence toward a parent. • Ensure service providers are trained and skilled. • Provide opportunities for cross-sector training. • Ensure a swift and appropriate response to violence by services and violation of court orders.
2.4 Standard operating procedures for coordination mechanisms	• Map local service providers. • Create a common understanding and principles of service delivery among providers. • Create a protocol for referrals and interactions among service providers. • Carry out training across sectors according to agreed standards. • Develop linkages with third parties (for example, schools). • Practice transparency subject to confidentiality requirements.
2.5 Community awareness of violence against women and girls	• Ensure that community awareness activities are conducted (for example, television and radio public service announcements, social media messages, billboards, publication of reports).
2.6 Monitoring and evaluation	• Identify purpose, scope, and timeline for monitoring and evaluation. • Focus monitoring and evaluation on the functioning of coordinated response to violence against women and girls. • Align with national monitoring and evaluation framework. • Identify baselines and indicators for measuring progress. • Require agencies to collect and share agreed data. • Develop capacity and resources for monitoring and evaluation. • Include victims/survivors in monitoring and evaluation process. • Track funding. • Report monitoring and evaluation findings to national or regional oversight body. • Comply with reporting requirements of high level entity.

ESSENTIAL ACTION: 3. STANDARD SETTING FOR ESTABLISHMENT OF LOCAL LEVEL COORDINATION	
Standards assist in creating consistent mechanisms and processes that support the accountability of coordinated responses. They are important in clarifying the expectations required of coordinated systems, and the stakeholders involved in coordination efforts.	
CORE ELEMENTS	**GUIDELINES**
3.1 Standards for creating local coordinated response	• Participants' agreement on a common understanding of violence against women and girls. • Agreement on primary goals: victim safety, offender accountability, agency accountability. • Role of victims, survivors and their representatives as leaders and/or primary informants to the process without creating a risk to their safety. • Agreement that state institutions and not victims/survivors are responsible for addressing violence. • Basic requirements for formal protocols/MOUs for local coordination, including collaborative relationships, coordination of services. • Roles and responsibilities of agencies and persons involved in coordinated response. • Standards specific to the needs of girls. • Commitment of resources to coordination by participating agencies. • Efficient use of resources by avoiding unnecessary duplication of services. • Participation of all critical parties.[8] • Role of victims/survivors and their representatives as leaders and/or primary informants to the process without creating a risk to their safety. • Participation by underrepresented or marginalized groups. • Identification of community champions, supporting and strengthening their efforts. • Promotion of community awareness of violence against women and girls and availability of Essential Services.
3.2 Standards for agency accountability for coordination	• Use strategies and interventions that are safe, effective and based on best practices. • Define roles of participating agencies. • Conduct internal and external audits to ensure agency accountability in implementing coordination. • Include broad stakeholder involvement. • Identify barriers to safety and services and unmet needs, based on victim/survivor feedback. • Monitor the coordination of responses by the police and justice sector, social service and health care sector. • Follow up on cases to learn outcome and improve responses (including review of fatalities to reduce risk of future homicides). • Create inter-agency tracking system to facilitate information sharing among agencies and follow the progress of a victim/survivor through the system. • Adopt and enforce ethical conduct for staff members and volunteers of participating agencies.
3.3 Systems for the recording and reporting of data	• Agree common terminology for all recording and reporting. • Require each agency to maintain data for monitoring and evaluation. • Obtain consent of victims and survivors before recording personally identifiable information (PII). • Protect confidentiality and privacy of victims and survivors when collecting, recording and reporting PII. • Allow access to PII only to individuals and entities with demonstrated need. • Keep PII data secure. • Anonymize data used for monitoring and evaluation purposes.

The most impactful research for this project was work completed in 2016 and 2020 regarding the development of the Wisconsin Sexual Assault & Domestic Violence Coordinated Community Response (CCR) Toolkit. The Coordinated Community Response (CCR) assumes that there must be a community-level response to address issues related to GBV and brings services together to ensure local systems keep victims safe, hold abusers to account, and prevent domestic abuse. CCRs recognize that to have an impact, the responsibility and intervention should be spread across agencies, and there must be a shared set of core values, principles, and approaches that underpin the work:

- Collaboration
- Connected with Gender Inequality
- Individual, Intersectional experiences
- Whole System / Whole Person
- Responsibility for safety rests with systems and community
- Perpetrators held accountable
- Support to existing organizational responses (not replacing them)
- Shared understanding, shared Leadership.[9]

CCRs can be divided into 12 components, encompassing the broadest possible response to GBV at the community level.



[10]

[9] Standing Together Against Domestic Abuse, "In Search of Excellence: A refreshed guide to effective domestic abuse partnership work – The Coordinated Community Response (CCR)" (2000), pg. 7
[10] Ibid, pg. 12.

CCR builds out the definition of collaboration, and emphasizes the need for coordination, suggesting that, "When individuals and systems interact effectively, we can maximize our resources and find solutions to seemingly intractable problems. As we move along the continuum from networking to collaboration, we increase the amounts of risk, commitment, and resources that participants must contribute to the exchange. At the same time, the capacity to produce significant community change also increases."[11]

A suggested action in jumpstarting CCR collaborative work is engaging in a Community Mapping process. Different than the network mapping that was intended for this project with CEVAW, the CCR Community Mapping begins with a facilitator reading a scenario of GBV and each organization flows through their response to the scenario chronologically. The intention of this process is to:

- Clarify the roles and responsibilities of each agency and how they interact with victims and offenders;
- Identify a continuum of services that is needed for people who have experienced sexual assault and/or domestic violence;
- Clarify the process for how agencies make referrals to each other or identify gaps in this process if referrals are not being made from agency to agency;
- Clearly identify the strengths, challenges and gaps that exist in community services for people who have experienced sexual assault and/or domestic violence.[12]

The Community Mapping process was a key factor in contributing to the shift in scope of the original plans for this project. Moving away from just one round of consultation, based on the best practices of the CCR process directly related to GBV, the Community Mapping activity was embedded as a value-add in an effort to assure validity of the referral map created. More can be found about that in the Consultation subsection below.

In terms of engagement strategies for collaboratives working to end GBV, information best practice guidelines have also been identified by the World Health Organization (WHO) based on global consensus. Specifically based on surveys from European health clinics, several factors were identified as key to making GBV work more sustainable and impactful: committed leadership, regular training, use of the trainer model with on-site trainers, and a clear referral pathway. The following graphic brings together these guidelines, factors, and Indigenous women's requirements to represent a trauma and violence-informed system approach that is gender-responsive, culturally safe, and contextually tailored. [13]

[11] Wisconsin Coalition Against Sexual Assault, "Wisconsin Sexual Assault & Domestic Violence Coordinated Community Response (CCR) Toolkit (2nd Edition)", 2016, pg. 30.
[12] Ibid., 47-48
[13] Hegarty, Kelsey L., Shawana Andrews, Laura Tarzia. "Transforming health settings to address gender-based violence in Australia." Medical Journal of Australia: Volume 217, Issue 3. P. 159-166.

There are extensive examples of referral pathway maps that have been developed in different contexts, countries, and for different audiences. A selection of relevant examples that have been used to guide this project are included in Appendix A.

Section 2: Network Mapping

To begin mapping referral pathways, a network mapping approach was undertaken to help draw out a baseline understanding of how referrals were being made related to GBV in Niagara. This undertaking is a key part in helping to provide a clearer understanding of flow of information and clientele within the GBV sector and related organizational touchpoints. This mapping analysis is integral to understanding system gaps and barriers, and opportunities for improved collaboration, coordination, access, and integration.

A network map represents people or organizations that form networks (intentional or unintentional). Network mapping is a systematic way of identifying people and organizations on the periphery of the network who could be invited to the table. The maps also help to identify new and emerging leaders who can contribute to network sustainability. The network maps built from the connections between individuals and agencies will allow CEVAW to maximize service pathways for those seeking support. As well, the

network analyses will help CEVAW support already-existing connections and strengthen other connections for future work in Niagara.

Visualization of the network shows the flow of communication between individuals or organizations. A dense network with far-extended edges means that the network is able to effectively and efficiently mobilize information, which enables consensus-building and coordinated action.

Individuals and organizations at the center of the network are considered key players; the bigger the "nodes" on the map, the more the individual or organization can influence the rest of the network. Alternatively, those on the edges are considered peripheral members. It is important to note that peripheral members are a healthy sign—they indicate new ideas and information coming into the network.

Analysis of the network produces "metrics" for each individual or organization, which are important calculations that supplement the visual network map. Metrics are essentially rankings of the individual's or organization's importance in the network. Individuals or organizations who have consistently high rankings in the analyses can be considered leaders or emerging leaders in the network. As well, individuals or organizations that have consistently low rankings can be considered peripheral members.

2.1: Methodology

To complete this work, CP distributed an online survey asking individuals to report on any individual they shared a meaningful conversation about GBV with within the last 6 weeks, with the ability to report on up to 30 listed individuals (for full survey copy, see Appendix B).

Network Mapping Survey Questionnaire

1. Name
2. Organization/business/group affiliation
3. Municipality you work in
4. What is your role within your organization:
    a) Frontline service provider
    b) Management
    c) Senior Leadership
    d) Other, please specify.
5. Did you know about CEVAW prior to this survey?
6. How aware are you of the work of CEVAW?
    a) Active member of CEVAW
    b) Inactive member of CEVAW
    c) Aware of CEVAW, but not a member
    d) Unaware of CEVAW
7. How long have you been involved in gender-based violence work in Niagara?

Network Mapping Survey Questionnaire cont'd

8. Which of the following best describes your organization?
    a) Government
    b) Educational institution
    c) Non-profit/community organization
    d) Not applicable/Unaffiliated
    e) Other (please specify)

In the area below, please identify the people with whom you have had a meaningful conversation** within the last SIX weeks about gender-based violence work and principles – a conversation about an idea you have had or a success/challenge you have experienced. You have the ability to add up to 30 people.

Emails were sent to the CEVAW email listserv asking for survey completion. A total of 3 asks were made to the group, as well as individual requests to a variety of organizations and their leaders. Direct engagement occurred at CEVAW meetings, and all members were asked verbally and by email to share widely with their network. Accompanying all emails was an infographic providing a broad overview of what the project was and what we were hoping to accomplish (Appendix C).

Regarding limitations, it is important to note that a key challenge of this approach is that the network map established is a 'snapshot in time', meaning it reflects the system at a given time and can inflate/reduce an individual or organization's role in the system generally, and may show external touchpoints that would not normally show up (for example, if a family was moving through GBV shelters and asking to relocate to a new location where they have kin, the map may show representation from organizations external to the region even though it is an unusual circumstance). Due to limited resources, this risk was mitigated in this project through extensive consultation with community organizations engaged with CEVAW to help build in nuance and ensure context is understood.

Additionally, network maps are as strong as the responses provided. The larger the number of the responses, and more complete their answers, the stronger the data to use to create the map. For this project we achieved a total of 115 responses, of which 87 were completed fully (with varying amounts of individual conversations identified - low of 0 reported conversations, high of 21 reported conversations).

2.2: Results

Including the 87 respondents, 127 individuals were identified as involved or connected to the CEVAW network. These individuals were from 48 different organizations, committees, or groups.

The majority of the respondents knew about CEVAW prior to the survey (73%) and had worked with CEVAW for 5 years or less (53%; 16% less than one year and 38% between 1 to 5 years). As well, most of the respondents identified as frontline workers (65%) or managers/senior staff (22%) and most worked in non-profit organizations (68.2%) throughout Niagara (53%).

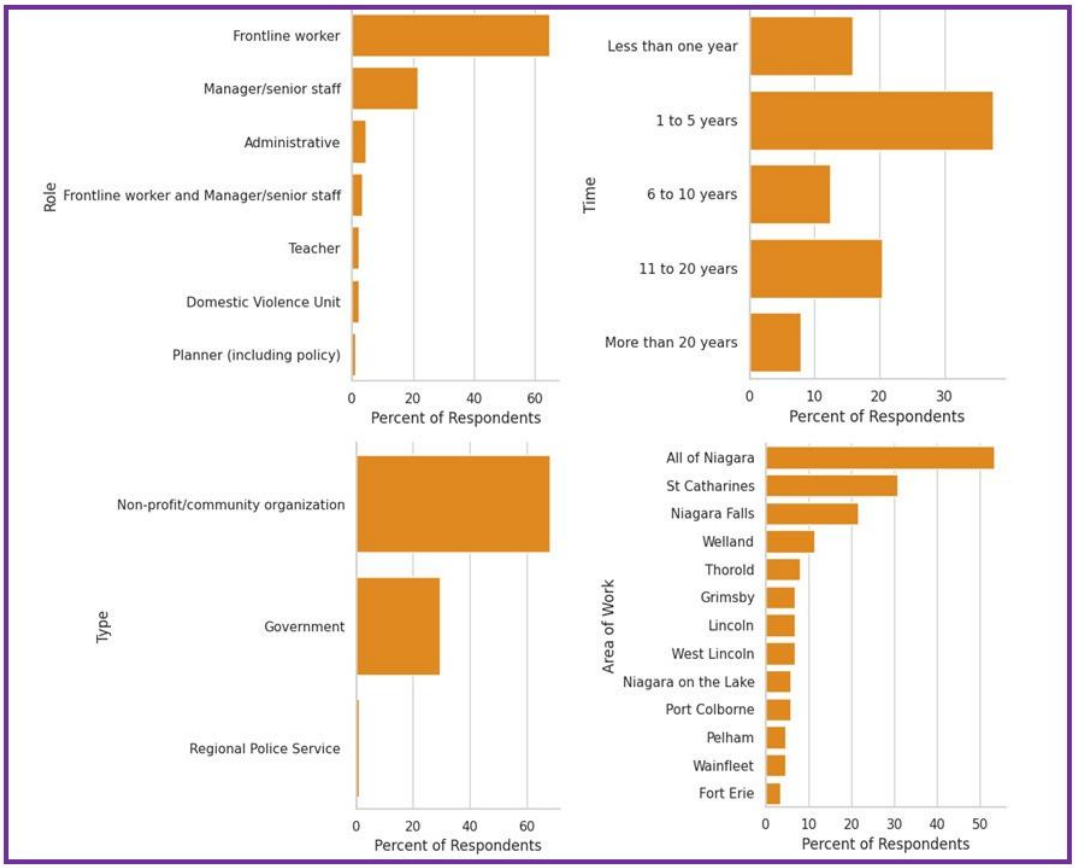
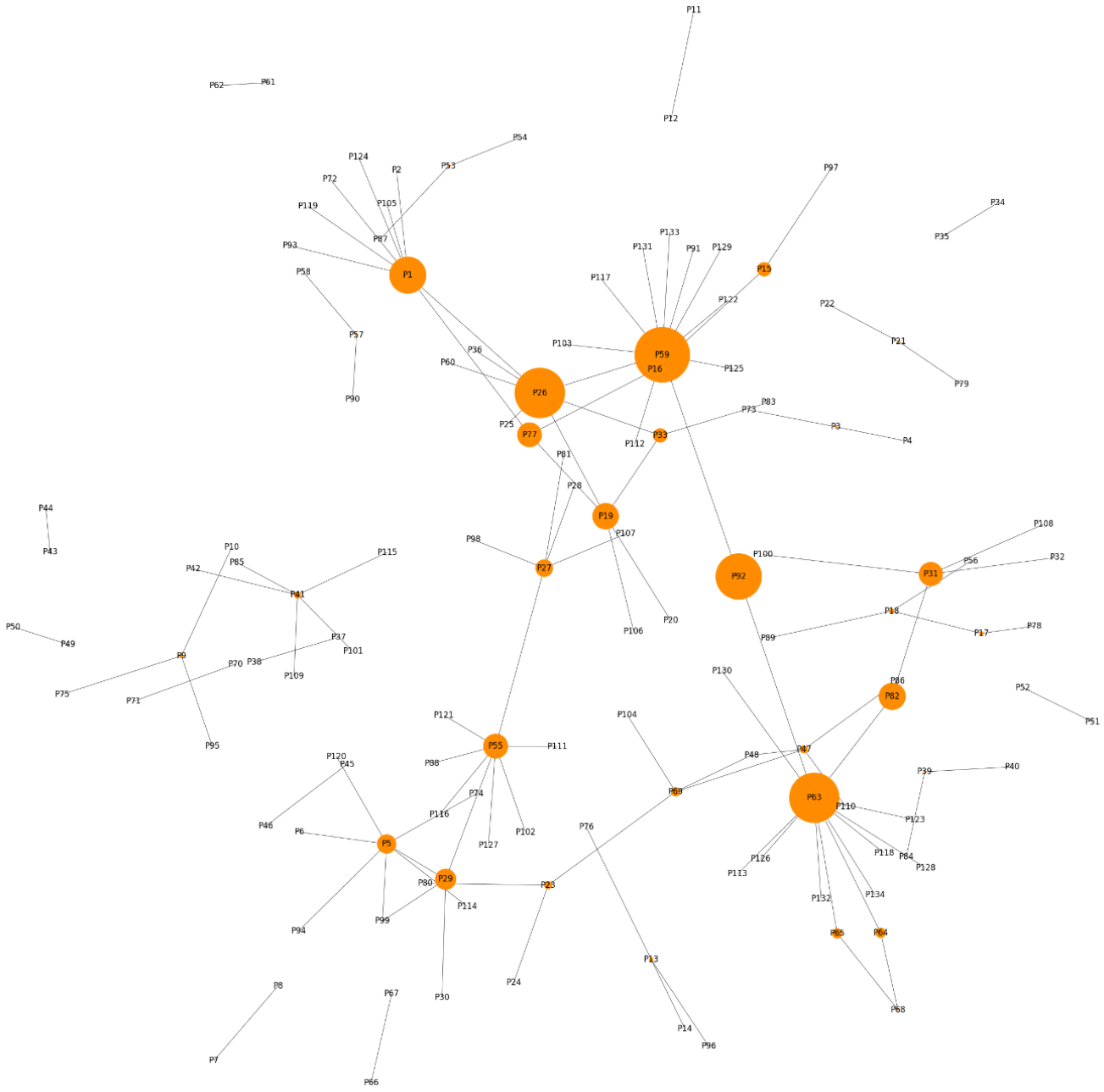


Fig. 1 Description of individuals who responded to the survey. From left to right, (A) individual's role, (B) time spent working with CEVAW, (C) type of organization the individual works for, and (D) main area of work.

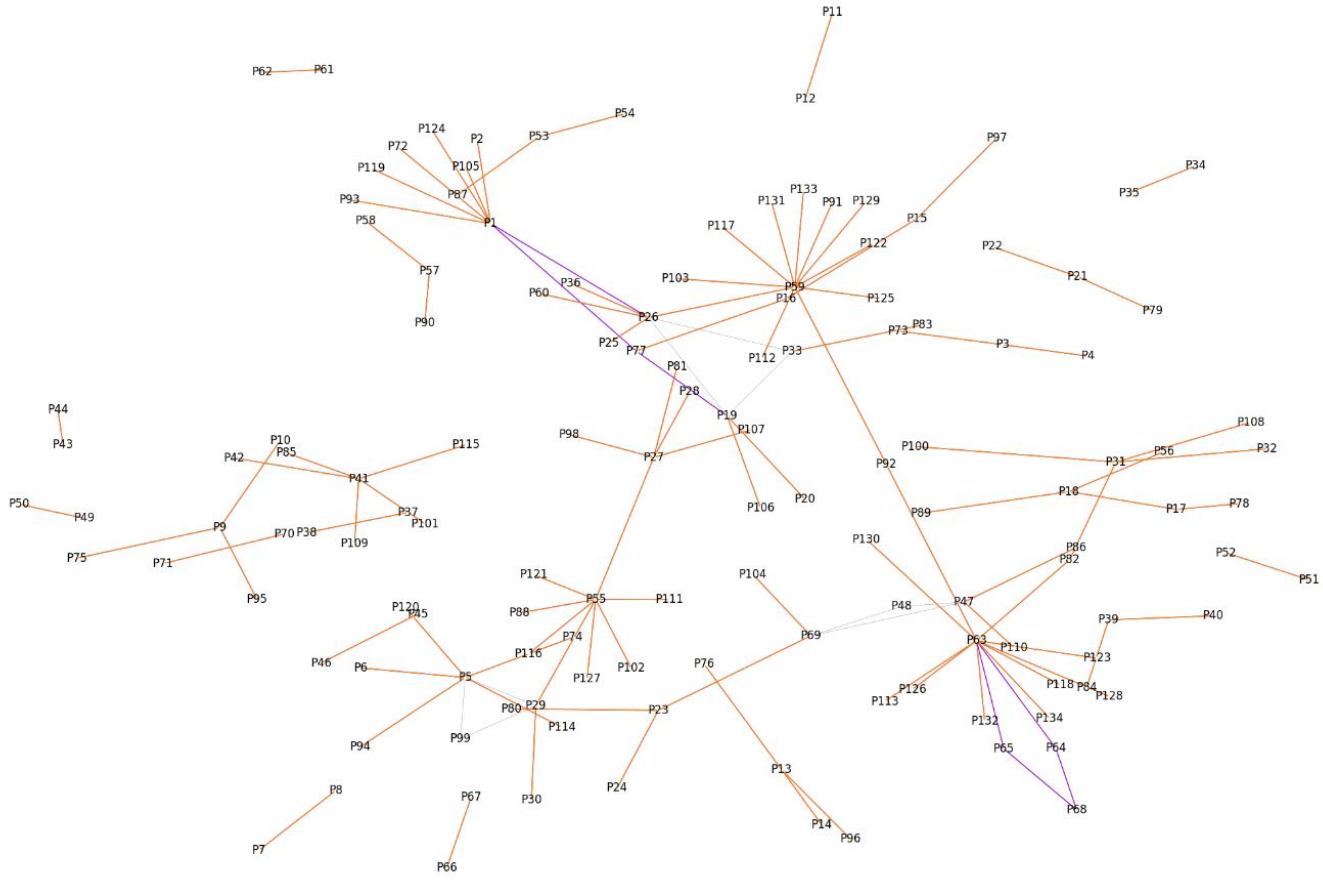
Individual Maps

Data collected from the survey was anonymized and constructed into the network map visualizations below. In the individual network map, there were 127 people with a total of 116 connections between them. On average, a person was connected to two other individuals. The analyses identified 7 bridges—which are the main channels of information between individuals in the network.

Each individual is represented by an orange dot on the map, with the size of the dot corresponding to their overall importance as information sharers in the network. They are individually identified by P-number (person number).



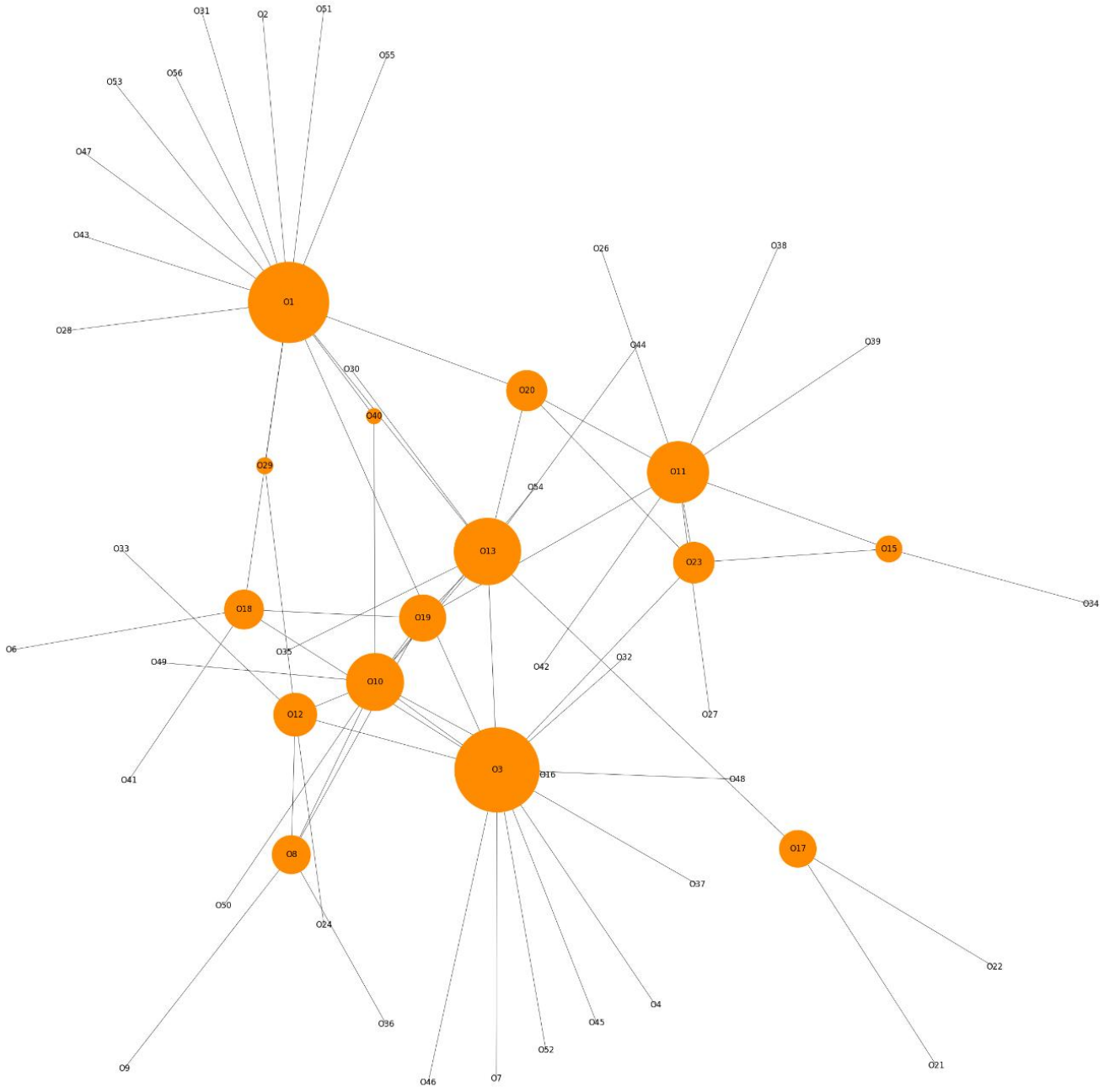
Analysis of the social network metrics revealed four key leaders and seven emerging leaders. As well, 37 individuals were identified as peripheral members in the network. Key bridges (represented by purple lines) of information within the individual network map.



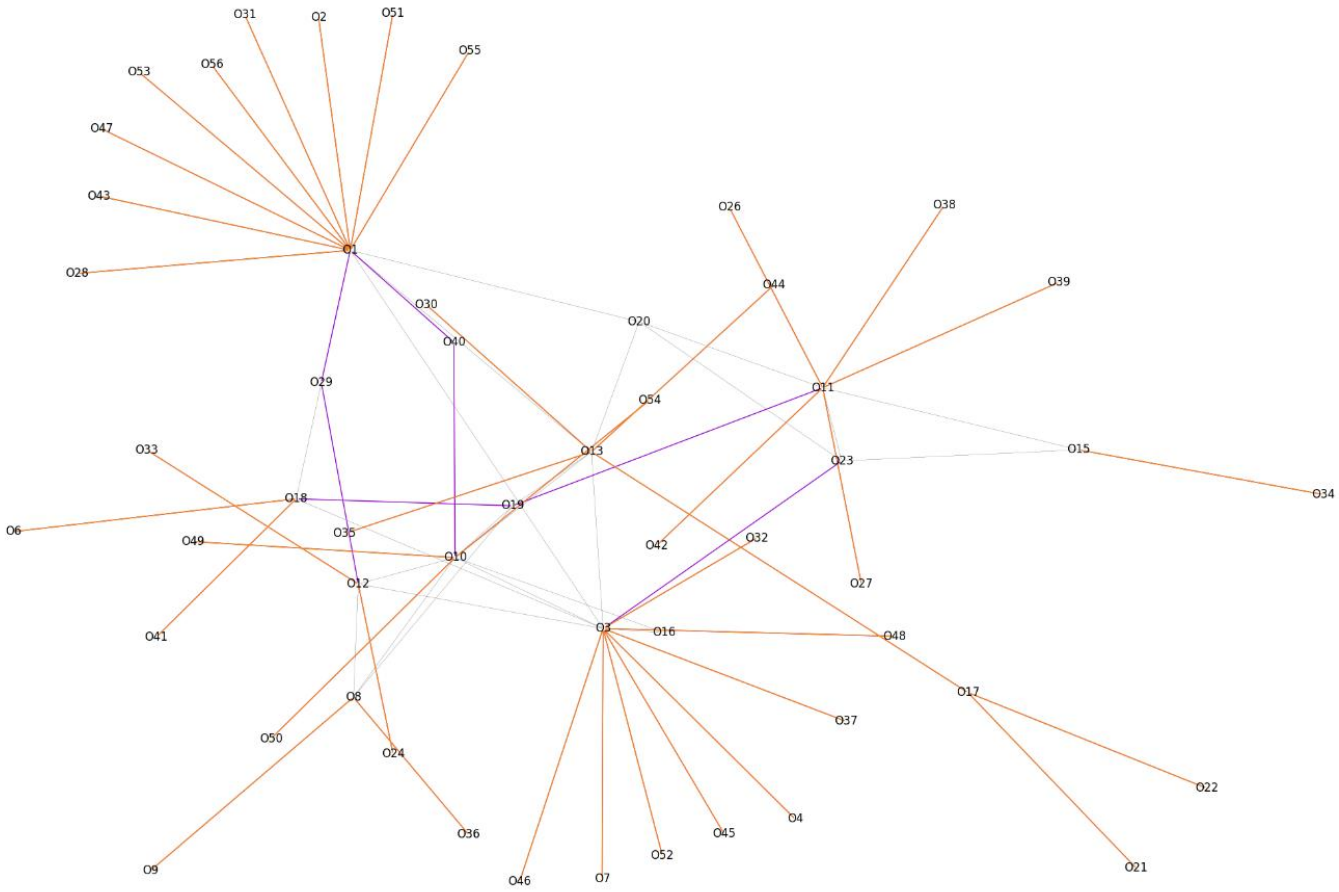
On average, the peripheral members were connected to only one other individual.

Organizational Maps

The organization network map contained 48 organizations with a total of 65 connections between them. Each organization is represented by an orange dot on the map, with the size of the dot corresponding to their overall importance as information sharers in the network. They are individually identified by O-number (organization-number).



On average, an organization was connected to three other organizations. The network map was found to be divided into two subgroups (grey lines) with 11 bridges (purple lines) that channeled information throughout the network.



Analysis of the social network metrics revealed four leading organizations—Gillian's Place, Victim Services Niagara, Birchway Niagara, and FACS Niagara. Emerging leaders include Bethlehem Housing and Support Services. As well, 13 organizations were identified as peripheral members in the network.

2.3: Analysis

The network maps illustrated a strong local base in Niagara with the majority of the respondents working in non-profit organizations as frontline workers or managers/senior staff. Leading organizations within the network are mainly non-profits involved in support services for women and children. As well, the organizations were found to be split into two subgroups within the CEVAW network. Involving other organizations, such as municipal or regional government, court, and police services, may be an important step to expanding the network and closing the gap between the two groups of organizations.

The social network analyses demonstrated that the connectivity of the CEVAW network is largely dependent on four core individuals. The engagement of emerging leaders to expand this core group will be an important step in CEVAW's network sustainability.

Notably, almost 30% of the individual network and 27% of the organization network are considered peripheral members. These individuals represent a wealth of information, connections, and unique

perspectives throughout Niagara. Engaging this peripheral membership can help to enrich the network and its reach.

Section 3: Community Consultations - Focus Groups & Mock Situation Tables

Despite best efforts, the data collected from the survey stage of this project resulted in a rudimentary map of connection in the GBV sector in Niagara. As expected, key organizations working in GBV work were highlighted significantly (e.g. domestic violence shelters Birchway Niagara and Gillian's Place, as well as Victim Services, Bethlehem Housing and Support Services, and Family and Children's Services (FACS) Niagara) by the network map. However, with careful analysis and understanding of the sector as it currently stands, researchers of this project identified that it was possibly not as accurate of the system as it could be, likely due to incomplete data/limited completed survey results.

Originally in the project plan, the consultation project called for approximately 5 community consultations with key organizations to take place. Due to confusion in the data, a more fulsome consultation process was designed with 11 organizations interviewed in total, representing health, mental health, shelter, substance use, children/youth, and newcomer services. These consultations were key in helping researchers in this project to create contextual nuance to the network map, and better develop meaningful understanding, opportunities, and engagement strategies for CEVAW.

3.1: Focus Group Methodology

Each organization was invited to bring any staff that had relevant insight into their place in the GBV sector. All consultations were held in a private location by the same researcher, and data was collected into written notes. Consultations were on average 60-90 minutes, and each participating group was asked the same set of questions.

Consultation Questions

1. How does your organization define gender-based violence?
2. From the point of view of the work you do in Niagara, what are your overall experiences of making referrals in the region?
    a. What are the top 3 things that are working?
    b. What are the top 3 barriers that you are experiencing?
3. In you were the boss and had an unlimited budget (i.e. in an ideal world), what would this sector look like? What would CEVAW/the coalition work look like?
4. How would you describe the culture difference between shelters in Niagara? Do they work well together? Do they have to?

These questions were designed to help gain insight into how GBV is defined and any differentiations, individual experiences of what is/is not working regarding referrals across the region, areas for opportunity for referrals and for CEVAW as an entity, and a nuanced understanding of community services more broadly as they relate to GBV. The final question asking about shelters specifically was designed in response to data gaps regarding shelters/housing and how information flows within the entire shelter/housing system (*not* just the GBV shelters) from the network mapping step done previously.

3.2: Focus Group Results

Participation within an individual organization ran from one-to-one interviews to nearly 20 participants in a single session. These consultations took place both in person and virtually, to allow for the most engagement possible.

For the section below, it is essential to clarify that all data collected reflects the information put forward by community service provider participants. Therefore, and importantly to remember, the information is opinion and experience rather than absolute fact. This feedback does not necessarily outline the actuality of services but instead helps to identify what general trends (including misconceptions and misunderstandings of services) exist currently and helps to guide strategic thinking regarding knowledge sharing and training for CEVAW members and the community more broadly.

3.2a: Definitions and Perspectives on Gender-Based Violence

Organizations participating in the consultations define GBV broadly, acknowledging it as a violation of human rights influenced by gender bias. There is a recognition that GBV manifests in various forms—physical, sexual, emotional, and psychological—while also disproportionately affecting marginalized groups, including women, non-binary individuals, newcomers, and people involved in sex work. Participants emphasized the importance of using a trauma-informed, intersectional lens to understand and address GBV, considering the complexity of survivors' experiences with colonialism, stigma, and systemic oppression.

While definitions of GBV vary slightly across organizations, there is a consensus that it includes not only IPV, but also other forms of violence directed at individuals due to their gender identity. One notable outcome from this consultation process was a suggestion to consider rebranding CEVAW in order to use more inclusive terminology, with participants recommending more gender-inclusive language to encompass the experiences of non-binary and gender-diverse individuals.

A compiled and comprehensive definition of both GBV and IPV was established based on all provided feedback as follows:

> **Gender-Based Violence (GBV)** is defined as any harmful act—physical, sexual, psychological, economic, or emotional—perpetrated against an individual or group based on gender, gender identity, or gender expression. It encompasses violence within intimate relationships (Intimate Partner Violence), family or domestic environments (Domestic Violence), human trafficking, sexual violence, elder abuse, and violence directed at marginalized communities, including women, girls, non-binary, transgender, gender-diverse individuals, and those experiencing intersectional vulnerabilities. GBV

includes acts that cause or are likely to cause harm, suffering, coercion, or deprivation of liberty, and it arises from structural power imbalances rooted in gender inequality, discrimination, and institutional or societal biases. It acknowledges intersectionality, recognizing how overlapping identities such as race, socioeconomic status, sexual orientation, immigration status, disability, and HIV status can amplify experiences of violence and create unique barriers to accessing support and justice.

This definition aims to be comprehensive, intersectional, trauma-informed, and inclusive, ensuring consistency and clarity for use across all organizations working in the field.

Intimate Partner Violence (IPV) refers to harmful acts—physical, sexual, psychological, emotional, economic, or coercive—used by a current or former partner to maintain power and control within an intimate relationship. IPV can affect people of all genders, sexual orientations, ages, abilities, and cultural backgrounds. It includes a range of behaviors such as threats, manipulation, isolation, financial abuse, stalking, harassment, and other controlling behaviors, in addition to physical or sexual harm. IPV acknowledges intersectional factors that can amplify vulnerability and barriers to accessing support, including race, ethnicity, socioeconomic status, immigration status, gender identity, sexual orientation, and ability.

These definitions offer a broad rallying point for CEVAW and can be simplified for public documents and education campaigns.

3.2b: Barriers to Referrals and Challenges in the Service System

One of the central themes of the consultations was the complexity and inconsistency of the referral system, which can pose significant barriers for survivors trying to navigate services, especially when having to do so independently. The information provided below considers the entire system of services (e.g. mainstream services as well as GBV-specific services) and highlights individual and worker experience not intentionality on the part of any particular service provider. Several systemic barriers were identified:

1. **Inconsistent Referral and Intake Processes**: Referral processes were frequently described as inconsistent and relationship-based, often leading to confusion and inefficiencies. Concern was expressed by many service providers about survivors often having to retell their story to gain access to a new service, which can contribute to re-traumatization and fatigue, and over time, a lack of trust in the system. Notably, differing operational and intake policies across both mainstream and GBV shelters (often due to limited space, catchment areas, mandate parameters, service delivery models and funder requirements) were identified as contributing factors to the exclusion of individuals with complex needs (such as substance use or mental health challenges), exacerbating their vulnerability.

2. **Challenges with Shelter Access**: Shelters across Niagara operate under different policies and criteria, which contributes to a fragmented system with incomplete referral pathways. It was identified by many service providers that it can be a challenge navigating an appropriate place for referral if a client has complex needs, in particular those struggling with substance use. As one

provider said, “If there was consistent shelter policy, it would be simpler for people to know what to expect and how to have a successful stay.” Due to inconsistencies between all of the shelters, some providers felt that it was difficult for people who may move in and out of the shelter system often to understand a given organization’s policies and ensure they respect the parameters of their stay.

Related to this, inconsistencies in harm reduction policies were flagged as a factor leading to discrepancies in service provision, and that this inconsistency particularly affects individuals with complex needs being turned away with more frequency. As well, concern was expressed for individuals that may be refused shelter access due to previous challenges during a shelter stay.

Across most consultations, issues with shelter capacity was identified as a key barrier to successful referrals, citing long waitlists and limited beds available, especially for those not deemed at "immediate risk," which can lead to survivors lacking safe housing options.

3. **Intersectionality: Systemic Stigma and Marginalization**: Marginalized groups, particularly non-binary individuals, newcomers, and sex workers, were identified as having to face additional layers of stigma when accessing services. Challenges addressing intersectional experiences creates significant gaps in service provision, as one provider noted, “When a survivor can check all the required boxes, the system kicks in and responds quickly. As soon as some of those boxes are left unchecked it becomes more and more challenging until we are stuck and not able to do anything to move the case forward.” Service providers cited challenges with large families, older youths, people without ID or missing important paperwork (e.g. filing taxes), language barriers, and people who are regularly unhoused as key examples of where the system can get stuck. Regarding gender diverse individuals, there was a mixed response and understanding to their specific needs/barriers, with some providers citing examples of service rejection and others citing successes and inclusive service responses.

4. **Mental Health and Addiction Gaps**: In general, it was highlighted within most of the consultations that the system struggles to provide adequate mental health and addiction supports, especially if someone is not staying at a GBV shelter. Long waitlists and limited access to long-term, low-barrier, trauma-informed counseling services prevent survivors from receiving timely and impactful care, which leads to gaps in recovery and an increased likelihood of re-traumatization. Due to resources, the lack of specialized mental health services, particularly for survivors with complex trauma, was repeatedly cited as a significant systemic shortcoming. Related to previous points, there was significant consistency between service providers that individuals with complex mental health or substance use needs, face many barriers in accessing long-term supports.

5. **Lack of Affordable and Safe Housing**: A lack of accessible, safe, and affordable housing outside of shelters was identified as one of the most significant barriers within the GBV system and mainstream housing systems. Survivors often find themselves in precarious situations post-shelter due to a shortage of housing options, with service providers citing examples such as returning to encampments, relocating away from kin or support networks due to affordability, or having to live in units that are too small for the family size. This issue is exacerbated by the housing crisis in Niagara, with skyrocketing rent and long waiting lists for subsidized housing, especially for those who are not able to qualify for “special status” as a GBV survivor. Without stable housing and increased

transitional housing options, many survivors are forced to return to unsafe environments, contributing to the perpetuation of cycles of violence.

3.2c: Successes and Opportunities in the System

Despite the numerous challenges, many successes and opportunities emerged from the consultations that provide a foundation for future improvements:

1. **Collaborative Networks and Relationship-Building**: Informal networks and collaborative relationships between service providers were seen as a key success in the region. These networks allow for better coordination and quicker referrals, even if the process is not always structured. Providers expressed that the level of collaboration has improved over time, helping to close gaps and prevent survivors from "falling through the cracks".
2. **Trust and Peer Support Among Survivors**: Programs that facilitate peer-to-peer support, such as small group discussions, were highly valued for fostering trust and creating safe spaces for survivors to share their experiences. This was explained as especially true for newcomers, and a key component in providing culturally relevant programming. Trust-building was noted as essential for effective intervention, especially in programs where survivors share lived experiences, such as grooming and violence, with each other.
3. **Adapting to Technology-Driven Services**: The COVID-19 pandemic accelerated the adoption of technology in service provision, which has been beneficial in making services more accessible. Providers and survivors alike praised the ability to connect via text, email, or Zoom, as it helped reduce some traditional barriers to access. This access is especially true for Niagara where public transit is not readily available across all municipalities and there are significant rural areas without local services. This shift to digital platforms, though initially a response to the pandemic, has become a critical aspect of service delivery moving forward. There are many ongoing platforms or digital apps being designed to help provide service delivery in the GBV sector. Although these would require resources and a financial investment to bring to Niagara, they remain an option for increasing service access as well as an option for information sharing between providers.
4. **Trauma-Informed Approaches**: Service providers celebrated that there has been a shift toward adopting trauma-informed approaches across many organizations, which has improved the quality of care and support for survivors. Providers are more aware of the need to address trauma in sensitive and supportive ways, which enhances service delivery and survivor engagement.
5. **Emergency and Long-Term Support Coordination**: Efforts to coordinate long-term support services, such as through the Situation Table, were cited as working well, especially for survivors with complex needs. This cross-agency collaboration has led to better wraparound services for those requiring housing, mental health care, and legal assistance, helping to mitigate the impact of systemic barriers. Many participants noted that developing an ad hoc GBV-specific table to provide support for particularly complex cases may be an asset to the community.

3.2d: Challenges in Shelter Culture and Organizational Dynamics

One of the more complex challenges discussed in the consultations was the knowledge and culture divide between frontline staff and senior leadership of organizations, as well as differences in organizational culture across the region. Feedback from participants highlighted, frontline workers often feel disconnected from decision-makers, which leads to misunderstanding, frustration and burnout. Additionally, due to mandates and often limited capacity and resources, there is more need for additional wraparound services provided at the shelter level because there isn't space/capacity in sector-specific services.

1. **Territorial and Siloed Practices**: Several participants noted that shelters (mainstream and GBV) and service providers in Niagara sometimes operate in silos, with a "territorial" attitude that can limit collaboration. Analysis of data across consultations identified that frustration around service delivery and policies by (often frontline) staff were frequently based in assumption about other organizations and not necessarily in actual policy. For instance, frustration at lack of phone answering by some shelters was viewed as "screening calls" when in reality it seems rooted in some shelters being single staffed and likely unable to always answer the phone.

   Additionally, challenges with siloed practices are particularly evident in how shelters approach harm reduction and the provision of services to complex cases. Some shelters have stricter rules around substance use or housing eligibility, which can create barriers for those most in need of support.

2. **Differences in Shelter Policies and Training**: Participants reported on significant disparities identified in the policies, training, and resources between shelters in Niagara. Some shelters have embraced harm reduction and trauma-informed practices, while others operate under more restrictive models that can contribute to limited access to services. Inconsistency in training and policy implementation contributes to uneven service delivery, sometimes resulting in service delivery not aligning with recognized best practices related to trauma-informed care, and diverse communities requiring a specific lens of service. Participants noted that such factors contribute to high turnover and burnout among frontline staff in the sector, and inconsistency in service delivery for survivors. However, it is worth noting that due to funding discrepancies, some service providers have more limited access to training opportunities than others, but many cited participating in CEVAW training as an equitable opportunity they appreciated.

3. **Marginalization of Complex and High-Needs Cases**: Many organizations expressed that they struggle to serve survivors with complex needs, such as those experiencing homelessness, substance use, and/or severe mental health issues concurrently. Shelters and other service providers often lack the capacity and resources to adequately serve complex individuals, which can leave clients without sufficient and impactful support. Across all consultations, all service providers anecdotally noted that there is an increase in complexity in their clients, as well as increased lethality of GBV cases occurring, further highlighting the need to increase collaboration and communication strategies between service providers.

4. **Limitations of Shelter Resources**: As noted previously, all service providers recognized an increase pressure on shelter and housing systems (both GBV and non-GBV specific), and that limited spaces often leads to frustration in both clients and workers. Some participants highlighted

the growing number of newcomer families, and gap in resources that address specific needs related to culturally relevant and adaptable sheltering to help provide stability. Other participants highlighted a lack of low-barrier wraparound and long-term support services to improve success rates for complex clients that have also experienced GBV. Notably, many providers spoke to the inability for clients to move out of transitional housing due to the lack of affordable housing options in the region, citing a feeling of "warehousing people" in transitional programs because there was just no where else for them to go.

3.2e: Opportunities: An Ideal Vision for the Future of GBV Services

When asked what an ideal world with unlimited resources would look like for the sector, many respondents emphasized the need for a holistic, coordinated approach to GBV service provision. While the unlimited resources idea may not be achievable, many of the underlying ideas offer an excellent place for strategic collaboration that can be spearheaded by CEVAW, community leaders, and other local initiatives.

Key elements of this vision include:

1. **Universal, Low-Barrier Access to Services**: Survivors should have universal access to shelters and other support services without being subjected to restrictive intake criteria. This does not mean that all services need to accommodate complex needs, but that there is a clear continuum of care of services that are equitably resourced and regarded (i.e. services that readily support complex needs are not stigmatized or poorer resourced than others). This includes an increased number of beds, a streamlined referral system that is prepared to serve complex needs, and the acknowledged need to ensure there is access to services that are low-barrier, and includes supports for people who are:
    - Managing substance use
    - Experiencing significant mental health concerns
    - Have complex trauma histories
    - Living with a cognitive delay, cognitive impairment, and/or acquired brain injury
    - Chronically unhoused

2. **A Comprehensive Housing Strategy**: A safe, affordable housing strategy was repeatedly highlighted as essential. Participants suggested that transitional housing programs should be expanded, with a focus on long-term supports that include programming such as life skills development and continued mental health counseling, to prevent survivors from cycling back into unsafe environments.

3. **Prevention and Education**: Many respondents stressed the need for prevention work, particularly youth education on healthy relationships and early signs of abuse. Prevention efforts should also include community-wide campaigns to reduce stigma and promote awareness about GBV, IPV, and trauma-informed practices. Consultations all pointed to the importance of involving education and programming for men and boys specifically, as a way of stopping violence before it starts. Some organizations also explicitly flagged the importance of targeting systems of oppression as a key prevention tactic.

4. **More Mental Health and Addiction Services**: There is a need for increased access to trauma-informed mental health and addiction services, especially services that can respond immediately to survivors in crisis and/or offer long-term low-barrier supports. This includes not only more counselors but also training for frontline workers to ensure they can support GBV survivors with complex mental health needs.
5. **Cross-Agency Training and Collaboration**: To break down silos, participants advocated for cross-agency training and stronger collaboration between organizations. A number of participants highlighted the desire to have a centralized referral and intake system with the opportunity to share data, standardized training on trauma and harm reduction, and regular opportunities for agencies to learn from each other. Many organizations highlighted the desire to gather for consortium or community of practice type events with regularity so that staff could stay up to date on what programs are being offered and had a chance to "put faces to names" of people they regularly work with or hear about within their network.

The overarching analysis of these consultation sessions underscored both the strengths and challenges in Niagara's GBV services. While collaboration and trauma-informed care have improved, there remain notable gaps in access to services, particularly for marginalized and high-needs populations. Addressing these systemic barriers requires both structural reform and a commitment to providing inclusive, survivor-centered support across the GBV system, and mainstream services that intersect frequently with GBV clients. By fostering a collaborative, low-barrier system, Niagara can better support survivors on their journey to safety and healing.

3.4 Mock Situation Table Methodology

A Community Mapping type exercise was identified in the environmental scan process of this project as an additional layer of data collection that could help solidify referral pathway analysis for GBV services in Niagara. Community Mapping is a key component of the Coordinated Community Response (CCR) model, with the understanding that this exercise lends itself to the deepening of interagency relationships, can foster a shared commitment for working together, and is an opportunity to learn more about collaborative partners. Additionally, it also provides an opportunity to learn more about other organizations' procedures, ask questions and together identify where you could better assist each other and enhance the community's response and services for victims.[14] Traditionally, this exercise is completed by having each organization walk through a pseudo victim case profile, beginning at where the victim would have entered the community services system, each detailing how they would respond and how their work is guided. Key questions to consider are:

- How does a victim present for services?
- How do people typically get referred?
- Who would a victim initially talk to? What does the initial conversation look like? Then what happens?
- At what point and in what way are other community partners brought in when responding to a case (i.e. when and how many referrals are made?)

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- When is a case closed or when does it move from one program/person to another program/person?
- What is the timeframe for a case moving through the system?
- What policies, procedures, laws, etc. guide your response and the action you take?
- How does one qualify for your services? What are your service parameters?
- What does your organization do really well? What is your organization's biggest challenge?

Traditionally, each organization would work through this list of questions until their work was outlined upon which the next organization the victim encountered chronologically is identified and begins the process again.

Researchers in this project identified that the referral pathway developed from network mapping and consultation could be validated by adapting the community mapping methodology into a series of focus groups that would use the process outlined above in an abridged fashion and have an open dialogue similar to a Situation Table where organizations are asked to respond to an immediate crisis and provide a wrap-around support care plan for a given client.

Three mock situation table style consultations were held separately, with individual representation from different organizations at each one, but using the same pseudo case studies (Appendix D). The case studies were designed in consultation with 3 different community organizations to highlight cases with complexity that they frequently encounter. These key challenges included:

- Older youth
- Historical trauma and mental health
- Developmental delay/brain injury
- No kinship or informal supports
- Chronic homelessness
- Severe mental health and addiction
- Prenatal supports
- Trauma
- Client resistance
- Newcomer with limited English
- Large family
- Cultural pressure/necessary access to culturally relevant services
- Physical trauma/newly acquired disability
- Older adult
- No income
- Concurrent disorders – mental health and cognitive decline
- Spouse with cognitive decline

Total participation in the 3 sessions of this consultation series was 16 individuals, representing 15 different organizations across a broad range of specialities, including: healthcare, housing, newcomer services, mental health services, harm reduction, policing, and child and youth services.

3.4: Mock Situation Table Results

Researchers began this round of consultations expecting that each situation table session would be similar (with broad representation at each session) and validating the overarching referral pathway structure that had been developed. Interestingly, each session was highly unique and had a different type of response, process, and some divergence in outcomes. Sessions were highly dependent on the knowledge, advocacy,

and expertise around the table. Across all sessions there were similarities in relying on crisis services to immediately respond to all cases (e.g. police, VSN, FACS), barriers to service delivery were highlighted that matched the "key challenges" identified for each case (Appendix D), and an effort to brainstorm service delivery options if there were not any immediately available.

The most challenging scenario for organizations to navigate was Case #2 (Appendix D). These challenges were related to the limitations for services due to previous service restriction, highly complex mental health and substance use needs, and distrust in the system. This validated our earlier findings in the first round of consultations, highlighting that with increased complexity, it becomes harder to access and maintain service within the GBV system. As well, consultation sessions that had specific expertise around the table often offered insight into a relevant case study and provided different nuanced understanding – this was especially true for Case #3 (Appendix D) and the emphasis on importance of culturally relevant programming/services/materials when newcomer services were present. In general, two of the sessions focused more on immediate interventions and gaps in service delivery, while the other session offered a more comprehensive, long-term approach/solutions, especially relating to youth and immigrant families.

There are several cross-cutting themes that emerged from all three sessions. These themes are reflective of information highlighted previously in the initial round of community consultations but deserve their own investigation. The themes from the mock situation table consultations reflect shared systemic challenges, frontline experiences, and opportunities for improved service delivery and coordination in supporting vulnerable populations.

Theme 1: System Navigation is Fragmented and Overwhelming
Across all sessions, a central theme emerged suggesting that navigating services—whether for housing, health, legal aid, or income support—is difficult and inconsistent. Participants suggested that:

- Frontline workers feel they are operating in silos and rely heavily on personal networks or known programs
- Clients are often lost in the system or bounce between organizations without a clear pathway
- Misunderstandings and miscommunication between agencies further complicate navigation
- There is frequent mention of clients needing someone to "walk alongside them" or "handhold" through the process

  "Clients are overwhelmed and not pursuing services. People are asking for individual support throughout the referral process."

  "Situations are so complex… frontline staff rely so much on a few programs… and better fit programs may exist, but staff don't know about them."

Theme 2: Service Gaps, Waitlists, and Eligibility Barriers
Participants repeatedly pointed to critical gaps in services, long waitlists, and ineligibility issues that create barriers to support—especially during crises.

- Sexual Assault/Domestic Violence (SADV) hospital units lack 24/7 staff; each session had participants flagging that often it will take 48-72 hours to be seen at a SADV unit, unless a survivor is willing to travel out of region, which raises re-traumatization and forensic concerns for survivors

- Mental health services, especially those specifically tailored to for youth and pregnant individuals, are limited and have waitlists
- Safe shelter access can be denied due to recent violence by the client, cognitive concerns for a client, or substance use
- Certain services (e.g., DSO, Mainstream) require formal diagnoses, which can be a challenge to get and take a long time, delaying urgent care options

"Hospital tends to release people to shelter even when it is not a good fit."

"With her consent, the ideal goal would be to get her VYSA'd (Voluntary Youth Service Agreement) through FACS… until then, she's stuck without options."

Theme 3: Mental Health, Brain Injury, and Substance Use Not Adequately Supported

The intersection of brain injury, mental health, developmental delay, and substance use is a significant and recurring issue. These clients often fall through the cracks or are misrouted in the system. Participants suggest that:

- Youth with cognitive impairments are often not eligible for GBV shelters or other housing options due to personal capacity limitations and a lack of staff resources to support needs
- Adults with mental health/substance use are frequently involuntarily admitted into hospital care but after a short period are released without long-term care or any service supports in place, which often leads to choosing unsafe options or landing back in the shelter system
- Local crisis services relating to mental health and substance use were referenced in all sessions, but access for the client was reported as inconsistent

"When someone is [involuntarily] formed [at the hospital] for drug use, it often means that they will be quickly released because they are there for "just drug use" and not mental health [even if it concurrent]."

Theme 4: Safety Planning is Crucial as a Preventative and Reactive Measure

Across all sessions, frontline workers frequently referenced safety planning, especially in cases involving domestic violence, sexual assault, or individuals in high-risk environments (e.g. street entrenched). However, this safety planning is often crisis-driven and implemented after harm has occurred rather than being part of a long-term strategy that leverages prevention work to minimize harm. Feedback suggests:

- In many examples, safety planning only starts after a police call, injury, or hospitalization, not earlier when red flags are present. Safety plans often include practical supports (e.g., phones, shelter placement, transportation), but emotional or long-term safety (e.g., relationship patterns, legal navigation, safety in community) are not always addressed/can be more challenging.
- VAW organizations and shelters are actively doing safety planning, but often only after crisis, or after perpetrator is apprehended, largely due to a limitation of resources.
- There are limited options for preventive approaches or early intervention options, due to a lack of resources and funding.
- Safety planning for vulnerable youth and newcomer women must consider a mistrust in systems, cultural shame, and a desire for privacy. All consultation sessions emphasized the importance of

peer supports, cultural liaisons, and trauma-informed staff in developing safety plans that feel relevant and accessible.

- For many clients, safety isn't static—it changes with housing status, family dynamics, mental health, and legal conditions. This makes static "plans" difficult to sustain without ongoing follow-up and relational support.

> *"Every situation that is culturally based, needs to be best handled with peer supports and supports from other newcomer services…The cultural shame that she would be feeling and pressure from family would leave her very open to suicide."*

Theme 5: Youth in Crisis have Limited Options

Youth aged 16-18 present unique challenges across all sectors. This age group falls into a service delivery gap where they are not fully eligible for child protection interventions but also not legally or developmentally equipped to access adult services. All consultation sessions identified these youth as exceptionally vulnerable, especially when intersecting with trauma, mental health, cognitive delay, or lack of family support. Participants highlighted key issues, including:

- Youth aged 16–18 are in a legal and programmatic limbo – they may qualify for *Voluntary Youth Services Agreements (VYSA)* through FACS, but these agreements are not mandatory, thus require youth consent
- Workers acknowledged that while youth in crisis might *technically* be eligible for services, the voluntary nature of services, consent requirements, and lack of clear communication often prevent timely engagement
- Waitlists for youth-focused counselling programs are long; interim supports are often ad hoc or patchwork (e.g., VQRP or temporary crisis counselling)
- Several participants noted youth had difficulty trusting support workers, especially if they had cycled through care, shelters, or other institutions in the past, and show wariness of another adult trying to make referrals rather than provide sustained individual support.

> *"Youth can choose OW route rather than VYSA… but VYSA is more hands-on…If she denies service, there is nothing FACS can do. We can re-engage later up until the day the youth turns 18, but the onus is on the youth to re-engage or a community support."*

Theme 6: Pregnant and Parenting Clients, High Risk and Low Support

Pregnant women and young parents, especially those experiencing homelessness, violence, or substance use, are one of the most high-risk groups discussed across all sessions. It is worth noting that while this theme is not as directly related to GBV-specific services as others in this consultation process, a GBV lens is essential in providing care for pregnant women and parents because it addresses the root causes of their vulnerability, and ensures trauma-informed and holistic approaches to care. Perhaps most importantly, it recognizes the intersectional impact of violence on individuals' lives, offering support across sectors, while centering mental health, safety, and empowerment that protects people from future violence and promotes long-term recovery and wellbeing for mothers and their children.

According to participants, in its current state, the community service system often fails to provide timely, holistic, and coordinated care for pregnant or recently post-partum individuals with complex needs—particularly after the birth of a child and for those who do not have their children in their care.

- Women who give birth while unhoused or using substances are often discharged from hospital without postnatal supports, particularly if their child is apprehended. There are no grief, recovery, or harm-reduction services automatically offered upon discharge from birth for mother's post child-apprehension, leading to increased risk of overdose and mental health decline.
- Public health outreach nurses and programs like Healthy Babies Healthy Children were cited as potential bridges, but engagement is voluntary, and involvement only possible if the child is in the mother's custody. Participants also noted inconsistent follow-through from hospital discharge teams.
- Service providers spoke of wishing there was a clear postnatal support path, especially for mothers who want to change their trajectory post-apprehension and work towards attaining custody of their child/ren.

Theme 7: Immigration and Cultural Barriers to Safety and Access

Participants highlighted that immigrant and newcomer women experience a unique set of compounding barriers when attempting to access safety and support services related to GBV and housing, including:

- Survivors often fear disclosing abuse due to cultural stigma, community pressure, or beliefs that prioritize family cohesion over individual safety. Disclosure is further complicated by language barriers, contributing to miscommunication or lack of personal agency in service engagement.
- There is frequently reported misinformation and fear that reporting abuse will lead to deportation or loss of immigration status—even though Canadian law protects victims. This fear often results in silence, even when abuse is severe.
- Individuals who are sponsored or undocumented face major restrictions in accessing housing, income assistance, and legal services. Their financial and legal dependency on the abuser becomes a major safety issue.
- There is often inherent distrust of systems when individuals are coming from regions where state involvement is associated with persecution and injustice. Mandatory reporting and arrests can cause extra layers of tension, because while it might create safety for victims, it often worsens family fear and results in avoidance of services.
- Peer supports and cultural navigators were cited as crucial in all sessions. These workers can validate experiences, explain systems in familiar terms, and build trust in ways that frontline institutional providers often cannot.
- Settlement agencies like TOES, Bridges Niagara, Welland Heritage Council & Multicultural Centre and Matthew House are seen as essential partners in providing wraparound supports: housing referrals, ESL classes, translation services, trauma-informed cultural counseling, and legal navigation.

Theme 8: Elder Abuse and Aging in Place: Limited but Promising Practices

Participants suggested that older adults, especially women experiencing GBV or cognitive decline, face serious gaps in services. This challenge can be compounded by physical and financial dependency, isolation, and stigma around abuse in older age. Support for older adults is recognized as a growing

component of GBV and crisis response work but is still under development. Key observations from this consultation include:

- Shelters often lack capacity to adequately house older adults with mobility issues, memory loss, or chronic health needs. Admission may be declined due to a client unable to care for themselves independently, and a lack of services in place to ensure their needs can be met while in shelter.
- Programs like Ontario Health at Home, Bridge Housing, and March of Dimes offer promising avenues for integrated supports, including personal support workers, home modifications, and community case management, that can increase safety of older adult survivors.
- Recoup/Recuperative beds are at times relied on as a transitional option for older adults leaving hospital who are too medically complex for shelter but not ill enough for continued inpatient care in hospital.

Theme 9: Interagency Collaboration is Both a Challenge and a Goal

Participants in all sessions clearly articulated that while collaboration is essential for client-centered care, it is often inconsistent, informal, or dependent on personal relationships rather than structured partnerships. Participants express a desire for more shared knowledge, cross-training, and networking.

- Lack of coordinated intake processes means clients may be referred multiple times to different places without continuity of care.
- Service awareness is inconsistent across the region. Frontline workers may not know what's available outside their core network or in other municipalities (especially rural vs. urban parts of the region), which can contribute to survivors not accessing the services that best suit their individual needs.
- Workers rely heavily on individual relationships with other service providers to "get things done," which is not scalable or sustainable and can lead to inequitable access for survivors based on who a given worker happens to know.
- All sessions express a strong desire for more networking opportunities, joint training, and cross-referral clarity. Building sector-wide directories or resource maps and having interagency case conferencing were suggested as ways to strengthen collaboration.

> *"This is so hard for frontline staff. They rely so much on a few different programs because they have gone to them before…There could be a better fit but [if staff] don't have communication or relationship with that program they don't know about it, and it is a loss for the individual client."*
>
> *Networking between organizations is crucial. We can better fulfill services when individual workers understand and are familiar with each other. Organizational awareness about programs, services and resources are critical in understanding what already exists and what* could *exist."*

Theme 10: Data and Follow-Up are Weak Points

There was widespread acknowledgment from participants that frontline staff often operate without visibility into the outcomes of their work once a referral is made, which can contribute to frustration and mistrust from staff toward the system. These systemic weaknesses include:

- No centralized database or tracking system exists to coordinate care or document outcomes across agencies, meaning clients often "disappear" between systems and organizations.
- Many referrals feel like "sending clients into a void" — staff don't know if they ever received help, dropped out, or improved.
- Participants expressed a desire for case management platforms, better information sharing protocols, and consistent feedback loops between referring and receiving agencies.
- Some expressed interest in shared case reviews or coordinated care teams, particularly for high-acuity or multi-barrier survivors.

> *"[There is a] huge lack of trust within the system because of workers' experiences of [working within the] services (like unanswered calls, eligibility, etc.). We need to rebuild trust between organizations and workers…almost always [the mistrust is] related to misunderstanding and miscommunication."*

3.5: Cross-Analysis of Consultations

This cross-analysis brings together the key themes and insights gathered from CEVAW's community consultations, including both the focus groups and mock situation tables, to offer a comprehensive view of the current gender-based violence (GBV) service landscape in Niagara. Through conversations with frontline workers, organizational leaders, and cross-sector partners, a nuanced picture has emerged—one that reflects both deep dedication to survivors and significant systemic challenges. While many providers are innovating within their own organizations and building strong informal networks, the broader system remains fragmented, inconsistent, and difficult to navigate, particularly for those with complex needs. The following analysis synthesizes the collective findings to identify recurring barriers, shared successes, and emerging opportunities for a more coordinated, inclusive, and effective GBV response in Niagara.

Shared Strengths Across Consultations

- Informal collaboration and peer networks are often successful in bridging system gaps despite structural barriers.
- Trauma-informed practices are increasingly integrated, improving survivor trust and engagement.
- Technology use has enhanced accessibility, especially for rural or transportation-limited clients.
- Cultural navigators and peer supports play a key role in enhancing engagement, especially for newcomer and marginalized populations.
- Expansion of Situation Tables to include GBV service-providers and a GBV-lens are a promising practice and represent the value of a cross-sectoral approach to service provision.

Recurring Challenges

- Referral systems are fragmented, inconsistent, and overly dependent on individual relationships or knowledge.
- Shelter access varies significantly across Niagara, with inconsistent harm reduction and intake policies that contribute to confusion and exclusion, especially for complex cases.
- High-needs populations (e.g., people with significant mental health or substance use challenges, transitional aged youth, newcomers, etc.) fall through gaps due to eligibility restrictions or lack of tailored services.

- Safety planning is often reactive, rather than integrated into early intervention/prevention.
- System navigation is overwhelming, both for clients and frontline workers, due to service silos and communication gaps.
- Data sharing and outcome tracking across agencies is virtually non-existent, reducing visibility and continuity of care.

Themes from Mock Situation Tables Validating Focus Group Findings

- Case complexity significantly limits access to effective interventions.
- Organizations with relevant expertise to survivor's needs contributes to more successful and holistic system responses.
- Immediate, crisis-based responses dominate service delivery.
- All sessions pointed to missing long-term planning and inter-agency collaboration as key service gaps.

The consultations gathered in this section reveal a GBV sector in Niagara that is deeply committed, highly skilled, and relationship-driven, yet burdened by fragmented systems, resource constraints, and siloed operations. While strengths like collaboration, trauma-informed practice, and cultural awareness have or are already emerging, structural weaknesses—particularly in referral consistency, service access, and coordinated response—remain significant barriers for survivors, especially those with complex needs.

The findings emphasize that true systems-level transformation lies in strategic coordination, capacity building, and intentional design of inclusive, accessible, and responsive services. CEVAW is well-positioned to lead this evolution, grounding its work in survivor-centered practices, equity, and system-wide collaboration.

Section 4: Resource Development

A key outcome expected of this project was the development of a knowledge toolkit to improve CEVAW members' knowledge and referral accuracy in assisting individuals seeking support. Multiple tools have been created for this project, including:

- A brochure providing top-level overview of system navigation for GBV survivors
- A 'placemat' sized one-pager to be widely distributed across community services and related public institutions (e.g. libraries, transit, etc.) that offers a more in-depth understanding of how to respond to a victim of GBV
- A data file that highlights all related community organizations that may need to be accessed for GBV support, with each individual record broken down by: Service Name, Category, Description, Target Population, program Location, Contact Info, and any related notes. This data is organized in 3 separate sheets within the file – by organization name, category of service, and municipality. This information is designed to be electronically available to organizations, and printable for easy access if necessary.

4.1: CEVAW System Navigation Brochure for Victims

This brochure is highly simplified and designed to provide key information for a person entering the GBV system. The brochure (Appendix E) highlights Safety planning, key support resources (phone lines), and an overview of frequent navigation of the system – moving from crisis response, to shelter, health/mental health care, housing and financial supports, legal support, and community support.

The brochure includes information on safety planning, and intentionally only lists the crisis line phone numbers of Gillian's Place, Birchway Niagara, Fem'aide (French speaking support through Centre de Sante Communautaire Hamilton/Niagara), and Talk4Healing (Indigenous focussed support). Through the extensive research completed in this project, it was consistently identified that having victims or concerned people funnel their questions through specifically designed services could help in improving systems navigation and ensure people are getting the right information and the right referrals. This funneling to those specific phone lines is also a way of ensuring anybody accessing support because of the brochure will speak with someone highly skilled and trained in safety planning and risk assessments.

4.2: GBV Systems Navigation Tool for Service Providers

This tool (Appendix F) is designed to be distributed widely across Niagara to organizations that serve the community, including community service providers, as well as broader institutions such as libraries, transit operators, hospital/healthcare settings, school boards, etc. The tool provides the same GBV definition designed through consultation and shared above. It highlights what to do when a victim discloses violence, simple steps to manage the encounter, and ways to protect the individual's wellbeing. The tool provides simple referral pathways for 4 victim profiles – victims who are pregnant/have children; victims who are older adults and/or experiencing elder abuse; victims who have experienced a sexual assault; victims who are struggling with acute mental health or substance use challenges. The tool highlights the crisis lines as the main point of access for all GBV victims and also provides information about Victim Services Niagara and 2-1-1 as tools to gain more information or support. This tool will be accompanied with access to a printed or digital version of the Community Organizations Reference Guide.

4.3: Community Organizations Reference Guide

The Community Organizations Reference Guide (Appendix G) is designed to accompany the GBV Systems Navigation Tool for Service Providers (Appendix F) and provide more extensive data of what community organizations exist and may be useful when supporting an GBV victim.

This Guide includes 85 entries, representing 53 unique organizations. Some organizations appear multiple times because they offer different programs or services.

The Guide is divided into 7 subcategories per entry, including:

- Organization Name
- Service Category
- Service Description
- Target Population
- Program Location
- Contact Information
- Notes

The Guide has 3 separate sheets that simply reorder the information according to Organization Name, Service Category, and Municipality. It is worth noting that an easy way to increase access to this broad information may be through embedding a QR code on the GBV Systems Navigation Tool that links to a web-hosted version of the Community Organizations Reference Guide (hosted via the CEVAW website, or through the Niagara Knowledge Exchange).

Section 5: Engagement

The CEVAW Engagement Strategy aims to create a coordinated, sustainable, and impactful response to gender-based violence (GBV) in Niagara, establishing a foundation for collective impact. At the heart of this strategy is a commitment to fostering collaboration across various sectors—service providers, survivors, law enforcement, healthcare, education, and policy makers. By harnessing collective impact and coordinated community responses (CCRs), the strategy strives to integrate services and create a seamless network of support for survivors while addressing systemic barriers.

Goal 1. Strengthening Existing Connections and Expanding Membership

Key Actions:

- Leverage Network Maps: CEVAW's current network includes 127 individuals from 48 organizations. The strategy calls for expanding this network by identifying and engaging peripheral members—those who are not yet fully integrated into the network but who bring valuable perspectives and resources. This includes reaching out to individuals and organizations that may have been overlooked in the past.
- Strengthen Membership Engagement: Build upon the membership that already exists for CEVAW. Work to develop value-adds for membership (such as opportunities for networking, collaborative exercises, training and events), and build ties to senior leadership of representative organizations that have the ability to make policy level decisions.

Engagement Tactics:

- Targeted Outreach to Peripheral Members: A key focus is building relationships with the 27% of peripheral members. This will involve creating opportunities for involvement through workshops, specialized training, and participation in task forces or strategic committees to enhance engagement.
- Emerging Leaders Program: Identifying and nurturing emerging leaders within CEVAW is essential for infusing fresh ideas and ensuring the sustainability of the coalition. The strategy encourages the integration of these emerging leaders into working groups or leadership roles, where they can make meaningful contributions to the coalition's mission.

Goal 2. Strengthening Inter-Agency Collaboration

Key Actions:

- Collaborative Training and Case Reviews: A central recommendation from consultations is the need for cross-agency training to ensure consistent service delivery. By facilitating regular inter-agency meetings, case reviews, and joint training sessions, CEVAW can improve mutual understanding among service providers and enhance the referral process.

- Community Mapping and System Coordination: Regular community mapping exercises will help clarify the roles and responsibilities of each agency, as well as identify gaps in service delivery. These exercises are integral to a broader Coordinated Community Response (CCR), ensuring that all parties involved in the GBV response are aligned, and contributes to the coalition's collective impact.

Engagement Tactics:

- Host Annual Collaboration Workshops: To foster networking and trust-building, CEVAW can host workshops focused on collaborative activities, such as mock situation tables or community mapping. These workshops will enhance system navigation and deepen partnerships among service providers.
- Share Data and Insights: CEVAW can move toward the establishment of a centralized repository for case studies, best practices, and data that can be accessed by all members. This resource hub will be essential for ongoing learning and information sharing across the network, ensuring that members are informed and engaged in real-time.

Goal 3. Promoting Inclusivity and Comprehensive Services

Key Actions:

- Inclusive Language and Practices: CEVAW's materials and communications can be updated to ensure they reflect an inclusive, gender-diverse approach. This could involve the consideration of CEVAW's name to be more inclusive of non-binary and gender-diverse individuals and ensuring that all coalition activities and materials are accessible to a broad spectrum of identities.
- Holistic Service Provision: CEVAW can focus on ensuring that its partners are survivor-centered and trauma-informed, thus contributing to building a comprehensive continuum of care that encompasses prevention, emergency response, housing, legal services, and long-term support in the broader community.

Engagement Tactics:

- Launch Awareness Campaigns: CEVAW can conduct public awareness campaigns to highlight the importance of inclusive services and the need for low-barrier access, especially for marginalized groups such as newcomers, people with disabilities, and those with mental health or addiction challenges.
- Create Focused Support Groups: CEVAW can help guide community organizations to establish or support already existing work related to peer support groups for specific communities—such as newcomers or gender-diverse individuals. CEVAW can give these groups a platform to voice their concerns and advocate for tailored services that meet their needs.

Goal 4. Enhancing Communication and Trust

Key Actions:

- Build Transparent Communication Systems: In response to feedback gathered during consultations, CEVAW can help develop clear, standardized referral pathways that ensure service providers and survivors have a more consistent and efficient experience. This transparency will help minimize frustration and confusion when navigating the GBV support system. This could include a centralized intake process/forms, and mapping of the full continuum of services available in Niagara to help workers make appropriate referrals based on fit for client.
- Develop Feedback Mechanisms: CEVAW can work toward establishing structured feedback loops where agencies and survivors can share their experiences and suggest improvements to the

services provided. This will ensure continuous improvement and responsiveness to emerging needs.

Engagement Tactics:

- Monthly Stakeholder Updates: Regular updates via email or virtual meetings can be provided to CEVAW members, keeping them informed about ongoing projects, new developments, and upcoming opportunities for involvement. This consistent communication will ensure that all members feel connected to the coalition's work.
- Create a Digital Hub: A centralized online platform could be created for CEVAW members to access resources, share updates, and communicate with one another. This platform could also serve as a members-only portal for case discussions, training materials, and event registrations.

By focusing on expanding membership, strengthening inter-agency collaboration, ensuring inclusivity, and improving communication, CEVAW will increase its impact and play a pivotal role in addressing gender-based violence across Niagara. A detailed 3-year Strategic Action Plan can be found in Appendix H. The strategy's key actions and engagement tactics are designed to build a stronger, more connected coalition, increase the integration of services, and ensure that survivors receive the holistic and inclusive care they need. Through sustained collaboration, regular training, and transparent communication, CEVAW will continue to evolve, drive systemic change, and create a safer, more equitable community for all. This strategic approach will not only increase CEVAW's effectiveness in the short term but also lay the groundwork for long-term, sustainable change in the region's response to GBV.

Conclusion

In conclusion, while the Niagara region benefits from a committed and resourceful network of organizations, the GBV sector is hindered by systemic fragmentation and inconsistencies that can make it difficult for survivors to navigate and access the support they need. Key findings from this project point to a lack of coordination among service providers, resource constraints, disparities in service availability, and inconsistent referral pathways. These challenges contribute to confusion, inefficiencies, and a lack of trust in the system among survivors.

However, and perhaps most importantly, the consultations of this project also revealed significant opportunities for improvement and a committed and impassioned ecosystem of service providers and organizations. By enhancing collaboration between organizations, streamlining referral processes, and integrating services, CEVAW can help create a more cohesive system of support. A unified approach will ensure that survivors receive the right care at the right time, minimizing the potential for re-traumatization and improving long-term outcomes. Additionally, expanding services for marginalized groups and addressing the gaps in mental health, addiction support, and housing are essential components in fostering a more inclusive and accessible system for all survivors.

The development of the network map and knowledge toolkit provides a valuable starting point for these efforts, offering CEVAW member agencies the tools to improve their engagement with survivors and their ability to navigate the referral system. Moving forward, the next step will be to implement these recommendations, focusing on the creation of a more integrated, trauma-informed, and survivor-centered approach. This will require ongoing commitment from CEVAW, its member agencies, and the broader

community to ensure that all survivors of GBV have access to the support they need to heal and rebuild their lives.

Through continued collaboration, strategic action, and a shared vision for a unified GBV support system, CEVAW can lead the charge in transforming the experience of survivors in Niagara. With the right investments in services and systems, Niagara can become a model for other regions, ensuring that survivors receive the care, dignity, and justice they deserve.

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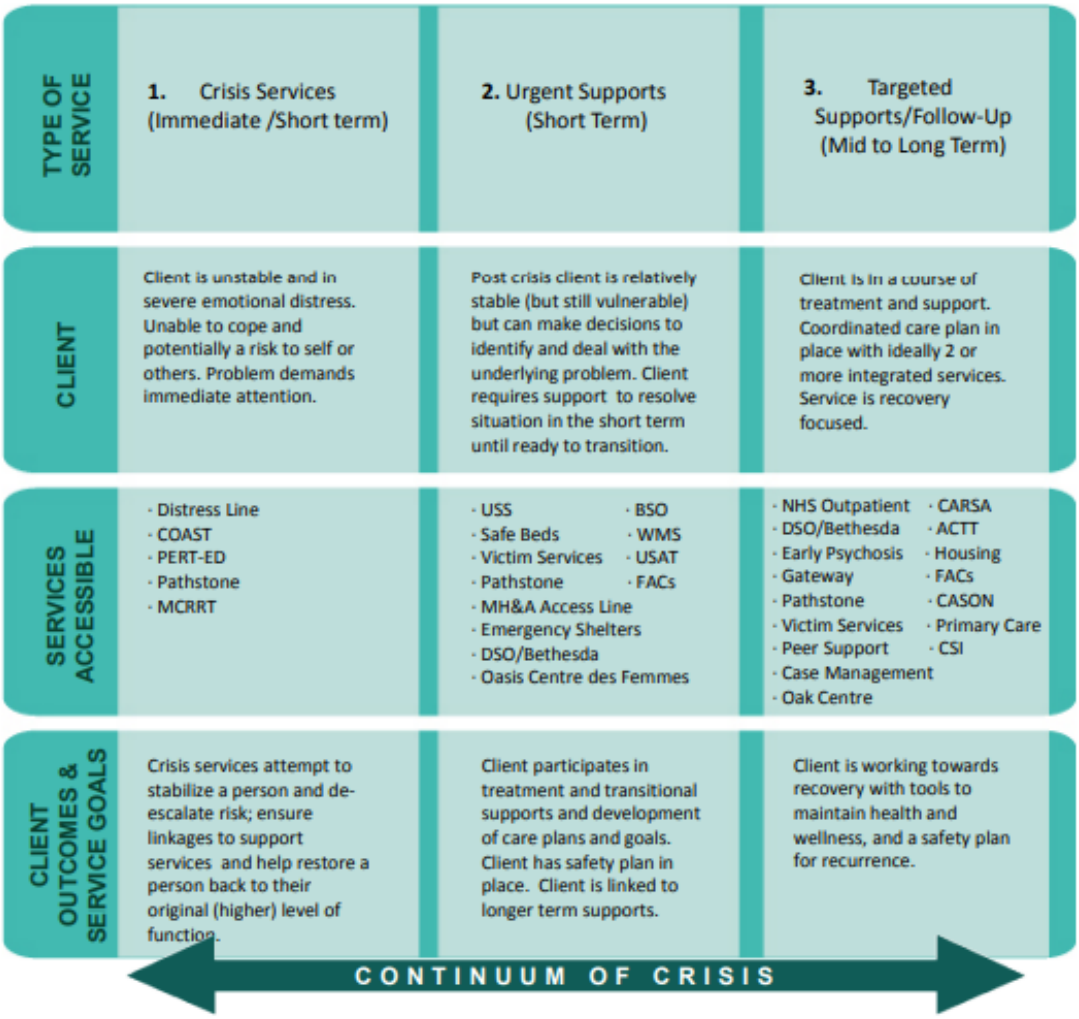
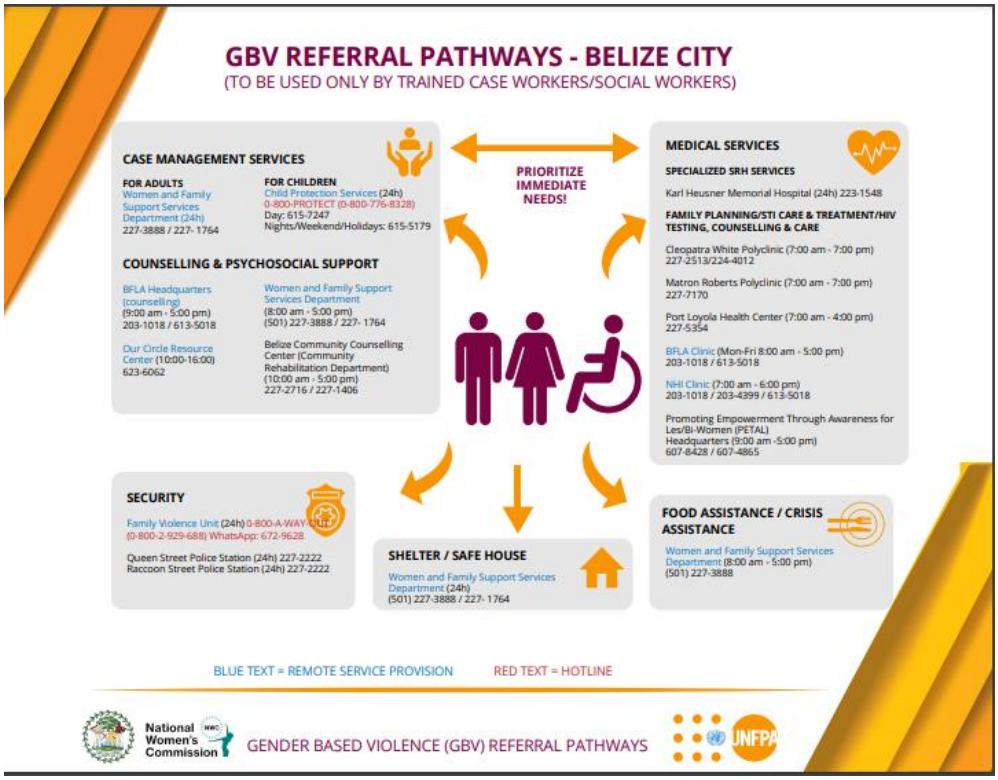
APPENDIX A: Examples of Referral Pathway Graphics

Retrieved from ***Mapping Mental Health Crisis Services in Niagara***

Figure 1: Continuum of Crisis Supports in Niagara, 2015

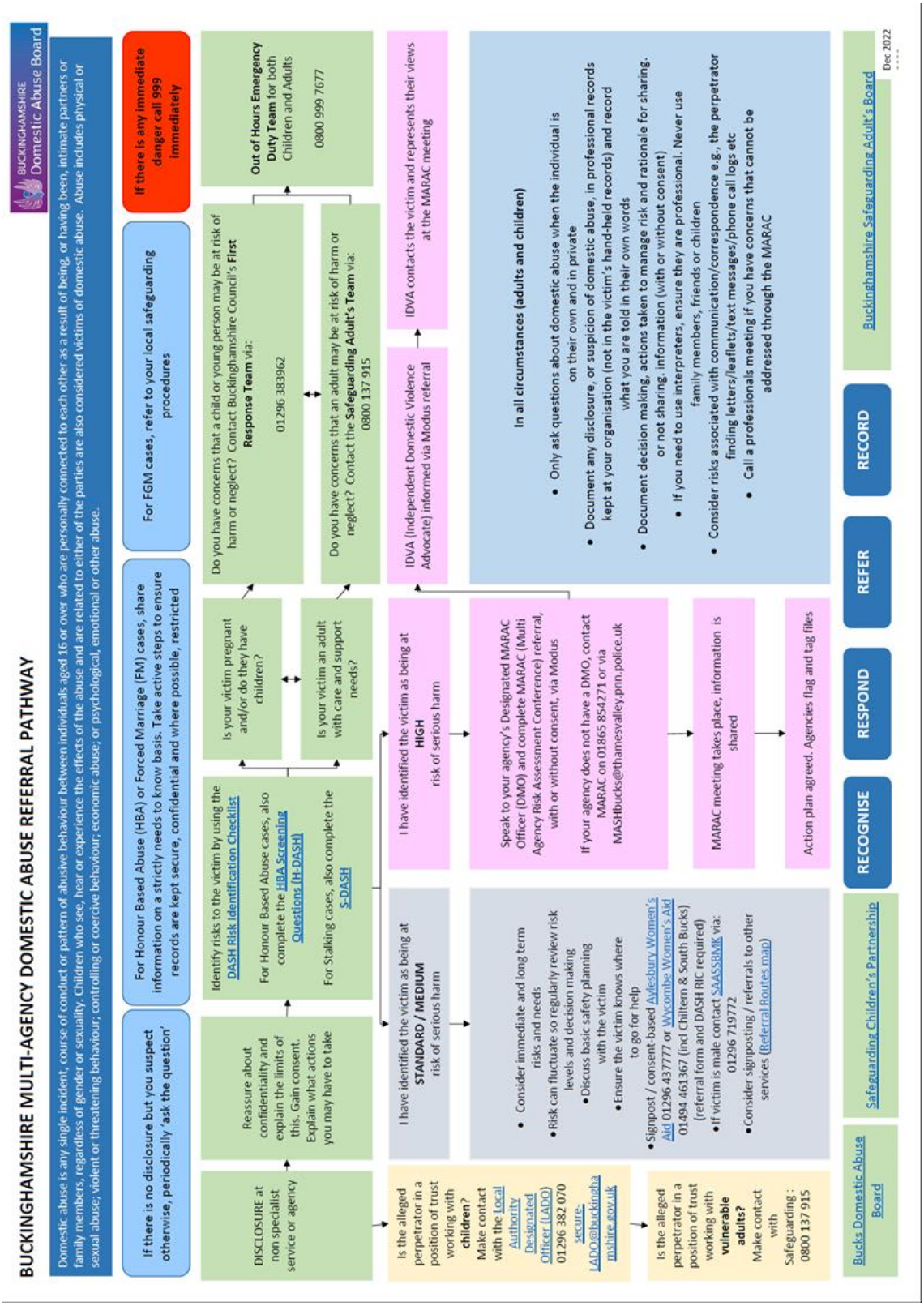


Retrieved from UNFPA Belize, ***National Women's Commission, Gender Based Violence Referral Pathways***


GBV REFERRAL PATHWAYS - BELIZE CITY
(TO BE USED ONLY BY TRAINED CASE WORKERS/SOCIAL WORKERS)
CASE MANAGEMENT SERVICES
FOR ADULTS
Women and Family Support Services Department (24h)
227-3888 / 227- 1764
FOR CHILDREN
Child Protection Services (24h)
0-800-PROTECT (0-800-776-8328)
Day: 615-7247
Nights/Weekend/Holidays: 615-5179
COUNSELLING & PSYCHOSOCIAL SUPPORT
BFLA Headquarters (counselling)
(9:00 am - 5:00 pm)
203-1018 / 613-5018
Our Circle Resource Center (10:00-16:00)
623-6062
Women and Family Support Services Department
(8:00 am - 5:00 pm)
(501) 227-3888 / 227- 1764
Belize Community Counselling Center (Community Rehabilitation Department)
(10:00 am - 5:00 pm)
227-2716 / 227-1406
PRIORITIZE IMMEDIATE NEEDS!
MEDICAL SERVICES
SPECIALIZED SRH SERVICES
Karl Heusner Memorial Hospital (24h) 223-1548
FAMILY PLANNING/STI CARE & TREATMENT/HIV TESTING, COUNSELLING & CARE
Cleopatra White Polyclinic (7:00 am - 7:00 pm)
227-2513/224-4012
Matron Roberts Polyclinic (7:00 am - 7:00 pm)
227-7170
Port Loyola Health Center (7:00 am - 4:00 pm)
227-5354
BFLA Clinic (Mon-Fri 8:00 am - 5:00 pm)
203-1018 / 613-5018
NHI Clinic (7:00 am - 6:00 pm)
203-1018 / 203-4399 / 613-5018
Promoting Empowerment Through Awareness for Les/Bi-Women (PETAL)
Headquarters (9:00 am -5:00 pm)
607-8428 / 607-4865
SECURITY
Family Violence Unit (24h) 0-800-A-WAY-OUT
(0-800-2-929-688) WhatsApp: 672-9628
Queen Street Police Station (24h) 227-2222
Raccoon Street Police Station (24h) 227-2222
SHELTER / SAFE HOUSE
Women and Family Support Services Department (24h)
(501) 227-3888 / 227- 1764
FOOD ASSISTANCE / CRISIS ASSISTANCE
Women and Family Support Services Department (8:00 am - 5:00 pm)
(501) 227-3888
BLUE TEXT = REMOTE SERVICE PROVISION
RED TEXT = HOTLINE
National Women's Commission
GENDER BASED VIOLENCE (GBV) REFERRAL PATHWAYS
UNFPA


1
A SURVIVOR DISCLOSES GENDER-BASED VIOLENCE TO SOMEONE TRUSTED
The survivor tells a trusted family, friend, or a community member OR The survivor self-reports to any service provider
IMMEDIATE RESPONSE
Respect the confidentiality and wishes of the survivor
Reliable and comprehensive information on the available services and support to survivors of GBV must be provided
Obtain informed consent.
When family/guardians make decision on behalf of the child, ensure the best interest of the child is given priority. Preferably, the accompanying adult should be selected by the child
Support survivors of rape to access medical care within 72 hours (but it is their choice).
DO
DO believe the survivor. Reassure the survivor that this was not his /her fault.
DO make sure that both the survivor and you are safe from immediate danger.
DO provide practical care and support (e.g. offer water, somewhere to sit, etc.)
DO listen to the person without asking questions.
DO be aware of and set aside your own judgments.
DO respect the right of the survivors to make their own decision.
Inform, do not give advice.
DO limit the number of people informed about the case (refer the case confidentially to appropriate GBV focal point, and only with the informed consent of the survivor).
DO NOT
DO NOT force help on people, be intrusive or pushy.
DO NOT pressure the survivor into providing information or further details.
DO NOT doubt or contradict the survivor.
DO NOT investigate the situation or provide advice
DO NOT mediate between the survivor and the perpetrator or a third person (e.g. family).
DO NOT write down or share details of the incident or personal details of the survivor
DO NOT assume you know what a survivor wants or needs. Some actions may put the survivor at further risk of stigma, retaliation, or harm.
Once a GBV referral has been made, DO NOT ask for extra information or contact the survivor directly.
ALWAYS PRACTICE THE SURVIVOR CENTERED APPROACH
PRIORITIZE the needs, wishes, and decisions the survivor expresses
ENSURE the survivor makes ALL decisions about accessing services and sharing information regarding her case
DO NOT PROVIDE ADVICE
NEVER blame the survivor
Be patient, be a GOOD LISTENER, and be NONJUDGEMENTAL
2
IF THE SURVIVOR HAS GIVEN INFORMED CONSENT, THE IMMEDIATE 2 RESPONSE SHOULD BE:
PRIORITIZE URGENT HEALTH CARE! PRIORITIZE SAFETY AND SECURITY!
SEXUAL VIOLENCE
If the survivor needs it - ensure immediate access to available medical care (within 3 days or 72 hours for emergency HIV treatment; within 5 days for emergency contraceptives and prevention of sexually transmitted infection).
PHYSICAL VIOLENCE
If the survivor needs it - seek medical care if she is experiencing severe pain, bleeding, or for the treatment of non-sexual violence related injuries
IF THERE IS AN IMMEDIATE RISK OF SAFETY FOR THE SURVIVOR/THERE IS A LIFE-THREATENING CONCERN
Contact competent authorities (e.g. police - 911) or other appropriate emergency support (e.g. Ambulance, Fire Dept.).
3
IF THERE ARE NO URGENT HEALTH OR SAFETY & SECURITY NEEDS, RESPOND TO OTHER SERVICE NEEDS
These can include Mental Health Services, Shelter, Non-food Items, Food, or Legal Information & Advice.
National Women's Commission
GENDER BASED VIOLENCE (GBV) REFERRAL PATHWAYS
UNFPA

Retrieved from ***The Bucks Referral Pathway, Buckinghamshire Domestic Abuse Board***



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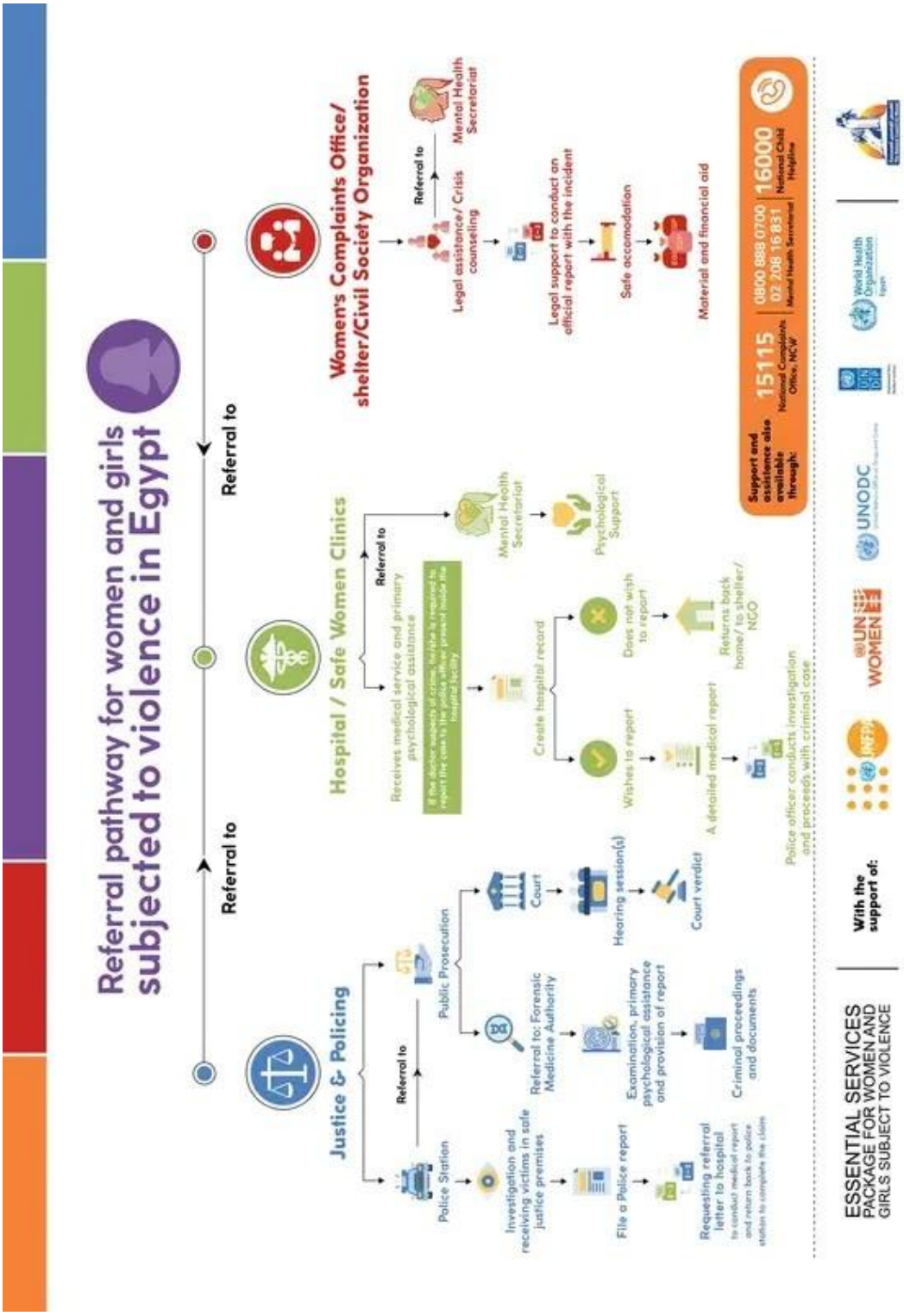

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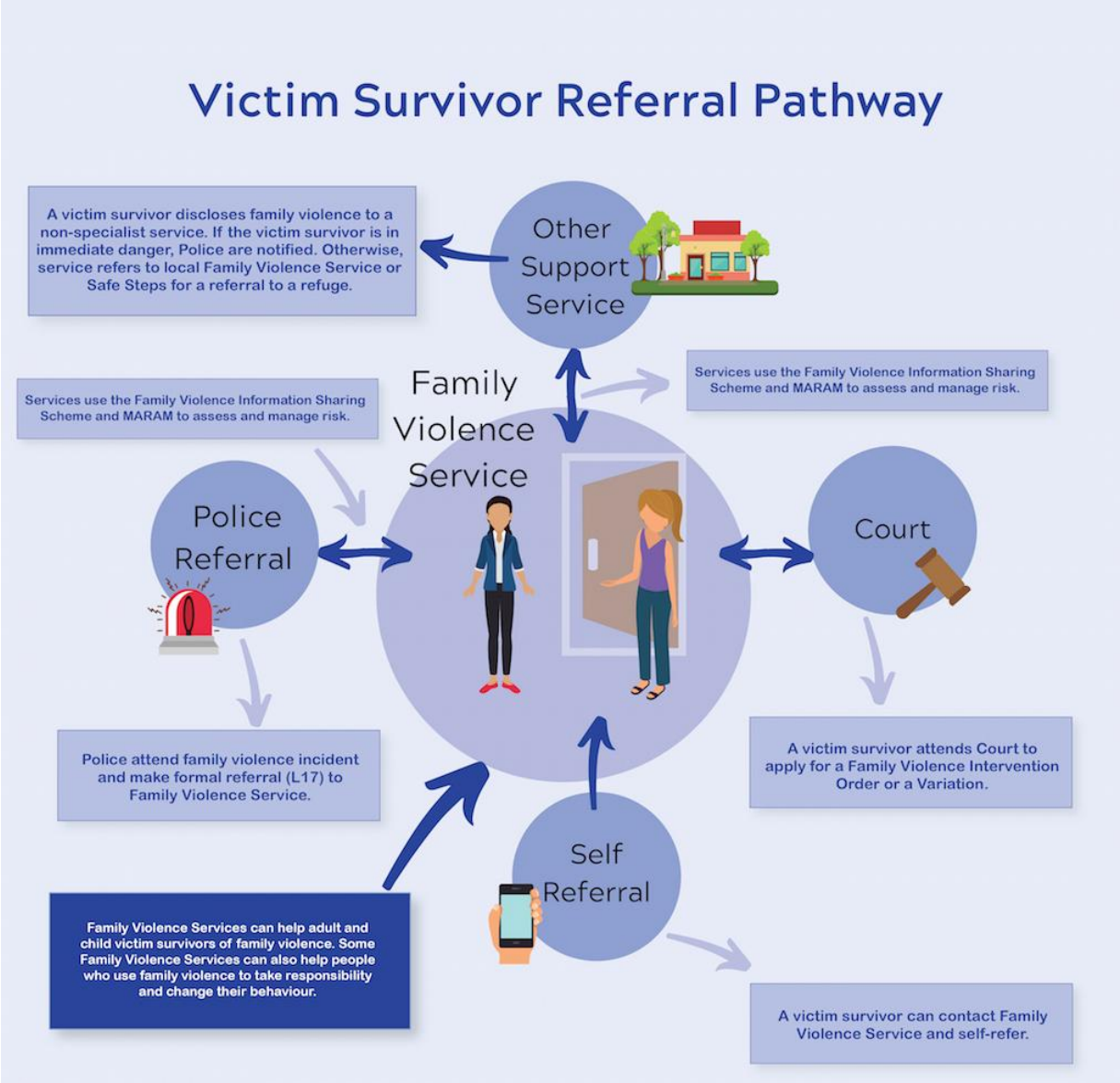

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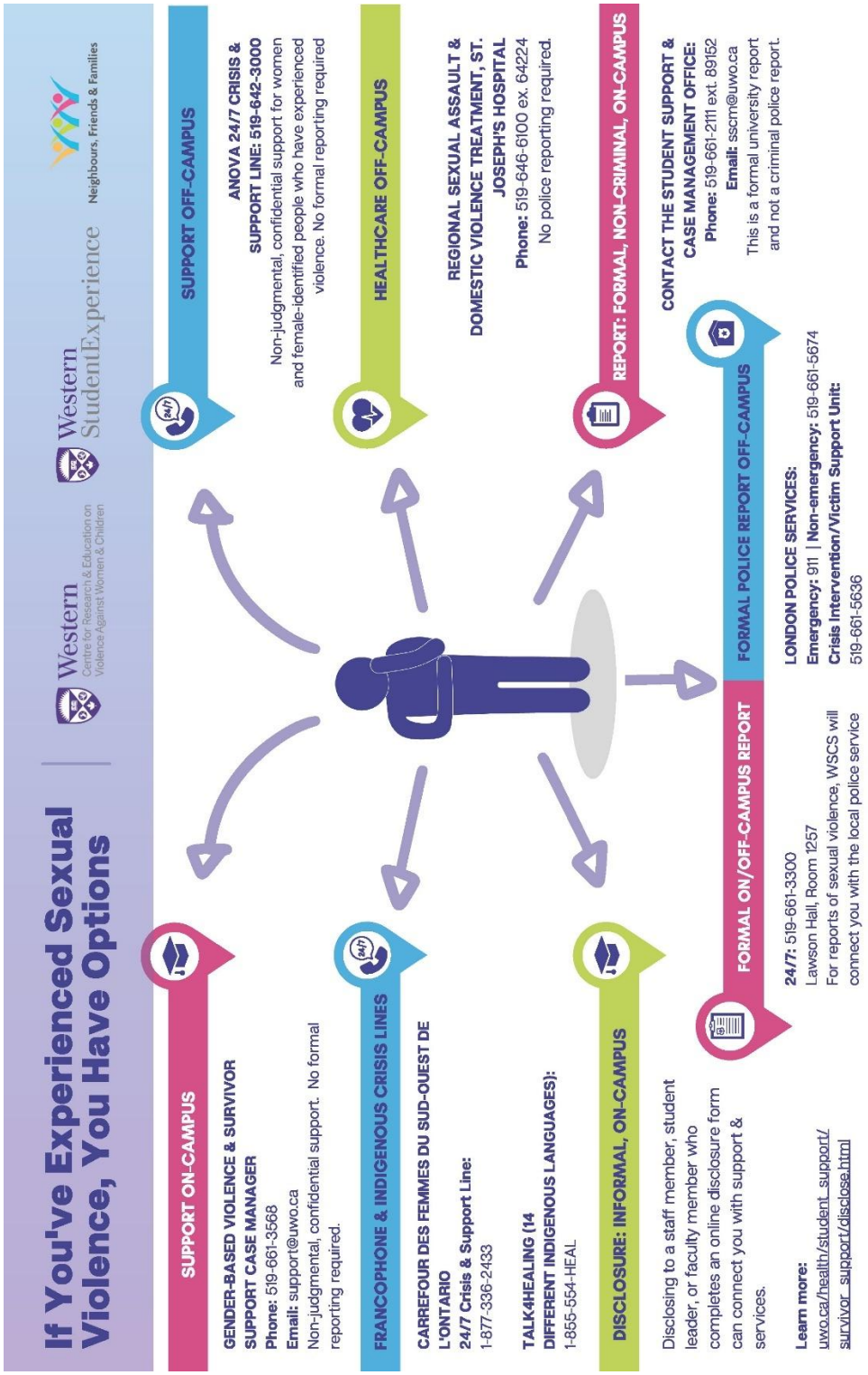


APPENDIX B: CEVAW Network Connectivity Mapping Survey Copy

CEVAW Network Connectivity Mapping Survey

Background

This survey is part of work that Niagara Connects is facilitating, in partnership with The Coalition to End Violence Against Women (CEVAW). The aim is to examine, identify, and help strengthen referral pathways for individuals accessing gender-based violence services through CEVAW member agencies.

The purpose of this survey is to gather information on where connections exist between individuals and agencies within CEVAW. Survey data will be utilized to create a visualization of current and potential connections, in Niagara and beyond. Ultimately, this will allow CEVAW members to identify and maximize service pathways for those seeking support.

The information you provide will strengthen collaborative CEVAW planning in Niagara. The goal is to support already existing connections and strengthen other connections for future work.

Confidentiality and Consent to Participate

All information you supply in the survey will be held in confidence and unless you specifically indicate your consent, your name will not appear in any report made public outside of CEVAW. Your name and affiliations may be used in the internal report submitted to CEVAW. Any names and affiliations that you provide for other individuals will not be made public within or outside of CEVAW unless the individual specifically indicates their consent.

Survey responses will be collected and analyzed by Niagara Connects. Your data will be safely stored in a password-protected file on the principal investigator's local computer. Only authorized members will have access to your information.

The data collected in this survey may be used, in its de-identified form, by members of the research team in subsequent investigations. Any secondary use of de-identified data by the research team will be treated with the same degree of confidentiality and anonymity as in the original project.

The researcher(s) acknowledge that the host of e-based platforms used in this project may automatically collect participant data without their knowledge (e.g., IP addresses). Although this information may be provided or made accessible to the researchers, it will not be used or saved without the participant's consent on the researchers' system. Since this project will use e-based platforms for collection and analysis, data may be subject to access by third parties because of various security legislation now in place in many countries. Thus, the confidentiality and privacy of data cannot be guaranteed during web-based transmission.

Q1 By providing your initials below, you consent to participate in the questionnaire, have understood the nature of this questionnaire, and wish to participate. You are not waiving any of your legal rights by providing your initials.

Instructions

Please respond to the questions based on your role in CEVAW. The survey will take 15-20 minutes to complete. If preferred, you have the option to save your answers and return later to submit the survey. At the end of the survey, there is an opportunity to provide additional comments.

Please have your calendar or meeting agenda available for reference, as we will be asking you to list the people who you had a meaningful conversation with about gender-based violence work and principles in the last 6 weeks. Please be assured that we will not be contacting these people.

You will have the ability to add up to 30 people. It may be helpful for you to have a piece of paper on hand to keep track of whom you have added to the list.

If you are not affiliated with any organization, please indicate "Independent" in the "Organization" field of the survey.

Thank you for taking the time to complete this survey!

2. What is your name (First and Last)?

3. What is your organization?

4. In which municipality do you work? (select all that apply)
All of Niagara
Fort Erie
Grimsby
Lincoln
Niagara Falls
Niagara-on-the-Lake
Pelham
Port Colborne
St. Catharines
Thorold
Wainfleet
Welland
West Lincoln
Other (please specify)

5. Did you know about CEVAW prior to this survey?
Yes
No

6. How aware are you of the work of CEVAW?
Active member of CEVAW
Inactive member of CEVAW

Aware of CEVAW, but not a member
Unaware of CEVAW
Unsure

7. How long have you been involved in gender-based violence work in Niagara?

Less than one year
1 – 5 years
6 – 10 years
11 – 20 years
More than 20 years
Other (please specify)

8. Which of the following best describes your role in your organization or affiliation?

Volunteer
Manager/senior staff
Frontline worker
Planner (including policy)
Student
Administrative
Other (please specify)

9. Which of the following best describes your organization or group?

Government
Educational institution
Non-profit/community organization
Not applicable/unaffiliated
Other (please specify)

10. In the area below, please identify the people who you had a meaningful conversation** with about gender-based violence work and principles in the last **SIX** weeks.

You will have the ability to add up to 30 people. It may be helpful to have a piece of paper on hand to keep track of who you have added.

If you are adding someone that does not have an organization or affiliation, please indicate "Independent" in the "Organization" field.

***A "meaningful conversation" may include and is not limited to: connecting with an individual from another organization at the committee level; the exchange of new ideas, innovations, or inspiration; helpful support, advice, or resources. You are encouraged to use your personal judgement to determine whether a conversation is meaningful since the definition is intentionally broad.*

10. Person's name (First and Last):

11. Person's organization:

12. This person is located: (please select one)

Within the Niagara region
Within Ontario

Within Canada
Outside Canada

* 13. Would you like to add another person?

Yes
No

Appendix C: Project Infographic

CEVAW
Systems Mapping Project

The Coalition to END VIOLENCE AGAINST WOMEN C.E.V.A.W · Niagara Connects · LIVING IN NIAGARA

WHAT ARE WE DOING?

Reviewing current community supports and referral pathways for those accessing gender-based violence services within CEVAW.

Developing a thorough referral pathway tool that can help improve the services and outcomes for those accessing the individual agencies within CEVAW.

Engage & Survey
Service providers complete surveys

Network Map
Understand how people are working together

Focus Groups
Test outcomes of network map and build recommendations

System Map
Tool to improve referral pathways

WHY IS IT BENEFICIAL?

Using referral pathways can improve knowledge and referral accuracy when provided to those seeking support.

SYSTEMS MAPPING

- Understanding inflow and outflow to/from services
- Illuminate issues and challenges in the current system
- Inform recommendations

Key purpose of this exercise is to identify key points people must go through in order to receive intended supports.

Helps create a more coordinated and integrated crisis system, improving overall access.

CEVAW
Projet de cartographie du système

The Coalition to END VIOLENCE AGAINST WOMEN C.E.V.A.W · Niagara Connects · LIVING IN NIAGARA

QUE FAISONS-NOUS?

Nous examinons les services de soutien communautaires actuels et les voies d'orientation pour les personnes qui accèdent aux services de lutte contre la violence sexiste au sein de la CEVAW.

Nous élaborons un outil d'orientation complet qui peut améliorer les services et les résultats pour les personnes qui accèdent aux organismes individuels au sein de la CEVAW.

Communication et sondage
Les fournisseurs de services répondent au sondage

Carte du réseau
Comprendre comment les gens travaillent ensemble

Groupes de discussion
Tester les résultats de la carte du réseau et formuler des recommandations

Carte du système
Outil pour améliorer les voies d'orientation

POURQUOI EST-CE BÉNÉFIQUE?

L'utilisation de voies d'orientation peut améliorer les connaissances et la précision de l'orientation lorsqu'elles sont fournies aux personnes qui recherchent de l'aide.

CARTOGRAPHIE DU SYSTÈME

- Comprendre les flux entrants et sortants vers/depuis les services
- Mettre en lumière les problèmes et les défis du système actuel
- Éclairer la formulation de recommandations

L'objectif principal de cet exercice est d'identifier les points clés par lesquels les personnes doivent passer pour recevoir les services d'aide prévus.

Contribue à créer un système d'intervention en cas de crise mieux coordonné et intégré, améliorant ainsi l'accès général.

Appendix D: Mock Situation Table Exercise Handout

CEVAW Referral Pathways Project
MOCK TABLE EXERCISE

About

These cases are all fictitious and have been developed in collaboration with several community organizations. The cases are specifically designed to be complex and highlight consistent challenges for the GBV system.

All data collected from this exercise will remain anonymous and contribute to the final report we are making for the CEVAW Referral Mapping Project. The purpose of the exercise is to validate our current findings, including the sector's current strengths, challenges, and opportunities.

Process

The facilitator will read a scenario describing domestic violence and/or sexual assault. We will aim to begin where victims often first encounter the service system in our community, the proceed to walk through the case chronologically following the typical referral pathway (i.e. what organization and programs the case will be directed to).

Things to consider when reflecting on your own organization's work:

- How does a victim present for services?
- How do people typically get referred?
- Who would a victim initially talk to? What does the initial conversation look like? Then what happens?
- At what point and in what way are other community partners brought in when responding to a case (i.e. when and how many referrals are made?)
- When is a case closed or when does it move from one program/person to another program/person?
- What is the timeframe for a case moving through the system?
- What policies, procedures, laws, etc. guide your response and the action you take?
- How does one qualify for your services? What are your service parameters?
- What does your organization do really well? What is your organization's biggest challenge?

If you have any questions, thoughts or concerns after participating in this event, please feel comfortable to reach out to Rachel Gillmore, project lead at rachel.gillmore@communitypotential.ca.

This process is adapted from the Coordinated Community Response model frequently used by communities to address gender-based and/or domestic violence. For more information about this model, please visit: https://s3-us-east-2.amazonaws.com/edaw-webinars/wp-content/uploads/2018/11/14124929/CCR-Toolkit.pdf
For a Canadian implementation of this model, please see: Justice and Public Safety, New Brunswick. Framework: Coordinated Community Response to High Risk/High Danger Domestic/Intimate Partner Violence in New Brunswick, (April 8, 2022). https://www2.gnb.ca/content/dam/gnb/Departments/ps-sp/pdf/Publications/coordinated-community-response-framework.pdf

Case #1: Lindsay

Lindsay is a 17-year-old, female identifying individual. Lindsay has no local kin or support network. Lindsay has an extensive history of sexual abuse from her father and is estranged from her mother, who lives out of country.

Lindsay has no formal diagnosis but appears to have a developmental delay and functions around a 10–12-year-old level. Her family has had a previous file with FACS Niagara, but there is no active file. Lindsay has experienced a recent sexual assault by another resident while staying in a local homelessness shelter and has now reported this to the police.

Due to Lindsay's life experience and an acquired brain injury, she has no real-life skills – she is unable to cook, navigate the community on her own, take transit on her own, or maintain her personal and household hygiene.

Key challenges:

- Older youth
- Historical trauma and mental health
- Developmental delay/brain injury
- No kinship or informal supports

Case #2:

Bridgette is in her early 30s and female identifying. Bridgette is in an advanced stage of pregnancy and has had no prenatal care during her entire pregnancy. Bridgette has been unhoused consistently for 2 years, primarily living in encampments.

Bridgette has a history of violent sexual trauma, and intense substance (opioid) use. Her current pregnancy is the result of a sexual assault by a former partner that is also a member of the homeless community. She has significant undiagnosed mental health concerns and struggles with anger and psychosis.

Bridgette is estranged from all kin. She has a long history of being violent towards community service supports and her family. She is resistant to help and frequently states how she has been failed by anybody who has ever tried to help her.

She is at high risk for continued violence from her previous partner and highly vulnerable.

She has a previous child who was apprehended and is in permanent care.

Key Challenges:

- Chronic homelessness
- Severe mental health and addiction
- Prenatal supports
- Trauma
- Client resistance

Case #3:

Amara is female presenting, in her 40s, and a newcomer to Canada. Amara speaks Arabic, with very little English. Amara has 6 children, all under 12, and was sponsored by her husband to come to Canada. They live in a small apartment and are well connected to other newcomers and extended family who have also come to Canada.

Amara and her husband have a very traditional/patriarchal view of marriage, with a long history of violence of all types experienced by Amara. Police were called by neighbors in the same building as the family overhearing a particularly violent assault by neighbours in Amara's building. Amara's husband was arrested upon police arrival. Amara refused medical care initially and refused to cooperate with police or ask for support from any other community agency.

After 72 hours, Amara had received numerous threats from her spouse's family, and his family had made a number of claims to officials to undermine her immigration status. At this time, Amara also began to experience significant health impacts from the assault and required hospitalization. Upon assessment, Amara was identified to have sustained a spinal cord injury and is now permanently disabled and requiring rehabilitation to be able to use her upper body.

Key Challenges:

- Newcomer with limited English
- Large family
- Cultural pressure/necessary access to culturally relevant services
- Physical trauma/newly acquired disability

Case #4:

Holly is an 82-year-old female identifying, living in her own home with her longtime spouse in the community. Holly has been experiencing cognitive decline but is able to maintain living independently with support from her spouse (i.e. she needs help with meal prep and cueing for other life skills). Holly also has minor undiagnosed mental health concerns and health conditions, primarily recovering from a surgery, and requiring daily medications to maintain her wellbeing.

Holly became involved with community services after a domestic violence incident with her husband, upon which the police were called. Upon assessment it appears Holly's husband is also experiencing cognitive decline.

Holly does not have local family, and there is no person now as her care partner. Holly has never worked and relies on her husband's pension.

Key Challenges:

- Older adult
- No income
- Concurrent disorders – mental health and cognitive decline
- Spouse with cognitive decline

Appendix E: CEVAW System Navigation Brochure for Victims

SAFETY PLANNING

If you're not safe at home, there are things you can do to help protect yourself and the people you love.

- **Set up a code word**
  Choose a word or phrase you can say or text to someone you trust — it's a signal that you need them to call for help now, especially if you can't leave right away.
- **Gather key documents**
  Keep important items (passports, social insurance numbers, bank cards, keys) in one safe, easy-to-access spot so you can grab them quickly if needed.
- **Make an exit plan**
  Have a plan to get out of your house in an emergency and find a safe place you and your children can stay, even temporarily.
- **Pack a go-bag**
  Prepare a small bag with essentials:
  - Important documents (or copies)
  - Medications
  - Clothing
  - Money
  - Anything else you may need if you have to leave quickly
- **Share your safety plan**
  If it's safe to do so, share this plan with someone you trust — like a friend or family member

IF YOU ARE A VICTIM/SURVIVOR

- **Call 911** if you fear for your safety or that of a children
- **Confide** in someone you trust
- **Call one of the access lines** listed on this pamphlet for help knowing what to do next

WHERE TO GET HELP

Connect (call or text) with a crisis line at a Domestic Violence shelter

Gillian's Place
905-684-8331
Serving Grimsby, Lincoln, West Lincoln, Niagara-on-the-lake, St. Catharines and Thorold.

Victim Services Niagara
905-682-2626
24/7 Response Line

Birchway Niagara
905-356-5800
Serving Niagara Falls, Fort Erie, Welland, Wainfleet, Port Colborne, Pelham and surrounding areas.

French-Speaking Supports
1-877-336-2433
Fem'aide and Centre de Santé Communautaire Hamilton/Niagara.

Indigenous Supports
1-855-554-4325
Talk4Healing

The Coalition to END VIOLENCE AGAINST WOMEN C.E.V.A.W

EVERYONE DESERVES TO BE SAFE.

Access resources and break the cycle

THE JOURNEY MOVING FORWARD

FIND SUPPORT TO LEAVE VIOLENCE

Address the Situation

If you or your children is in immediate danger

Call 911 right away.
Police will respond and help you.

If you're unsure what to do but no immediate danger is present

Call one of the help lines listed at the back of this brochure *(see the section Where To Get Help).*

→ *A trained responder will help you assess your options.*

Find Safety & Shelter

If it's not safe to stay at home, you can contact a domestic violence shelter like **Gillian's Place** or **Birchway Niagara.**

→ *Shelter and crisis staff can help you create a safety plan to protect you and any children.*

Get Healthcare & Counselling

Hospitals have dedicated Sexual Assault and Domestic Violence care teams.

Victim Services Niagara can connect you to:

- Counselling
- Mental health services
- Support groups

Use Expert Legal Help

Legal advocates at the domestic violence shelters can help with you navigate the legal system.

→ *Contact them for support with custody, separation, restraining orders, etc.*

Connect With Support

Referrals can be made to:

Find peer support groups, culturally relevant community groups, language and interpretation support.

Find ongoing support from professionals you would like to stay connected to as you begin your next chapter.

Access Housing & Financial Supports

Support programs are available to help you move from shelter into transitional or long-term housing.

→ *The phone lines listed at the back will connect you to people that can help you find and apply to financial support programs*

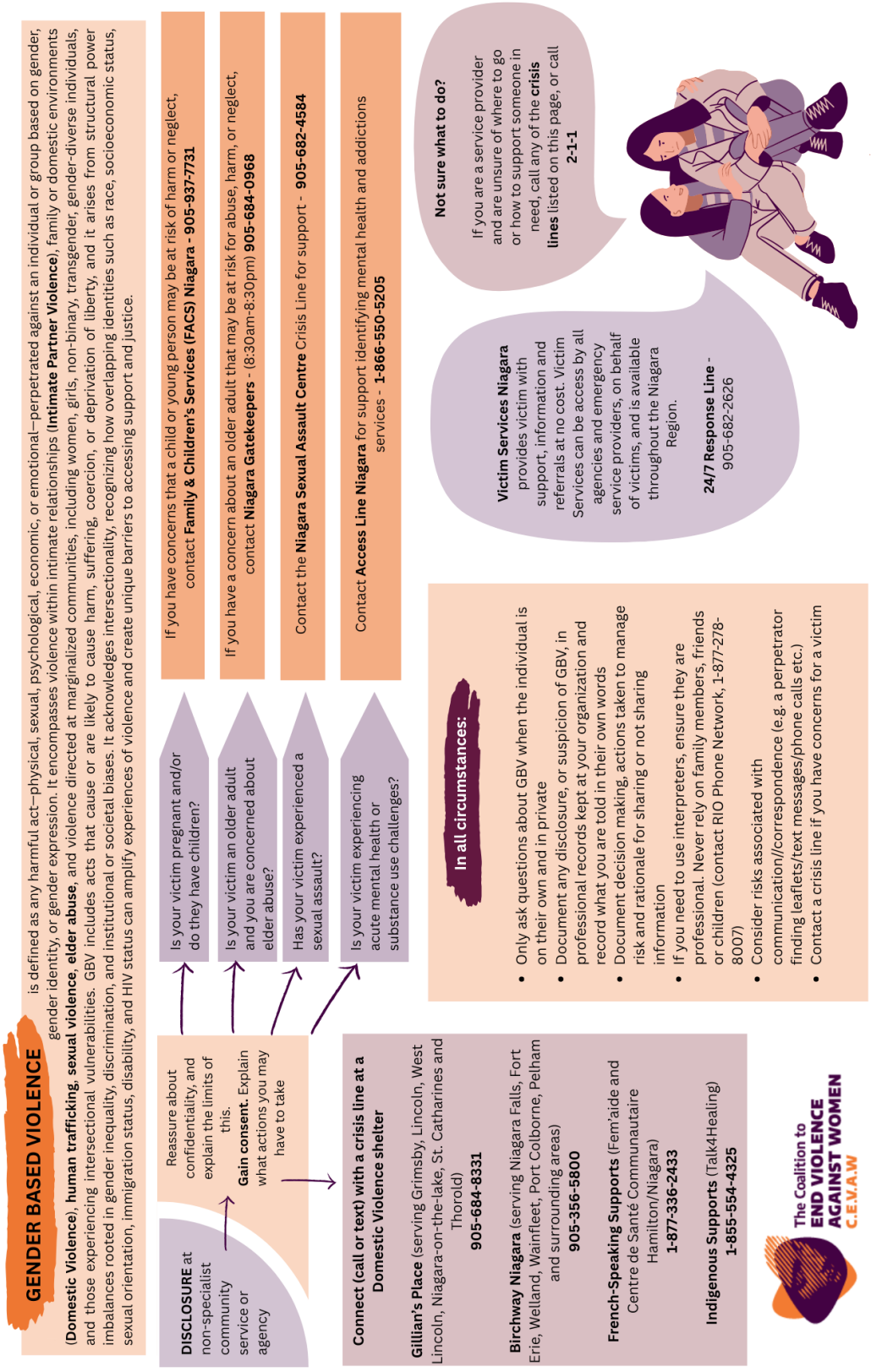
Understanding the justice process

In Canada, the justice process for domestic violence cases involves criminal charges, protection orders, and specialized court programs. Police can arrest and charge individuals suspected of domestic violence, and the court may issue protection orders to ensure the safety of victims. If there are children involved, Family & Children's Services Niagara may be required to investigate alongside police. A worker trained in understanding intimate partner violence will be there to assist you and connect you with the resources you need.

The Coalition to END VIOLENCE AGAINST WOMEN C.E.M.A.W

COMMUNITY POTENTIAL

Appendix F: GBV Systems Navigation Tool for Service Providers



Appendix G: Community Organizations Reference Guide

Organization Name	Type of Service	Service Description	Target Population	Program Location	Contact Info	Notes
Access Line Niagara	Community & System Navigation (Substance Use; Mental Health & Addictions); Crisis Response Services	Matches individuals with mental health and addiction support services across Niagara.	Adults; Youth 16+	Niagara Region	1-866-550-5205	24/7 Crisis Support Line
ARID Recovery Homes	Substance Use	Offers structured residential support for individuals recovering from addiction.	Adults; Youth	St. Catharines, ON	(905) 227-1113	
Assaulted Women's Helpline	Crisis Response Services	free, anonymous and confidential 24-hour telephone line to all women in the province of Ontario who have experienced any form of abuse	Domestic Violence Survivors	Ontario	1-866-863-0511	
Bethlehem Housing & Support Services	Shelter & Housing	Supportive, transitional, and permanent affordable housing for singles and families.	Adults, Families; Youth; Domestic Violence Survivors	St. Catharines	905-641-1660	
Birchway Niagara	Community Outreach and Education (Domestic Violence Prevention)	Programming for community regarding domestic violence, including educating about signs of domestic violence, how to support victims of abuse, and available services	Community Prevention Programming	Niagara		
Birchway Niagara	Shelter & Housing	Provides emergency shelter and support for women and children facing domestic violence.	Women and Women-Identifying Adults and Youth, Families, Domestic Violence Survivors	Niagara Falls	905-356-3933; Crisis Line: 905-356-5800	24/7 Crisis Support Line
Birchway Niagara	Community & System Navigation	Assists survivors with navigating resources, such as housing, legal aid, and financial support.	Women and Women-Identifying Adults and Youth; Families; Domestic Violence Survivors	Niagara Falls	905-356-3933; Crisis Line: 905-356-5800	
Bridges Community Health Centre	Healthcare Services	Provides a full range of client-centred primary care services, particularly to those with limited access to health services	Adults; Youth	Fort Erie, Port Colborne, Wainfleet	Port Colborne Site: 289-479-5017; Fort Erie Site: 905-871-7621	
Bridges Niagara - Immigrant and Refugee Services	Advocacy & Education	Offers education and workshops to support cultural integration and community engagement.	Newcomers; New Immigrants; Adults; Families; Older Adults; Youth	Niagara Region	905-685-6589	
Bridges Niagara - Immigrant and Refugee Services	Community & System Navigation; Newcomer Services	Helps clients navigate settlement processes and access government and community resources.	Newcomers; New Immigrants; Adults; Families; Youth	Niagara Region	905-685-6589	Provides referrals to legal, housing, and employment services.
Bridges Niagara – Immigrant and Refugee Services	Counseling & Mental Health Services; Newcomer Services	Provides culturally relevant counseling to support newcomers facing challenges. First-language mental health support in Arabic, Spanish, and Mandarin.	Newcomers; New Immigrants; Adults; Families; Older Adults; Youth	Niagara Region	905-685-6589	
Canadian Mental Health Association (CMHA) Niagara	Mental Health Services	Provides a continuum of mental health services, including immediate access and longer-term support.	Adults; Families; Youth	Niagara Region	905-641-5222	Programs include: Crisis Outreach & Support Team (COAST); Mobile Crisis Rapid Response Team (MCRRT); Safe Beds
Centre de Santé Communautaire Hamilton/Niagara	Community & System Navigation	Helps French-speaking clients connect with local services, including healthcare and social supports.	Francophone Adults and Youth	Niagara Region	1-866-437-7606 ext. 222	
Centre de Santé Communautaire Hamilton/Niagara	Healthcare Services (Francophone)	Provides integrated health services for Francophone populations, including mental health and addiction support.	Francophone Adults and Youth	Niagara Region	1-866-437-7606 ext. 222	
COAST Niagara	Mental Health Services	Provides crisis intervention services for individuals experiencing a mental health crisis.	Adults; Youth	Niagara Region	Crisis Line: 1-866-550-5205 ext. 1	Operated by CMHA Niagara in partnership with Niagara Regional Police Service
Community Addiction Services of Niagara (CASON)	Substance Use	Provides comprehensive alcohol, drug and gambling addiction treatment for individuals and their families.	Adults; Youth; Families;	Niagara Region	905-684-1183	Offers satellite offices throughout the Niagara Region for accessible support
Community Care of West Niagara	Community Support & Food Security	Provides food and support services to residents of West Niagara.	Adults; Youth; Families;	Lincoln, ON	905-563-5822	
De Dwa Da Dehs Nye>s Aboriginal Health Centre	Indigenous Health & Mental Health Services	Offers holistic and culturally safe healthcare, including mental health and addiction support.	Indigenous Adults; Youth; Families	Niagara, Hamilton, Brantford	289-438-1540	Three locations: Hamilton, Brantford, and Niagara
Design for a New Tomorrow	Counseling & Mental Health	Provides support to women and women-identifying adults who have experienced abuse in intimate adult relationships.	Adults (Women & Women Identifying)	Niagara Region	905-684-1223 ext. 1	
Design for a New Tomorrow	Community Outreach and Education (Domestic Violence Prevention)	Programming for community regarding domestic violence, including educating about signs of domestic violence, how to support victims of abuse, and available services	Community Prevention Programming	Niagara Region	905-684-1223 ext. 1	
Distress Centre Niagara	Crisis Response Services	Provides a free, confidential 24-hour distress line for individuals in crisis or needing emotional support.	Adults; Youth	Niagara Region	Crisis Line: 905-688-3711; St. Catharines, Niagara Falls and Area Office: 905-688-3711; Port Colborne, Wainfleet and Area Office: 905-734-1212; Fort Erie and Area Office: 905-382-0689; Grimsby, and West Lincoln Office: 905-563-6674	Call, Text and Online Chat options available
Family & Children's Services (FACS Niagara)	Advocacy & Education	Offers educational resources and advocacy to strengthen family units and promote child safety.	Children, Youth and Families	Niagara Region	905-937-7731	
Family & Children's Services (FACS Niagara)	Child and Youth Services	Provides mandated and volunteer child welfare services to ensure safety, well-being, and permanency for children.	Children, Youth and Families	Niagara Region	905-937-7731	
Family & Children's Services (FACS Niagara)	Crisis Response Services	Emergency intervention services for at-risk children and families.	Children, Youth and Families	Niagara Region	905-937-7731	

Family Counselling Centre Niagara	Counseling & Mental Health	Provides a range of professional counseling services (both walk in and longer term) for individuals, couples, and families, as well as programs specific to women who have experienced domestic violence, and mothers/children who have experienced domestic violence in their family.	Adults; Youth, Children and Families	Niagara Region	905-937-7731 ext. 3345	Walk In Clinic Available. Domestic Violence specific programs include: Side by Side and For Me and My Mom (& Mothers in Mind)
Fort Erie Multicultural Centre	Community & System Navigation; Newcomer Services	Provides settlement services, language training, and community integration programs.	Newcomers; New Immigrants; Adults; Families; Older Adults; Youth	Fort Erie, ON	905-871-3641	
Gateway Residential & Community Support Services of Niagara Inc.	Mental Health Services; Housing Services	Supportive housing and wide variety of services for people living with mental illness.	Adults; Youth	Niagara Region	Phone: 905-735-4445	
GBF Community Services	Community Support & Food Security	Food, housing support, wellness programming, and thrift store to assist individuals and households in meeting their basic needs.	Adults; Youth; Families	Grimsby, ON	905-309-5664	
Gillian's Place	Community Outreach and Education (Domestic Violence Prevention)	Programming for community regarding domestic violence, including educating about signs of domestic violence, how to support victims of abuse, and available services	Community Prevention Programming	Niagara		
Gillian's Place	Community & System Navigation	Community supports and programming for women, 2SLGBTQI+, and families,	Women; 2SLGBTQI+ Adults and Youth; Youth; Families; Children	St. Catharines	905-684-4000	24/7 Support Line: 905-684-8331
Gillian's Place	Counseling & Mental Health	Counsellors available on-site and 24 hour through the Support Line traines specifically in domestic and gender based violence	Women; 2SLGBTQI+ Adults and Youth; Youth; Families; Children	St. Catharines	905-684-4000	24/7 Support Line: 905-684-8331
Gillian's Place	Legal Support	Provides legal advice and assistance for survivors of domestic violence.	Women; 2SLGBTQI+ Adults and Youth; Youth; Families; Children	St. Catharines	905-684-4000	24/7 Support Line: 905-684-8331
Gillian's Place	Shelter & Housing	Provides safe shelter for survivors of domestic abuse and other forms of gender-based violence, including crisis and transitional housing programs	Women; 2SLGBTQI+ Adults and Youth; Youth; Families; Children	St. Catharines	905-684-4000	24/7 Support Line: 905-684-8331
Kids Help Phone	Crisis Response Services (Children & Youth)	Kids Help Phone is Canada's only 24/7 e-mental health service offering free, multilingual and confidential support to help all young people	Children; Youth	Canada	1-800-668-6868	Text option: 686868
Kristen French Child Advocacy Centre Niagara	Advocacy & Education	Education and community outreach services regarding child abuse, trauma-informed practice, and trafficking, luring and exploitation.	Children; Youth; Families	Niagara Region	905-937-5435	
Kristen French Child Advocacy Centre Niagara	Child and Youth Services	Programs and services for children and families in the Niagara region who have been impacted by child abuse.	Children; Youth; Families	Niagara Region	905-937-5435	
Kristen French Child Advocacy Centre Niagara	Community & System Navigation	Assists families in navigating legal and support systems related to child abuse cases.	Children; Youth; Families	Niagara Region	905-937-5435	
Kristen French Child Advocacy Centre Niagara	Counseling & Mental Health	Offers trauma-focused counseling for children and youth.	Children; Youth; Families	Niagara Region	905-937-5435	
Mainstream	Developmental Services	Supports individuals with developmental disabilities through housing assistance, employment training, and community programs.	Adults; Youth	St. Catharines, ON	905-934-3924	
Ministry of the Attorney General Victim/Witness Assistance Program	Justice System Navigation and Support	Assists victims and witnesses in navigating the criminal justice system and connecting to additional resources, while educating victimes and witnesses of their rights.	Victims and witnesses of crime.	Niagara Region	905-685-2671	
Newark Neighbours	Community Support & Food Security	Provides a food bank and thrift shop services to local residents.	Residents of Niagara-on-the-Lake needing food assistance.	Niagara-on-the-Lake, ON	905-468-3519	
Niagara Chapter - Native Women Inc.	Advocacy & Cultural Education	Enhances the quality of life for Indigenous women through cultural programs, advocacy, and support services.	Indigenous Women and Families	Niagara	Phone: 905-871-8770	
Niagara Chapter - Native Women Inc.	Community & System Navigation	Offers services and programs for violence prevention, advocacy, and child welfare.	Indigenous Women and Families	Niagara Region	905-871-8770	
Niagara Chapter - Native Women Inc.	Counseling & Mental Health	Provides culturally relevant counseling and support programs.	Indigenous Women and Families	Niagara Region	905-871-8770	
Niagara Community Legal Clinic - Queer Justice Project Niagara	2SLGBTQI+ Legal Support & Advocacy	Provides legal services for Niagara's 2SLGBTQI+ communities, including support with human rights violations and gender ID changes.	2SLGBTQI+ Adults	St. Catharines, ON	905-682-6635	Partnership project with OutNiagara
Niagara Falls Community Health Centre	Health Services	Provides integrated health services for marginalized populations, including mental health and addiction support.	Adults; Youth	Niagara Falls, ON	Phone: 905-356-4222	
Niagara Falls Community Health Centre - LGBTQ+ Youth Group	2SLGBTQI+ Youth Support & Advocacy	Provides a safe space for 2SLGBTQI+ youth with support groups and health services.	2SLGBTQI+ Youth	Niagara Falls, ON	Phone: 905-356-4222	
Niagara Gatekeepers Program	System Navigation (Older Adults)	A phone line connecting at-risk older adults, their supports and caregivers with programs and services, focusing on preventing neglect and abuse.	Older Adults	Niagara	905-684-0968	Phone line program run through Niagara Region
Niagara Health - Emergency Department Services	Crisis Response Services	Provides immediate medical attention for emergencies, including injuries resulting from violence or assault.	General	Niagara Region	Phone: 905-378-4647	
Niagara Health - Indigenous Helath Services & Reconciliation	Indigenous Health & Mental Health Services	Delivers culturally sensitive health services, advocacy, and mental health counseling.	Indigenous Adults; Youth; Families	Niagara Region	905-378-4647 x43211	
Niagara Region - Niagara Parents Program	Advocacy & Education	Phone line for parents to connect with a public health nurse about parenting, children's health, or pregnancy	Adults; Families; Children	Niagara Region	Parent Talk Line: 905-688-8248 or 1-888-505-6074 Ext. 7555	
Niagara Region - Seniors Community Programs	Older Adult Services	Offers a variety of social, wellness and outreach services to older adults. Programs are intended to help older adults to remain safe and independent at home for as long as possible.	Older Adults	Niagara Region	Phone: 905-984-2621	

Niagara Regional Housing	Shelter & Housing	Provides community and subsidized housing options in Niagara, including specific programming for victims of domestic violence	Adults; Families; Youth	Niagara Region	905-682-9201	
Niagara Regional Native Centre	Indigenous Services	Provides culturally relevant services, including housing support, health, healing, and wellness programs.	Indigenous Adults; Youth; Families	Niagara	905-688-6484	
Niagara Regional Police Service	Crisis Response Services	Provides emergency response and law enforcement services for the Niagara Region.	General	Niagara Region	Emergency: 911 Non-Emergency: 905-688-4111	
Niagara Sexual Assault Centre	Counseling & Mental Health	Provides support and counseling for individuals who have experienced sexual assault, incest, childhood sexual abuse, and human trafficking.	Adults; Youth	Niagara Region	Office: 905-682-7258 Crisis Line: 905-682-4584	
Niagara Sexual Assault Centre	Crisis Response Services	Operates a 24-hour crisis line for survivors of sexual violence.	Adults; Youth	Niagara Region	Office: 905-682-7258 Crisis Line: 905-682-4584	
Niagara Sexual Assault Centre	Advocacy & Education	Delivers public education programs to raise awareness of and prevent sexual violence.	Community Prevention Programming	Niagara Region	Office: 905-682-7258 24-hour Crisis Line: 905-682-4584	
Open Arms Mission of Welland	Community Support & Food Security	Offers a food bank and community support services to those facing financial challenges.	Adults; Families; Children; Youth	Welland, ON	905-788-3800	
OUTniagara	2SLGBTQI+ Community Support & Advocacy	Connects and supports Niagara's 2SLGBTQI+ communities through resources, events, and advocacy.	2SLGBTQI+ Adults and Youth	Niagara	info@outniagara.org	
Pathstone	Mental Health Services	Mental health care for children, youth and families, including long-term supports, walk-in clinics and a crisis phone line.	Children; Youth; Families	Niagara	Office: 905-688-6850; Crisis Line: 1-800-263-4944	
Pelham Cares	Community Support & Food Security	Offers assistance with transportation, food support, and referrals to additional services.	Adults; Families; Children; Youth	Fonthill, ON	905-892-5300	
Port Cares	Community & System Navigation	Offers emergency assistance, housing support, and employment services to individuals in need.	Adults; Families; Children; Youth	Port Colborne	905-834-3629	
Port Cares	Community Support & Food Security	Offers a range of services, including food bank support, housing assistance, employment services, and community programs.	Adults; Families; Children; Youth	Port Colborne, ON	905-834-3629	
Positive Living Niagara	Substance Use; Harm Reduction	Support for individuals affected by HIV, HCV, STBBIs and substance use.	Adults; Youth	St. Catharines, ON	905-984-8684	
Project Share Niagara Falls	Community Support & Food Security	Provides food, housing, and utility assistance to individuals and families in financial crisis.	Adults; Families; Children; Youth	Niagara Falls	905-357-5121	
Quest Community Health Centre	Healthcare Services	Provides primary helath care services, health promotion initatives, and community capacity building programs for individuals experiencing social, economic and cultural barriers.	Adults; Youth	St. Catharines, ON	905-688-2558	
Quest Community Health Centre - Rainbow Niagara 2SLGBTQ+ Services	2SLGBTQI+ Health & Mental Health Services	Offers primary health care, trans-specific health care, mental health support, and community initiatives for the 2SLGBTQI+ community.	2SLGBTQI+ Adults and Youth	St. Catharines, ON	905-688-2558	
REACH Niagara	Healthcare Services	Provides primary care, counseling, harm reduction supplies, preventative screenings, and referrals.	Adults; Youth	Niagara Region	905-730-5647	Operates a Mobile Health Clinic offering trauma-informed care. No health card required.
Salvation Army Niagara Region	Community Support & Food Security	Provides food assistance and support for individuals in crisis. Operates mens emergency shelter	Adults	Niagara Falls, Niagara Region	905-358-8394	
Seniors Safety Line	Crisis Response Services (Older Adults)	24 hour crisis and support line for seniors in Ontario who	Older Adults	Ontario	1-866-299-0008	
Sexual Assault/Domestic Violence (SADV) Treatment Program Niagara	Crisis Response Services	Provides immediate crisis intervention and emotional support in a safe and confidential setting.	Adults; Youth	Niagara Region	905-378-4647 ext. 45300 (business hours only)	Operates through Niagara Health, St. Catharines site Hospital
Southridge Shelter	Shelter & Housing	Operates emergency shelter, and provides supports and referrals to other community services as needed.	Adults	St. Catharines	905-682-2477	
Start Me Up Niagara	Support for Specific Populations	Provides support and access to their resource center for marginalized with wrap-around services providing food, transportation, clothing, medical and employment supports.	Adults	Niagara Region	Work Action Centre & Offices: 289-438-3939; Resource Centre: 905-984-5310	
Suicide Crisis Helpline	Crisis Response Services (Phone)	Trained response for people dealing with thoughts of suicide, or people worried about someone else's thoughts of suicide. Crisis phone response that co-delivers services within local community of caller.	Adults; Youth	Canada	Phone or text: 988	
Talk4Healing	Crisis Response Services (Phone)	Culturally appropriate counselling services to Indigenous Women for Indigenous Wome	Indigenous Women	Canada	1-855-554-4325	Program offered through Beendigen Women's Crisis Home & Family Healing Agency (Thunder Bay, ON)
The Hope Centre	Community Support & Food Security	Provides a food bank and various support programs for individuals in need.	Adults; Youth; Families	Welland, ON	905-788-0744	
The RAFT	Youth Support Services	Provides housing and support services for at-risk youth, including emergency shelter and educational programs.	Youth (16-24)	Niagara Region	905-984-4365	
TOES Niagara	Community Support & System Navigation	Offers programing for immigrant and racially marginalized women and their families, including culturally responsive educational programs and support services.	Women; Families; Newcomers	Niagara Region	905-714-4326	
Victim Services Niagara	Crisis Response Services	Provides short-term emotional, financial, and practical assistance to victims of crime or tragedy.	Adults; Youth; Families	Niagara Region	905-688-4111 ext. 5084	
Victim/Witness Assistance Program (VWAP)	Legal Support & Advocacy	Assists victims and witnesses through the criminal justice system with emotional support and resources.	Adults; Families; Children; Youth	Niagara Region	905-685-2671	
Welland Heritage Council and Multicultural Centre	Community & System Navigation	Assists with navigation of government and community services for settlement and support.	Newcomers; Adults; Youth; Families	Welland and Niagara Falls	905-732-5337	
West Lincoln Community Care	Community Support & Food Security	Offers food bank services, emergency assistance, and community support.	Adults; Youth; Families	Smithville, ON	905-957-5882	
West Niagara Mental Health Program	Mental Health Services	Offers in-person and virtual evidence-based consultation, assessment, and treatment for individuals experience mental health challenges.	Adults	West Niagara	905-309-3336	Funded by HNHB LHIN and OHIP
Youth Wellness Hub	Youth Mental Health & Addictions	Provides tailored mental health and addiction services for	Youth (12-25)	St. Catharines, ON		

		mental health challenges.				
Youth Wellness Hub	Youth Mental Health & Addictions	Provides tailored mental health and addiction services for youth, including peer support and counseling.	Youth (12-25)	St. Catharines, ON	905-229-9946	
YWCA Niagara Region	Advocacy & Education	Provides education on homelessness and housing instability specifically as it relates to women and women-identifying people as part of raising community awareness.	Women/Women-Identifying Adults; Families	Niagara Region	905-988-3528	
YWCA Niagara Region	Shelter & Housing	Provides emergency shelter and supportive housing for homeless women and their families. Provides housing supports for women exiting human trafficking.	Women/Women-Identifying Adults; Families	Niagara Region	905-988-3528	

Appendix H: CEVAW 3-Year Engagement Strategy

CEVAW Engagement Strategy

Three-Year Engagement Strategy for Establishing a Collective Impact Response to Gender-Based Violence (GBV) with CEVAW as the lead collaborative and Community Potential as Backbone

Vision: To establish a coordinated, sustainable, and impactful response to gender-based violence (GBV) in Niagara through collective impact, with CEVAW serving as the lead coalition to collaborate, and Community Potential as backbone support organization to guide, support, and sustain efforts across interested and affected partners.

The Why: Harnessing Collective Impact and Coordinated Community Responses to Address Gender-Based Violence

Collective impact and coordinated community responses (CCRs) are essential for driving systems change to address gender-based violence (GBV). The collective impact model emphasizes structured collaboration among diverse sectors, fostering shared goals, aligned strategies, and consistent communication (Kania & Kramer, 2011). By engaging stakeholders such as social services, law enforcement, healthcare providers, educators, and survivors themselves, this approach ensures that responses to GBV are comprehensive and tailored to the needs of the community. Collective impact's focus on creating a backbone organization to oversee coordination, measure progress, and build trust is critical for sustaining efforts and achieving meaningful change.

Coordinated community responses further amplify the effectiveness of collective impact by addressing GBV through a holistic lens. CCRs integrate services and policies across sectors to ensure survivors receive seamless support and that systemic barriers are addressed (Shepard & Pence, 1999). For instance, coordinated responses can enhance safety planning, improve access to resources, and hold perpetrators accountable by aligning the efforts of the criminal justice system, advocacy organizations, and public health agencies. Studies show that CCRs reduce victimization rates and improve survivor outcomes by ensuring a cohesive and survivor-centered approach (Cattaneo & Goodman, 2015).

Both collective impact and CCRs recognize that GBV is a deeply entrenched societal issue requiring systemic change. These approaches foster cultural shifts by challenging harmful norms, addressing root causes, and promoting prevention efforts. Additionally, they emphasize the importance of engaging community members and survivors as key partners in creating solutions. By uniting diverse stakeholders under a common agenda and leveraging shared resources, collective impact and CCRs build the foundation for sustainable systems change that addresses GBV's complexities and interconnections. As such, these strategies offer a robust framework for creating safer, more equitable communities.

Year 1: Re-Building the Foundation

1. Strengthen Governance and Structure

- **Action**: Formalize CEVAW's role as key collaborative for collective action on GBV.

  - Re-visit and update governance framework, including leadership roles, decision-making processes, and accountability structures.
  - Recruit a diverse and representative membership comprising key stakeholders, including survivors, service providers, policymakers, and community leaders.

- **Outcome**: A well-defined structure that enables effective decision-making and oversight. Increased membership and active participation from members.

2. Engage Stakeholders

- **Action**: Conduct a comprehensive stakeholder mapping exercise.
  - Identify and engage all relevant stakeholders, including community organizations, law enforcement, healthcare providers, housing services, education systems, and policymakers.
  - Establish subcommittees for key focus areas (e.g., housing, mental health, prevention, legal advocacy).
- **Outcome**: Broad and inclusive stakeholder participation, ensuring diverse perspectives are incorporated.

3. Establish Shared Goals and Metrics

- **Action**: Convene stakeholders to develop a shared vision and establish action items with measurable goals.
  - Define success indicators for collective impact, focusing on prevention, intervention, and long-term support.
- **Outcome**: Clear and agreed-upon goals and metrics to guide the collective effort. Ability of membership to explain purpose and value of CEVAW as collaborative force for collective action.

Year 2: Strengthening Collaboration and Scaling Impact

1. Facilitate Action Items

- **Action**: Begin work on previously identified action items addressing identified gaps and areas for opportunity (e.g., low-barrier shelters, centralized intake systems, prevention education programs).
  - Focus on trauma-informed, culturally competent, and harm-reduction approaches.
  - Ensure ongoing evaluation for action items, consider scalability and effectiveness.
- **Outcome**: Tangible initiatives that address immediate needs while building momentum for long-term solutions.

2. Expand Training and Capacity Building

- **Action**: Continue cross-agency training programs. Access financial resources where necessary to implement training.
    - Focus on GBV awareness, harm reduction, cultural competency, and trauma-informed care. Work in partnership with Anti-Human Trafficking Coalition.
    - Include leadership development for emerging leaders in the sector.
- **Outcome**: A well-trained and knowledgeable workforce equipped to respond effectively to GBV.

3. Strengthen Policy Advocacy

- **Action**: Advocate for systemic changes.
    - Push for policy reforms addressing housing, mental health, and funding inequities.
    - Develop a policy brief with actionable recommendations informed by lived experiences and data.
- **Outcome**: Policies that better align with the needs of survivors and service providers.

Year 3+: Sustaining Impact and Driving Long-Term Change

1. Scale Successful Initiatives

- **Action**: Expand proven action items across the region.
    - Secure sustainable funding to ensure longevity where necessary.
    - Leverage partnerships to extend the reach of services.
- **Outcome**: Broader impact and improved access to services. Improved coordination and resources sharing between services.

2. Foster a Culture of Continuous Improvement

- **Action**: Establish a system for regular feedback and evaluation.
    - Conduct annual reviews of goals, metrics, and initiatives.
    - Use findings to refine strategies and address emerging challenges.
- **Outcome**: An adaptive and resilient response system.

Long-Term Efforts

1. Build Public Awareness and Prevention Efforts

- **Action**: Launch community-wide awareness campaigns.
    - Use storytelling, data, and survivor voices to shift public attitudes regarding GBV.

    - Continue to improve access to prevention training and programming wherever possible
- **Outcome**: Increased public awareness and proactive prevention of GBV.

2. Institutionalize Collective Impact

- **Action**: Formalize CEVAW's role in the region's GBV response.
    - Develop long-term funding and sustainability plans.
    - Embed collective impact principles in local and regional governance structures and at other related collaborative tables that overlap with GBV work.
- **Outcome**: A sustainable, integrated, and impactful response to GBV.

Key Principles Underpinning Strategy:

- **Survivor-Centered Approach**: Ensure all actions prioritize the safety, dignity, and autonomy of survivors.
- **Equity and Inclusion**: Address the unique needs of marginalized communities, including Indigenous, LGBTQ+, newcomer, and racialized groups.
- **Collaboration and Transparency**: Foster trust and accountability through open communication and shared decision-making of membership.
- **Innovation and Adaptability**: Embrace new ideas and technologies to address evolving challenges.

This three-year strategy aims to transform CEVAW into a key actor that demonstrates the principles of effective collaboration and drives a collective impact approach in the fight against GBV. By building strong partnerships, addressing systemic barriers, and championing innovative solutions, CEVAW will play a pivotal role in creating a safer, more equitable community for all.

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