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FINAL REPORT
September 30, 2024

Examining the Black Box: A Formative and Evaluability Assessment of Cross-Sectoral Approaches for Intimate Partner and Sexual Violence

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Acknowledgments

First and foremost, the research team would like to thank the participants in this study, namely client-survivors and organizational partners of the co-located centers. We are grateful for their time and energy in responding to our recruitment emails and sharing their experiences with us. We believe their contributions will enhance services and effectiveness for future client-survivors. Here and throughout, we use the term client-survivors to describe clients at our partner organizations who had experienced intimate partner or sexual violence. In particular, we use the term survivor in line with an empowerment perspective to convey that these clients have started the healing process.

Further, we would like to thank the leadership teams at each of the eight co-located centers. These leaders dedicated resources, helped recruit participants, and provided countless documents for analyses.

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List of Abbreviations

IPV	Intimate Partner Violence
SV	Sexual Violence
CDC	Center for Disease Control and Prevention
CSA	Cross-sectoral Approach
FJC	Family Justice Center
MAMC	Multi-Agency Model Center
EPIS	Exploration, Preparation, Implementation and Sustainment
EAG	Expert Advisory Group
DV	Domestic Violence
SNL	Service Navigation Log
PAT	Partnership Assessment Tool
ROI	Release of Information
DVPO	Domestic Violence Protection Order
MOU	Memoranda of Understanding
SANE	Sexual Assault Nurse Examiner
AOC	Administrative Office of the Courts
MOA	Memoranda of Agreement

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Executive Summary

Background

Intimate partner violence (IPV)—the intentional physical or nonphysical violence between current or former intimate partners—and sexual violence (SV)—non-consensual sexual activities—are pervasive, serious criminal legal system and public health problems in the United States (Centers for Disease Control [CDC], 2017; CDC, 2019; Smith et al., 2018). Survivors of IPV and SV bear the burden of numerous deleterious short- and long-term consequences. To address their myriad service needs, survivors must navigate multiple systems, organizations, and professionals. The complexity of navigating multiple service sectors means IPV/SV survivors often do not receive the help they need at the time when services are most needed. Recognizing this barrier, IPV/SV service providers, including advocates, criminal legal system professionals, and healthcare providers, have been increasingly interested in using cross-sectoral approaches (CSA) to coordinate service delivery to IPV/SV survivors (Gwinn et al., 2007).

Family Justice Centers (FJC) and Multi-Agency Model Centers (MAMC) are two commonly implemented CSA models (Alliance for Hope International, 2024; Rizo et al., 2022; Shorey et al., 2014; Simmons et al., 2016). A key underlying assumption of FJCs and MAMCs is that co-location, collaboration, and coordination of services across multiple providers and disciplines will increase survivors' access to services and ultimately lead to better outcomes. However, limited research exists regarding the implementation and effectiveness of these co-located models. To address these gaps, the research team conducted an evaluability assessment and formative evaluation of IPV/SV CSAs, with a focus on the similarities and differences across co-located models. The project was comprised of two phases:

- Phase 1: Evaluability assessment of IPV/SV co-located CSAs.
- Phase 2: Formative evaluation of IPV/SV co-located CSAs.

The project was conducted in North Carolina, with eight co-located centers participating in the evaluability assessment and six participating in the formative evaluation.

Approach

The **evaluability assessment** was guided by the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework (Aarons et al., 2011) and followed the four steps outlined by Trevisan and Walser's (2014) evaluability assessment model: (1) focus the assessment, (2) develop the program theory and logic, (3) gather feedback, and (4) apply the assessment findings. Prior to developing the proposal and launching the project, our team worked with a group of statewide leaders to determine the focus of the assessment (e.g., goals, objectives, research questions). The research team then engaged in three primary data collection activities—document review, affiliate interviews, and client-survivor interviews—to document the program theory and logic model of co-located service models and to identify promising strategies for evaluating co-located IPV/SV service models. In total, the team reviewed 199 documents and conducted interviews with 58 affiliates and 30 client-survivors. Following these activities, the

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research team sought feedback from our Expert Advisory Group (EAG) and partnering sites and used the evaluability assessment findings to develop practice and research materials.

The **formative evaluation** comprised three components—a process evaluation focused on implementation, a client outcome evaluation, and an assessment of the evaluation's overall feasibility. The implementation evaluation research activities consisted of gathering four different types of data: (1) aggregate annual programmatic data from six partnering sites; (2) client-level service need data (n = 764 completed service navigation logs); (3) staff collaboration survey data (n = 126); and (4) adaptive fidelity self-assessment data (n = 11). The outcome evaluation research activity involved collecting survey data from clients at three timepoints (i.e., intake/baseline: n = 41; 3-month follow-up: n = 28; 6-month follow-up: n = 24). The feasibility assessment was based on focus group data with leaders and key contacts at partnering centers (n = 12) to explore their perspectives on the overall evaluation and specific research activities.

Key Findings

Core and Adaptive Components of Cross-Sectoral Approaches (CSA). The integrated theory of change across centers was: "Multi-disciplinary co-located and survivor-centered services increase survivor safety, wellbeing, and hope through robust collaboration and communication that enhances safety planning, service navigation and coordination, and wraparound care to ensure clients have rapid access to services and feel supported and safe." This theory of change describes the centrality of collaboration, the functions at the core of co-located service models, and how these functions relate to organizational and survivor outcomes (Appendix B1). Although there is consistency in the model's function across centers, the form that these functions take can vary. In other words, centers may adapt or tailor their specific activities to the context and resources of the center (e.g., specific co-located partners, physical space, type of funding, and priorities). This consistency in function and variation in form is depicted in the logic model that contains both core elements of the model as well as its adaptive components (Appendix B2). Notably, outcomes of these co-located models are multi-level, such that inputs or resources paired with the activities result in changes in partner relationships, services delivery, survivors, and communities. Consequently, evaluation methods for programs will necessarily be complex and multilevel.

Best Strategies for Evaluating Cross-Sectoral and Co-Located Centers. Research and evaluation of CSAs and co-located centers require various sources of data, including center data, partner data, and client data. Examples of center and partner data include information on co-location, collaboration, and service delivery; provider satisfaction, perspectives, and experiences; service outputs; and criminal legal system indicators. Client data examples include information on service accessibility and barriers, needs and goals met, client satisfaction, and client outcomes (e.g., violence victimization, sense of safety, mental health, support, empowerment, hope). Notably, engaging in research and evaluation of this complex model can be challenging. Overall challenges for centers and partners to engage in research and provide data include limited capacity, concerns related to confidentiality, variation in partners' data and evaluation practices, data systems and platforms, definitions of success, and a general reluctance to share data. It can also be challenging to engage clients in research and evaluation, as they are generally seeking co-located services in a moment of crisis.

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Despite these challenges, Phase 1 findings identified a number of recommended best practices for conducting research and evaluating CSAs and co-located centers. To address capacity, participants recommended developing center-researcher collaborations, creating a position in the center and each partner organization responsible for data and evaluation, and making engagement and participation in research as easy as possible (e.g., using available data whenever possible). Another recommendation was to create buy-in and synergy around research and evaluation by involving centers and partners early in the planning stage and using this time to make collective decisions around common language and data collection practices. Participants also recommended clarity and transparency about evaluation activities, only gathering data necessary to answer the evaluation questions, and sharing findings with partners. In terms of engaging clients in research and evaluation, participants recommended providing flexibility and control over research participation (e.g., use of multiple recruitment strategies with key information, use of multiple data collection strategies, offering options when possible) while maximizing confidentiality and safety, reducing burden, and offering compensation and research supports (e.g., childcare, transportation).

Dose and Demand. In terms of service demand, most visits were for domestic violence (DV), and of those, most clients sought information about their options and requested safety planning and crisis support. These trends were consistent across centers. In terms of the dose of the services—meaning the degree to which service demands were met by center personnel—nearly all service needs were addressed onsite by a center navigator or an onsite partner. This pattern of addressing needs onsite was largely consistent across centers and is aligned with the core elements of the model.

There was wide variation in the aggregate data collected from partners, including whether or not the data were available, how the indicators were defined, and how the data were aggregated (e.g., combining DV calls with SV calls versus reporting on both call types separately). Consequently, interpreting aggregate data across centers has limited value. However, using this type of data collection longitudinally for one agency may be useful as long as the data collection methods and definitions are held constant over time.

Adaptive Fidelity. Although centers varied in the types and number of partners that were co-located at the center, there was overall consistency in the types and comprehensiveness of services provided. This is true even among centers with fewer partners onsite and suggests that center staff and onsite partners fill a variety of roles. Across co-located partners, co-located services, and infrastructure, there was some conflicting information for various items. For example, one person from a center may report that a forensic exam is not a co-located service, whereas another person from the same center may report that it is. It is unclear why these discrepancies occurred, but the emergence of differences in perspectives is a relevant finding.

There was wide variation in how partners co-located at the centers, including part-time and full-time co-location, whether the partner had designated desk space or a private office, and how much time they spent co-located, with most participants reporting either 75% or more of their time or 25% or less of their time. A majority of the participants saw the value and benefits of collaboration and partnership, and few reported drawbacks. There was wider variation across

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centers in terms of frequency of communication and providing and receiving guidance from partners and some variation in participants' degree of trust that a partner organization would be supportive in response to clients' needs. Although there is significant consistency in services offered, there is wider variation in the co-located partners at the center and the relationships between organizations. Understanding how model effectiveness varies with partner co-location, service adaptations, and collaborative relationships is outside the scope of the study, but it presents an opportunity for future research and evaluation. Collaboration is a critical component of the model and is measurable and modifiable. Consequently, if collaboration is linked to model effectiveness, the quality of collaboration itself can be a target for intervention. Additionally, tools like the collaboration survey used for this study can be used longitudinally, and these results can identify organizational and center-based strategies for enhancing partnerships.

Client Outcomes. Participants had positive perceptions of and experiences receiving services at the various centers participating in this research activity. Overall, participants felt safe at the center and believed the services were helpful and easy to access. Additionally, participants believed that the staff offered choices, were respectful, honored their confidentiality, and believed that decision-making belonged to the client. Participants also reported changes in their needs from intake to follow-up, including an increase in basic needs (e.g., clothing, shoes, personal hygiene items) and health needs (e.g., medical and dental care), and a decrease in law enforcement and legal needs (e.g., help filing criminal charges; help with divorce, custody, or will; court accompaniment), and IPV/SV needs (e.g., advocacy, safety, restraining order). Despite the decrease in IPV/SV needs, about a third of participants reported still having IPV/SV-related needs at their six-month follow-up.

In addition, participants reported improvements in their experiences of violence victimization, sense of safety, and sense of hope. Participants demonstrated decreases in their experiences of physical IPV, psychological IPV, financial IPV, stalking, IPV, and SV. Whereas statistically significant changes in financial abuse were evident between baseline and three-month follow-up, significant decreases in physical IPV were not apparent until the six-month follow-up. These findings suggest that it might take longer to experience changes in experiences of physical IPV victimization. Participants also experienced continuous improvements in their perceptions of overall safety, internal safety tools (i.e., safety-related goals and confidence in one's ability to reach those goals), and expectations of support (i.e., belief one has the support needed to increase safety) from baseline to three-month follow-up and from three-month follow-up to six-month follow-up, as well as an increase in their overall sense of hope from three-month follow-up to six-month follow-up.

Feasibility. Overall, the formative evaluation was feasible as the six partnering centers involved in the formative evaluation were able to participate in all of the implementation activities and the client outcome activity. Key challenges focused on capacity, timing, duration, and the nature of crisis work. Nonetheless, participants recommended several strategies to enhance feasibility, including (1) fostering center, partner, and staff buy-in and support early on; (2) using flexible evaluation designs and data collection methods; (3) engaging in clear and ongoing communication using multiple strategies (e.g., meetings, phone calls, emails); and (4) minimizing data collection burden (e.g., model activities after existing practice and data, reduce the duration of data collection activities). Other recommendations included revising data

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collection tools to enhance clarity, including more comprehensive and open-ended response options (e.g., service navigation log, collaboration survey, adaptive self-assessment tool), and ensuring sampling frames are clear (i.e., participating centers have a clear understanding of who should be participating in each research activity) and include multiple perspectives (e.g., collaboration survey sampling frame, adaptive fidelity self-assessment sampling frame). Participants also recommended that staff involved in recruitment and data collection receive training and technical assistance support. Finally, participants recommended that client data collection include compensation (e.g., gift cards) and the capacity to offer data collection activities in multiple languages.

Key Takeaways

Observations about Model Implementation

It's not just *whether* a partner is co-located but *how*. If co-location (and, by extension, collaboration) is the key function of these centers, the form that this function can take may vary widely. Given the cost of space and the degree to which potential partners would be able to co-locate a portion of their staff's time, understanding how this variation impacts outcomes is a relevant topic to explore. Notably, this flexibility in co-location form may only apply to certain partners and activities.

The number and type of co-located partners vary, but service offerings do not. Although the number of partners per center varied widely, the number and type of services offered were consistent. Additional research needs to be conducted to determine whether there are differences between larger co-location models and smaller co-location models in terms of client outcomes, particularly when these models offer the same types of services.

Knowledge about co-located partners and referral processes should be consistently high. From a theoretical perspective, there was some unexpected variation in self-report regarding knowledge about other co-located partners and understanding of their referral processes. These findings suggest that co-location alone and the proximity to and collaboration with others may not be enough to foster knowledge about center partners, referral protocols, and related processes. Given these findings, additional attention could be paid to managing the co-location partnership.

Observations about Survivor Outcomes

Centers should consider changes in clients' needs at different timepoints. One takeaway from the outcome evaluation findings is that clients' needs vary over time after the initial visit. These findings can provide useful information to centers about service priorities at the time of the first visit and then subsequently at follow-up. This attention to differences in client needs at different timepoints also appears in the data pertaining to client perceptions of the center and staff. Given the small sample size, generalizing this finding to any center or a specific service is not possible; however, it identifies an area for future consideration and examination.

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Experiences of victimization declined significantly. Aggregated across centers, survivors reported a significant decline in physical, psychological, and financial IPV, as well as stalking. Further, any IPV or IPV/SV declined significantly between Timepoint 1 and Timepoint 2 and between Timepoint 1 and Timepoint 3. During these same time periods, survivors' self-reported sense of safety also improved. Given limitations in the design and the data, these findings warrant further examination with larger sample sizes.

Clients may be feeling more hopeful at follow-up. Between Timepoints 1, 2, and 3, survivors' sense of hope increased. Centers that have not already adapted programming on hope and integrated this into foundational program components may consider doing so, given the potential for hope to be a protective factor in a survivor's healing journey.

Observations about Research and Evaluation

Engaging clients in research and evaluation during the intake period is feasible. Overall, the formative evaluation was feasible as the six centers were able to participate in client recruitment at the time of the initial visit, and external data collectors were able to enroll and complete baseline surveys with clients from five of the centers. Additionally, the research team was able to follow up with clients over six months, although there was some expected attrition.

Collecting implementation-related data alongside outcome data is important. It is important to consider any outcome evaluation data alongside service and programmatic data pertaining to implementation. Although understanding whether a client's sense of safety or experiences of victimization improved is crucial, it is also important to collect service data. These service-related outcomes can be linked to outcome data in a larger-scale study that examines the relationship between service dose (i.e., the number and type of services received) and outcomes (e.g., sense of safety, hope, victimization). This type of analysis can provide valuable insights into how co-located service models impact client-level outcomes.

Resource-intensive challenges will hamper widescale rigorous evaluation. The purpose of this project was to determine the evaluability of co-located centers, particularly within the context of larger-scale rigorous evaluations that may aim to either compare across models or examine change in outcomes within a center. There are a number of factors that can inhibit this type of rigorous evaluation that should be considered from the outset (e.g., center partner and staff variation in terms as well as evaluation and data practices, lack of data integration, and center capacity for evaluation and data collection activities). Multi-site evaluations or research studies will require significant resources to engage centers, develop protocols, and use longer-term engagement time for collecting client outcome data.

Approaches, strategies, and conditions that can foster evaluation. Although there are various challenges to conducting a rigorous evaluation of co-located centers, there are a number of factors that can foster an environment for evaluation. First, evaluators should aim to reduce the burden on agency staff, clients, and any other partners who may be contributing to the data collection protocol. Another factor that aids in evaluation is center engagement. Lastly, having the evaluation completed by an external evaluator was helpful for some of the centers, particularly those who did not already have evaluation partners or designated staff to lead

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evaluation activities. In lieu of internal evaluators, it is possible for centers to engage academic partners to assist with program evaluation activities or consider contracting with a consultant.

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Chapter 1: Introduction

1.1 Overview and Significance of Intimate Partner Violence and Sexual Violence

Intimate partner violence (IPV)—the intentional physical or nonphysical violence between current or former intimate partners—and sexual violence (SV)—non-consensual sexual activities—are pervasive, serious criminal legal system and public health problems in the United States (Centers for Disease Control [CDC], 2017; CDC, 2019; Smith et al., 2018). IPV/SV affects millions of people in the United States each year, with data from the National Intimate Partner and Sexual Violence Survey indicating more than 1 in 3 women (43.6%) and nearly 1 in 4 men (24.8%) have experienced lifetime contact SV; and more than 1 in 3 women (36.4%) and men (33.6%) have experienced lifetime contact SV, physical violence, and/or stalking by an intimate partner (Smith et al., 2018)

Survivors of IPV and SV bear the burden of numerous deleterious short- and long-term consequences, including physical, sexual, and reproductive health problems; mental health concerns; risky health behaviors such as substance abuse; financial and housing instability; and protracted legal and criminal legal system involvement (Black, 2011; Breiding et al., 2008; Campbell et al., 2007; Coker et al., 2002; Dillon et al., 2013; Dichter et al., 2017; Fanslow et al., 2019; Peled & Krigel, 2016; World Health Organization, 2013).To address their myriad service needs, survivors must navigate multiple systems, organizations, and professionals. For example, a survivor might need to seek crisis services from an IPV/SV service provider, medical attention from a healthcare provider, criminal and civil legal services from an attorney, a protection order from the courts, and trauma-informed counseling from a mental health professional.

1.2 Cross-Sectoral and Co-Located Approaches to Address Clients' Safety and Needs

1.2.1 Growth of IPV/SV Cross-Sectoral Approaches. Even when IPV/SV services are available, the complexity of navigating multiple service sectors, particularly in the midst of a crisis, means IPV/SV survivors often do not receive the help they need at the time when services are most needed. Recognizing this barrier, IPV/SV service providers, including advocates, criminal legal system professionals, and healthcare providers, have been increasingly interested in using cross-sectoral approaches (CSA) to coordinate service delivery to IPV/SV survivors (Gwinn et al., 2007). Since the 1990s, state and federal policymakers have shown a growing interest in funding CSA models to address the needs of IPV/SV survivors (Post et al., 2010; Shorey et al., 2014). From 1996 to 2000, the Centers for Disease Control and Prevention funded 10 Coordinated Community Response projects aimed at preventing and addressing IPV (Post et al., 2010). In 2004, the President's Family Justice Center Initiative provided $20 million in funding for 15 Family Justice Centers across the country (USDOJ, 2007), and in 2018, California's governor allocated $10 million to fund FJCs (California Governor's Office of Emergency Services, 2018).

Family Justice Centers (FJC) and Multi-Agency Model Centers (MAMC) are two commonly implemented CSA models (Alliance for Hope International, 2024; Rizo et al., 2022 Shorey et al., 2014; Simmons et al., 2016). FJCs and MAMCs provide co-located IPV/SV services spanning multiple agencies and disciplines (Alliance for Hope International, 2024). The MAMC model allows for considerable variation in the program's makeup, but MAMCs typically include a minimum of three providers from different disciplines working together to provide services in

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one location. Providers might work at the MAMC full- or part-time, with or without a centralized intake and data sharing across providers. In contrast, FJCs must include full-time providers from the following disciplines: IPV/SV, law enforcement (investigators, detectives), and legal (specialized prosecutor or unit, civil services). FJCs are also required to have a centralized intake and formal protocol for information sharing (Alliance for Hope International, 2024).

A key underlying assumption of FJCs and MAMCs is that co-location, collaboration, and the coordination of services across multiple providers and disciplines will increase survivors' access to services by reducing barriers (e.g., travel issues, the trauma of recounting the IPV/SV incident multiple times; Shorey et al., 2014; Murray et al., 2014). In turn, it is assumed this increased access to services will lead to greater service uptake among agencies (i.e., more referrals) and survivors (i.e*.,* more survivors engaging in services post-referral), streamlined case management, and enhanced interagency communication (Shorey et al., 2014; Murray et al., 2014; Townsend et al., 2005). Moreover, because of survivors' increased service use, communities will also increase perpetrator accountability. Conversely, it is assumed if services and systems remain siloed and fragmented, survivors are less likely and less able to navigate multiple services and agencies (Shorey et al., 2014).

Overall, these co-located models are presumed to create better outcomes for communities, partnering agencies, and survivors by leveraging the strengths and capabilities of each co-located partner through coordination and collaboration (Andres & Entwistle, 2010; Provan & Milward, 2001; Provan et al., 2007; Provan & Kenis, 2008). Coordination refers to a "formalized system of ongoing collaboration between professional service agencies within a community" (Pennington-Zoellner, 2009; p539), while collaboration is "a process in which organizations exchange information, alter activities, share resources, and enhance each other's capacity for mutual benefit and a common purpose by sharing risks, responsibilities, and rewards" (Himmelman, 2004; p3). Co-located models emerged as a promising practice (Andrews & Entwistle, 2010; Craig et al., 2008; USDOJ, 2007); however, only limited research exists regarding best practices in implementing these co-located models or their effectiveness in addressing survivor well-being and perpetrator accountability.

1.2.2 Research on IPV/SV Co-Located Service Models. Funding for and dissemination of co-located service models for IPV/SV have clearly outpaced their evidence (Alliance for Hope, 2024; Shorey et al., 2014). Our team conducted a systematic review of evaluation and intervention research on Family Justice Centers that summarized the existing research and identified the gaps in the evidence base (Rizo et al., 2022). Our review found: (1) the vast majority of studies were process evaluations or needs assessments focused on organizational or implementation factors (e.g., staffing patterns, service utilization, inter-agency collaboration); (2) few studies were outcome evaluations; (3) there was a lack of survivor perspective across studies; and (4) studies including multiple co-located sites provided a cursory understanding of the evaluability of this service approach. In addition, research examining the implementation of these models has generally focused on descriptive characteristics (e.g., number of partner agencies/sectors) as opposed to examining components that are essential to the model, components that may vary to address contextual factors, and related intervention activities. In particular, a near-vacuum of research exists around the black box of coordination and collaboration within and across models. To address this gap, this report shares findings from an

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evaluability assessment and formative evaluation examining service and survivor outcomes.

1.3 Research Phases, Goals, Objectives, Research Questions, and Study Sites

The overall project is guided by two broad goals (each corresponding to a separate phase of the project)—to conduct an evaluability assessment of co-located services models for IPV/SV followed by a formative evaluation testing the feasibility of the developed practice and research materials.

1.3.1 Phase 1: An Evaluability Assessment of IPV/SV Co-located CSAs. Phase 1 involved an evaluability assessment of co-located service models (Trevisan & Walser, 2014; Davies & Payne, 2015; Leviton et al., 2010; Trevisan, 2007) to inform the development of practice and research materials. Phase 1 was guided by the following questions: (1) What are the core components of co-located service models? (2) What are the adaptive components of co-located service models, and how do they vary? (3) What are the best methods for conducting rigorous evaluations of co-located service models? To answer these questions, the research team documented service delivery (Objective 1) and service variation (Objective 2) and then assessed the evaluability of co-located service models by examining research capacity (Objective 3).

With the information gathered from the evaluability assessment activities, the research team then developed practice materials (e.g., theory of change, logic model, and adaptive fidelity instruments) and research materials (e.g., recruitment strategies, measures, and data collection procedures). Study methods were developed with feedback from our partnering agencies and Expert Advisory Group, or EAG (Trevisan & Walser, 2014). The evaluability assessment products were then used to conduct the formative evaluation of the participating centers (i.e., Phase 2).

1.3.2 Phase 2: A Formative Evaluation of IPV/SV Co-located CSAs. Building off the evaluability assessment, Phase 2 consisted of a formative evaluation of co-located service models (Campbell et al., 2007; Bowen et al., 2009; O'Cathain et al., 2019; Orsmond & Cohn, 2015) to inform future evaluation and research efforts. The formative evaluation consisted of three components: (1) a process evaluation focused on program implementation (Objective 1), (2) a client outcome evaluation (Objective 2), and (3) an assessment of the evaluation's overall feasibility. The research questions guiding Phase 2 of this project were: (1) Are the practice and research materials feasible and meaningful? and (2) How can these materials be enhanced? To answer these questions, the research team defined and measured (1) demand, (2) dose, and (3) adaptive fidelity.

1.3.3 Study Setting and Context: IPV/SV Services in North Carolina. The research was conducted in North Carolina. Of North Carolina's 100 counties, most have their own IPV/SV agency, and several larger counties have multiple IPV/SV organizations. Since 2010, North Carolina has implemented several IPV/SV co-located service models (i.e., FJCs and MAMCs). For this study, we invited eight to serve as project sites for data collection, five of which were FJCs and three were MAMCs. All eight centers agreed to be project sites for the evaluability assessment component of the project, of which six agreed to be project sites for the formative evaluation component of the study. The research sites were representative of the geographic,

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racial, and economic diversity across the state and southeast. These sites were located in counties that ranged from large metropolitan areas to smaller rural counties.

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Chapter 2: Methods

2. 1 Evaluability Assessment Methods

2.1.1 Overview. The purpose of the evaluability assessment was to explore the participating centers' core components, adaptive components, intervention activities, and intended outcomes, as well as determine promising strategies for evaluating implementation and client outcomes. Thus, the evaluability assessment was guided by the following research questions: (1) What are the core components of co-located service models? (2) What are the adaptive components of co-located service models, and how do they vary? (3) What are the best methods for conducting rigorous evaluations of co-located service models?

The evaluability assessment followed the four steps outlined by Trevisan and Walser's (2014) evaluability assessment model: (1) focus the assessment, (2) develop the program theory and logic, (3) gather feedback, and (4) apply the assessment findings. Prior to developing the proposal and launching the project, the team worked with a group of statewide leaders to determine the focus of the assessment (e.g., goals, objectives, research questions). The research team then used three primary data collection activities—document review, affiliate interviews, and client-survivor interviews—to document the program theory and logic model. Following these activities, the research team sought feedback from the project's Expert Advisory Group (EAG) and partnering sites. Evaluability assessment findings were used to develop practice and research materials.

Another framework that guided the evaluability assessment was the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework (Aarons et al., 2011). The research team collapsed the four phases of this framework (i.e., exploration, preparation, implementation, and sustainment) into two phases: pre-implementation (exploration and preparation) and implementation (implementation and sustainment). The team then categorized the participating centers based on their phase of implementation. Further, the framework delineates important contexts (i.e., inner and outer context) and factors (i.e., bridging and innovation factors) that can enhance or impede implementation. The evaluability assessment activities sought to better understand important inner context, outer context, bridging factors, and innovation factors specific to co-located service models.

2.1.2 Data Collection and Analysis.

Document Review. The research team conducted a document review to develop an initial program theory (Trevisan & Walser, 2014) across participating centers. The goal of developing an initial program theory was to identify core components and to understand how the components are intended to be implemented. The document review obtained information related to factors impacting the adoption (i.e., the decision to implement) and adaptation (i.e., adjustments to the model at the implementation phase) of the participating co-located centers (Aarons et al., 2011; Proctor et al., 2011) to better understand how and why model implementation varies across centers (i.e., adaptation) and to identify ways to measure implementation indicators for model fidelity and variation.

In Spring 2021, the research team hosted a project initiation meeting with leaders of partnering centers and their designees. In addition to orienting partners to the overall project, the research

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team described the document review activity and process, reviewed the web-based document collection instrument (i.e., Qualtrics survey), and answered any questions about the document collection procedures. The research team then sent the document collection link to the partner representatives and requested that the form be completed within four weeks. Several reminder emails were sent during this period.

A total of 199 documents were collected, ranging from 5 to 73 documents per partnering center. In terms of analysis, the research team uploaded all 199 documents into Dedoose and iteratively developed a codebook. This codebook included six major themes, each of which contained two or more codes describing the content of those themes. The first theme used the constructs associated with the EPIS framework—inner context, outer context, bridging factors, and innovation factors—to characterize document content that pertained to factors impacting planning and implementation. The second theme captured content that could be used to develop a logic model across centers, including center aims, inputs, activities, outputs, and outcomes. The third theme captured document content that could be used to develop a program theory (or theory of change), meaning a description of how the program achieves the intended outcomes. The fourth theme pertained to the application of the EPIS framework's four phases—exploration, preparation, implementation, and sustainment. The research team collapsed these into two phases: pre-implementation (exploration and preparation) and implementation (implementation and sustainment, including early implementation and full implementation). The fifth theme is evaluation, documented data analysis procedures, data collection, data sources, evaluation design, and key outcomes. The sixth theme focused on perceptions of co-location and collaboration, including benefits, challenges, and perceptions of law enforcement staff.

Interviews with Center Affiliates. Purposive, expert sampling was used to identify potential participants from across the eight participating centers. The research team asked center leaders to identify center staff, staff from partner organizations, and other key affiliates to participate in an interview. The research team then emailed potential participants to provide study information and invited them to sign up for an individual interview with a member of the research team.

At the start of each interview, the research team member reviewed the consent form, answered any questions, and sought verbal consent. The interviews were facilitated using a semi-structured, standardized guide and note-taking form comprised of open-ended questions and prompts. The interview guide varied slightly based on the implementation phase of the participant's affiliated center and was informed by the research team's literature review and EAG feedback. The interview guide was divided into three sections: (1) factors that influence implementation and adaptation, (2) center outcomes, activities, and collaboration, and (3) evaluation of co-located centers. Overall, the interview questions focused on center development, core and adaptive components, intervention activities, and evaluation recommendations. To the degree possible, a research team member digitally audio-recorded the interviews and took verbatim notes. At the end of the interview, participants were invited to complete a brief online demographic and work history survey.

A total of 58 affiliates participated in an interview. The interviews took place between May 2021 and November 2021. On average, interviews lasted approximately 86.49 minutes (SD = 18.24). Most of the interviews were conducted via Zoom with video (94.8%, n = 55), the remainder were

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conducted via Zoom without video (1.7%, *n* = 1), via telephone (1.7%, *n* = 1), or in-person (1.7%, *n* = 1).

On average, participants were 45.62 years of age (*SD* = 10.73). The majority of participants identified as female (79.3%, *n* = 46); 12 identified as male (20.7%). Participants reported their race/ethnicity as White (74.1%, *n* = 43), African American/Black (13.8%, *n* = 8), Native American/Alaska Native (1.7%, *n* = 1), Latina/o/x (5.2%, *n* = 3), and Multiracial (3.5%, *n* = 2); one person preferred not to answer (1.7%, *n* = 1). The participants' highest level of education included high school (1.7%, *n* = 1), some college (5.2%, *n* = 3), college (19.0%, *n* = 11), some college (8.6%, *n* = 5), and graduate (65.5%, *n* = 38). Participants reported working in the area of IPV/SV for an average of 13.66 years (*SD* = 8.99) and at their particular center for an average of 4.71 years (*SD* = 3.37). The types of agencies represented by participants included anti-trafficking (5.2%, *n* = 3), child advocacy (5.2%, *n* = 3), county government (20.7%, *n* = 12), court/legal (20.7%, *n* = 12), social services (5.2%, *n* = 3), healthcare (3.5%, *n* = 2), IPV/SV (27.6%, *n* = 16), law enforcement (10.3%, *n* = 6), mental health (3.5%, *n* = 2), and other (17.2%, *n* = 10).

Data analysis occurred in two steps. The first step consisted of analyzing notes in Dedoose to inform Phase 2 of the overall project in a timely manner, whereas the second step consisted of analyzing the full transcripts in Dedoose once Phase 2 was underway. Each step applied content analysis and followed a similar approach. An initial codebook was developed by deductively identifying codes from the research questions, interview guides, and existing literature review. Two members of the team independently coded a sample of interviews and then met to discuss their codes for each interview and identify and confirm any inductively identified codes. During step one, the remaining notes were divided among two members of the research team. For step two, each interview transcript was double-coded with disagreements adjudicated by one of the co-PIs.

Client-Survivor Interviews. Convenience sampling was used to identify and recruit former clients to participate in an in-depth, qualitative interview using Zoom video conferencing. To maintain survivors' confidentiality, center staff recruited potential participants using recruitment materials (e.g., emails, flyers, telephone scripts, social media posts) developed by the research team. Interested potential participants contacted a research team member to (a) learn more about the study, (b) determine study eligibility, and (c) schedule their interview.

At the beginning of each interview, a member of the research team reviewed the consent form, answered any questions, and sought verbal consent. Interviews were facilitated using a semi-structured, standardized guide and note-taking form comprised of open-ended questions and prompts. The standardized guide included questions regarding (a) experiences receiving co-located services and related perceptions (e.g., What types of services did you receive from the center? What do you think about this approach where multiple types of services are offered in one place?), (b) preferences for engaging in research and evaluation (e.g., How would you like to be asked to participate in a research study about co-located centers? Which of these are the best ways to collect data from survivors?), and (c) general questions (e.g., As we close, is there anything else you would like our team to know?). All interview discussions were digitally audio-

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recorded, supplemented by verbatim notes. At the end of the interview, participants were invited to complete a brief demographic survey with the research team member facilitating the interview.

A total of 30 survivors participated in an interview. The interviews took place between December 2021 and April 2022. On average, interviews lasted approximately 61.20 minutes (*SD* = 19.81). Nearly half of the interviews were conducted via Zoom with video (46.7%, *n* = 14), and the remainder were conducted either via Zoom without video (13.3%, *n* = 4) or via telephone (36.7%, *n* = 11).

Participants ranged in age from 20 to 83 years old (*M* = 40.27, *SD* = 14.05). Most participants (86.7%, *n* = 26) identified as female, and four participants identified as male (13.3%). The majority of participants (83.3%, *n* = 25) identified as heterosexual, and the remainder (16.7%, *n* = 5) identified as asexual, bisexual, gay, lesbian, or pansexual. Participants described their race/ethnicity in the following ways: Asian (6.7%, *n* = 2), Black (26.7%, *n* = 8), Latina/o/x (13.3%, *n* = 4), White (43.3%, *n* = 13), and multiracial (6.7%, *n* = 2); one person did not answer this question (3.3%). Although most participants (73.3%, *n* = 22) were born in the United States, slightly over one-fifth (23.3%, *n* = 7) were born outside of the United States (i.e., Costa Rica, Honduras, Korea, Mexico, Nigeria, Philippines, Zimbabwe; one person did not answer this question, 3.3%). On average, foreign-born participants came to the United States in 2006 (*SD* = 9.99, range = 1996–2020). The majority of participants (83.3%, *n* = 25) identified English as their primary language; others included Spanish (10.0%, *n* = 3), Tagalog (3.3%, *n* = 1), and multiple languages (3.3%, *n* = 1). Participants described varying levels of education, including less than a high school degree (6.7%, *n* = 2), high school degree (10.0%, *n* = 3), some college coursework (30.0%, *n* = 9), college degree (20.0%, *n* = 6), some graduate coursework (10.0%, *n* = 3), and graduate degree (23.3%, *n* = 7). Approximately 73.3% (*n* = 22) of participants were parents. Participants had an average of 1.90 children (*SD* = 1.56, range = 0–5). Moreover, about 36.7% of participants had children ≤ 5 years old (*M* = 0.68, *SD* = 0.84, range = 0–3). On average, participants (a) started receiving services in 2018 (*SD* = 2.70), (b) ended services in 2020 (*SD* = 2.12), and (c) received services for a total of 21.50 months (*SD* = 15.02). Notably, 10 participants (33.3%) were still receiving services at the time of their interview.

In terms of analysis, the interview notes were checked for accuracy and to remove any information that could result in deductive disclosures. The cleaned notes were uploaded into Dedoose for analysis using a content analysis approach. Two team members developed the coding scheme based on the research questions, interview guides, extant literature, and double coding of 20.0% (*n* = 6) of the interview notes to reach a consensus. The coders then independently coded the remaining notes using the coding scheme. The coders identified codes, categories, and subcategories. Throughout the process, the coders engaged in negative case analysis to seek divergent perspectives and disconfirming opinions. The coders also created an audit trail to document coding decisions and to summarize the various codes.

2.2 Formative Evaluation Methods

2.2.1 Overview. The purpose of the formative evaluation was to test the practice and research materials developed based on the evaluability assessment and to preliminarily examine demand, dose, adaptive fidelity, and client outcomes. The research questions guiding the formative evaluation included the following: (1) Are the practice and research materials feasible and

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meaningful? and (2) How can these materials be enhanced? The formative evaluation was comprised of three components—a process evaluation focused on implementation, a client outcome evaluation, and an assessment of the evaluation's overall feasibility. The implementation evaluation research activities consisted of gathering four different types of data: (1) aggregate annual programmatic data, (2) client-level service needs data, (3) partner collaboration data, and (4) adaptive fidelity self-assessment data. The outcome evaluation research activity involved collecting survey data from clients at three timepoints (i.e., intake/baseline, 3-month follow-up, 6-month follow-up). The feasibility assessment collected feedback from leaders and key contacts at partnering centers to explore their perspectives on the overall evaluation and specific research activities and methods. The following sections provide detailed information regarding each of the formative evaluation research activities.

2.2.2 Data Collection and Analysis.

Annual Programmatic Data. This research activity aimed to collect aggregate annual programmatic data on key service indicators and was guided by methods described in the Family Justice Center Evaluation Toolkit (Murray et al., 2018), specifically the Partners' Annual Organizational Data protocol. The data collection methods were slightly adapted based on Phase 1 findings and feedback from leadership at the six partnering centers. To introduce the aggregate annual programmatic data collection process, the research team held separate informational and feedback meetings with leadership at the six partnering sites in September 2023. Following each meeting, the research team emailed a list of service indicators to the partnering centers' leaders and requested that they either provide the calendar year 2022 aggregate data for each indicator or name the agency partner with access to the data (see Appendix A1 for the full list of service indicators examined). Centers were also invited to share year-end reports that summarized the requested service indicators. The research team sent up to six email reminders. All data provided by centers were entered into Excel by a member of the research team. A second research team member double-checked all data entries, and a third member then used the spreadsheet to develop data summary tables.

Client-Level Service Need. This research activity collected anonymous client-level service data and was informed by a routine data collection process at one of the partnering centers, Phase 1 findings, and feedback from leadership at the six partnering centers. The resulting Service Navigation Log (SNL, see Appendix A2) consisted of a checklist to document information about the visit (e.g., center name, point of entry, date, check-in time, check-out time, type of visit), service type (e.g., domestic violence, sexual assault/abuse, child abuse/neglect, elder abuse/neglect, stalking/harassment, other) and information about service needs and referrals. For each service category (i.e., intake and needs assessment, advocacy services, court-based services, civil/legal services, health and emotional/wellness services, law enforcement, social services, specialized services for vulnerable populations, other services) there was a list of related services with space to document if the service was requested by a client, as well as whether it was provided by the navigator/intake specialist, or whether it was provided by, scheduled with, or referred to an onsite or offsite partner. In August 2023, the research team held separate informational meetings with leadership at the six partnering sites to introduce this research activity. Leaders were invited to (1) select a 3- to 6-week period to pilot the SNL, (2) identify staff at their center to complete the SNL, and (3) determine whether to complete the SNL for all client visits or only new client visits. Although most centers choose to complete the SNL for each

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client visit during that period, one chose to only complete the SNL for new client visits. Following the meetings with center leadership, a member of the research team delivered hard copies of the SNL and a lock box to each partnering site and, as needed, facilitated virtual meetings between September 2023 and October 2023 to train staff on the SNL and process for gathering these data. SNL data collection occurred between September 2023 and October 2023. At the close of the pilot period, a team member collected the lockboxes with the completed anonymous SNLs from each partnering site. The SNL data were then entered by one of two research team members into a Qualtrics survey, resulting in an Excel spreadsheet with all the data from this research activity. A data entry quality check was performed on 10% of the SNLs randomly selected from each partnering site. Basic descriptive statistics (e.g., mean, frequency, percentage) were calculated using Stata 18 to summarize service demand (i.e., number of visits for which a particular service was requested) and dose (i.e., the number of visits for which the service was provided and by whom). Total scores were summarized across centers.

***Partner Collaboration*.** Phase 1 findings highlighted collaboration as a core component of the co-located center model. These findings were used to develop a roster-based survey in which respondents were asked to answer questions about their collaborative relationships with each of the center's partnering organizations (Appendix A3). The collaboration survey consisted of four sections: (1) respondent information, (2) knowledge of partners, (3) relationship information, and (4) partnership assessment. Items in the *respondent information* section included the respondent's center name, organization name, primary role at the center, area of practice, length of time worked at the center, percentage of time spent onsite at the center, and whether they have designated office or desk space at the center. The *knowledge of partners* and *relationship information* sections used a roster-based method in which respondents were asked to answer questions about their knowledge of and collaborative relationships with each of the center's partnering organizations. The knowledge of partners section asked the respondents to indicate how knowledgeable they are about the services the partner organization provides to clients at the center using a 5-point Likert type scale from *not at all* (1) to *extremely* (5). Respondents were then asked to indicate how confident they are in their ability to make appropriate referrals to the partner organization using the same 5-point Likert-type scale ranging from *not at all* (1) to *extremely* (5).

The *relationship information* section asked respondents to indicate whether they have communicated with each of the center's partnering organizations within the last three months. The respondent was then asked follow-up questions about communication and collaboration with the partners they had contact with during the last three months. First, the respondents were asked to indicate how frequently they communicated with the partner using a Likert-type scale ranging from *almost daily* (1) to *monthly or less* (4). The same Likert-type scale was used to assess how frequently the respondents both received and provided guidance, relevant information, or consultation with a partner regarding a case. The last question in this section asked respondents how true the following statement was about each partner at the center: "I trust this organization to respond to survivors in ways that make them feel supported." A 6-point Likert-type scale was used for this question, ranging from *totally true* (1) to *completely untrue* (6).

The *partnership assessment* section used a modified version of the Partnership Assessment Tool, also known as PAT (Schubert, 2018), to examine perceptions of partnership in the co-located

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center, as well as perceived benefits and drawbacks of being part of the center. The first item in the PAT asks respondents to indicate their level of agreement with a series of statements describing activities that center staff and partners may do to foster partnership. Agreement was measured using a 5-point Likert scale that ranged from *strongly disagree* (1) to s*trongly agree* (6). The next two items asked respondents to choose from a list of potential benefits and drawbacks of being a part of the center partnership.

The survey was developed iteratively based on leadership feedback, and the final version was uploaded into Qualtrics—an online survey platform. The online survey was piloted by members of the research team to confirm the survey logic and roster accuracy. The sampling frame for this activity was developed by asking leadership at the six partnering sites to provide the names, organizational affiliations, and contact information for all core partners as well as center staff. Center leadership exercised their discretion on who to include (e.g., roles that require interaction with center partners). Collaboration survey recruitment and data collection occurred during an 11-week period between July 2023 and October 2023. Each center's director or designee sent an introductory email to the partner list they provided to explain that members of the research team would be contacting them to participate in a collaboration survey. The research team then sent out an initial recruitment email and up to four reminder emails with a personalized link to the collaboration survey. Staff who worked at multiple centers or center locations were invited to complete one survey for each center.

Of the 330 partner members invited to participate, 126 completed the survey (38% response rate), and participation rates ranged from 34% to 70% across centers. Approximately one-third of respondents (n = 40) indicated that they provided direct care to clients, another third (n = 37) reported being in a supervisor or administrator capacity of a co-located partner, 13% (n = 15) described themselves as being a supervisor or administrator of the co-located center, and just under a quarter (n = 27) indicated being in another type of position. Respondents were from a wide range of positions, including administrators (25%, n = 30), domestic violence and sexual assault advocates (13%, n = 16), and law enforcement (11%, n = 13). On average, respondents had worked an average of 3.78 years (SD = 2.95) at their center.

Prior to data analysis, scores for frequency of communication, receiving guidance, providing guidance, and perceptions of trust were reversed scored, such that higher scores indicated greater frequency or trust. Data were analyzed both at the respondent level and at the organizational level. For the respondent-level analysis, frequencies were used to describe co-location characteristics and benefits and drawbacks of partnership. Mean scores were calculated to assess relationship characteristics and perspectives on activities that promote partnership. For the organizational-level data, a mean score was calculated for instances in which multiple respondents were from the same organization and within the same center. For example, if three respondents were from the same organization, the average of their scores was calculated for each response about a partner in the roster. These scores were then averaged across the center, and an additional mean was calculated across all centers and partners.

Adaptive Fidelity Self-Assessment. The goal of this implementation evaluation research activity was to examine adaptive fidelity—including core functions and specific forms or activities—within and across the different co-located centers. Informed by Perez Jolles and colleagues'

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(2019) function and form matrix, Phase 1 findings, and feedback from leadership at the partnering sites, the research team developed an adaptive fidelity self-assessment survey. The survey included four sections: (1) respondent information, (2) center partners, (3) center services, and (4) center infrastructure and operations (see Appendix A4). The *respondent information* section asked respondents to indicate the center where they provide services. The *center partners* section included a list of co-located partners that, according to the Alliance for Hope International, comprise typical partners at FJCs and MACs. For each partner listed, respondents were asked to indicate if the partner was co-located at their center, how essential the partner's co-location is to ensure the effectiveness of their center, and whether the way the agency partners with a co-located center could look differently in other communities and still be effective. The *center services* section included a list of services and supports that some communities offer in their co-located center serving IPV/SV survivors. Respondents were asked to indicate whether the service or support is co-located at their center, how essential the service or support's co-location is to ensure the effectiveness of their center, and whether the way the service or support is implemented could look different in other communities and still be effective. The *center infrastructure and operations* section included a list of infrastructure and process components that some communities include in their co-located center. Respondents were asked to indicate if their center implements each infrastructure or process, if the infrastructure or process is essential, and whether it could look differently in other communities and still be effective. The survey also included open-ended questions to assess what makes some partners, services and supports, and infrastructure or processes essential, as well as how these elements could look differently across centers. An initial draft of the adaptive fidelity self-assessment was revised based on leadership feedback and uploaded into Qualtrics. The online version of the survey was piloted by various members of the research team and refined accordingly. Center directors and key formative evaluation contacts at each partnering site were invited to participate in this activity. The research team sent out an initial recruitment email and up to three reminder emails with a personalized link to the survey. Recruitment and data collection took place between December 2023 and January 2024. A total of 11 participants completed the adaptive fidelity self-assessment survey. All six Phase 2 partnering sites were represented in the completed surveys, with one to two respondents per center.

Client Outcomes. This research activity examined clients' needs, service experiences, and outcomes across three timepoints (i.e., intake/baseline, 3-month follow-up, and 6-month follow-up). The recruitment materials, data collection approach, and client outcome survey were developed based on Phase 1 findings and revised based on leadership feedback. The client outcome survey (Appendix A5) was comprised of study-developed questions and standardized measures focused on clients' service needs, opinions about the co-located center, and well-being, and included the following six sections: (1) service needs and center experiences (2) victimization, (3) severity, (4) sense of safety, (5) well-being, and (6) demographic information. The section on *service needs and center experiences* provided a list of needs and asked participants to indicate whether each was a current need (*yes* = 1, *no* = 0), whether the center was helping them address the need (*yes* = 1, *no* = 0), and their level of satisfaction with the support being provided by the center using a 5-point Likert scale ranging from *completely dissatisfied* (1) to *completely satisfied* (5). Participants were also asked to indicate barriers experienced in having their needs met by the center. A modified version of the Survivor Defined Practice Scale (Goodman et al., 2014) was used to examine participants' perceptions and experiences receiving

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services at the center using a 4-point Likert scale ranging from *strongly disagree* (1) to *strongly agree* (4). The *victimization* section asked participants to indicate the frequency in which they experienced different forms of IPV (i.e., physical violence, psychological abuse, sexual abuse, financial abuse, legal abuse, and stalking) and SV over the past 3 months, whereas the *severity* section included questions about the frequency in which they experienced various IPV/SV-related injuries and impacts (*never* = 0, *once* = 1, *twice* = 2, *3-5 times* = 3, *6-10 times* = 4, *11-20 times* = 5, *more than 20 times* = 6, and *this happened but not in the past 3 months* = 7; recoded to mid-point for analysis). As part of the *severity* section, participants were also asked whether they had experienced loss of hearing, loss of vision, or a brain injury because of IPV/SV victimization (*yes* = 1, *no* = 0). The *sense of safety* section used the Measure of Victim Empowerment Related to Safety (Goodman et al., 2015) to examine participants' sense of safety using a 5-point Likert scale ranging from *always true* (1) to *never true* (5). The *well-being* section used the Hope Scale (Snyder et al., 1991) to assess participants' sense of hope using an 8-point Likert scale ranging from *definitely false* (1) to *definitely true* (8). *Demographic information* section questions focused on age, gender identity, sexual orientation, race/ethnicity, primary language(s), country of origin, children, relationship status, education, employment, and health insurance. The two follow-up surveys also included an *overall perceptions* section with three open-ended questions asking about the ways in which the center supported the participant over the past 3 months, any life changes over the past 3 months attributed to the center and help provided, and anything else the participant would like to share about their experiences with the center. The survey was translated into Spanish. Both the English and Spanish versions of the survey were uploaded into Qualtrics, piloted internally by members of the research team, and refined accordingly.

Prior to launching this research activity, the research team held meetings with each partnering site and their staff between April 2023 and June 2023 to introduce the activity, review the recruitment flyer, and train staff on recruiting and connecting interested clients with onsite team data collectors. The research team then worked with contact(s) at each partnering site to schedule days for onsite recruitment and data collection. On those days, partnering site staff shared the recruitment flyer with eligible participants (i.e., 18 years of age or older, seeking IPV/SV services from the partnering center, completed an intake form at the center that day, comfortable reading and speaking in English or Spanish) and then connected interested clients with an onsite trained data collector. The research team data collector shared study information, answered any questions, assessed for eligibility, inquired about participation interest, reviewed the consent form, and obtained written consent. The data collector then collected preferred contact information and invited the participant to complete the initial survey either on their own or with the data collector's assistance using one of the following formats: (1) paper-pencil or (2) electronic using a secure study laptop. Participants received study "check-ins" at designated time points prior to the two follow-up surveys, and at each follow-up time point, they received a brief prompt and up to three reminders using their preferred contact method (e.g., email, text, phone call). For each follow-up survey, participants could complete the survey on their own using a link to the electronic survey or could schedule a time to complete the survey together with a data collector either by phone or video conferencing. At each timepoint, participants received a $50 e-gift card to Target, Walmart, or Amazon in appreciation of their time. Recruitment and data collection for this research activity occurred between May 2023 and February 2024.

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All demographic information was collected at intake/baseline ($N = 41$). At the time of study enrollment, participants ranged in age from 19 to 69 years of age ($M = 35.83$, $SD = 11.51$). Of the 39 participants who responded to questions about gender and sexual orientation, the majority of participants identified as female (94.9%, $n = 37$) and heterosexual (94.9%, $n = 37$); 2 participants identified as male (5.1%) and 2 identified as bisexual (5.1%). Participants reported varying racial and ethnic identities, including Black or African American (53.7%, $n = 22$), White (39.0%, $n = 16$), Hispanic or Latino/a/x/e (12.2%, $n = 5$), American Indian or Alaska Native (2.4%, $n = 1$), Asian (2.4%, $n = 1$), and Middle Eastern or Northern African (2.4%, $n = 1$). Approximately 95% of participants ($n = 39$) indicated that English was their preferred or primary language, whereas about 5% ($n = 2$) indicated it was Spanish. Of the 39 participants who reported where they were born, the majority were born in the United States (87.2%, $n = 34$); the other five participants who responded to this question indicated they were born in Guatemala, Mexico, Nepal, Portugal, and Trinidad. Of the 39 participants who responded to the question about children, 79.5% ($n = 31$) had children. In terms of relationship status, 39.0% were single ($n = 16$), 21.9% were in a relationship but not living together ($n = 9$), 17.1% were separated ($n = 7$), 9.8% were married ($n = 4$), 7.7% were in a relationship and living together ($n = 3$), 2.4% were divorced ($n = 1$), and 2.4% indicated "other" ($n = 1$). Participants reported varying levels of education: 12.2% ($n = 5$) did not graduate from high school or receive a GED equivalent, 29.3% ($n = 12$) had graduated from high school or received a GED, 24.4% ($n = 10$) had completed some college/technical schoolwork, 24.4% ($n = 10$) had completed a college/technical school degree, 7.3% ($n = 3$) had completed a graduate degree, and 2.4% indicated "other" ($n = 1$). Forty participants answered questions about their employment and insurance. In terms of employment, 32.5% ($n = 13$) were employed full-time, 32.5% ($n = 13$) were unemployed, 10.0% ($n = 4$) were employed part-time, 10.0% ($n = 4$) were self-employed, 7.5% ($n = 3$) were homemakers, 7.5% ($n = 3$) were retired, and 7.5% ($n = 3$) indicated "other" for employment (e.g., SSI, disabled veteran, cleaning business). The majority of participants indicated they had Medicaid/Medicare (65.0%, $n = 26$); other forms of insurance included private health insurance (10.0%, $n = 4$), government insurance (7.5%, $n = 3$), no insurance (20.0%, $n = 8$), and "other" (5.0%, $n = 2$).

Demographic characteristics were summarized using Excel. All other analyses were conducted using SAS 9.4 and consisted of descriptive and bivariate analysis. For the bivariate analysis, hypothesis tests of no time effect for each time pair (1 v. 2, 1 v. 3, and 2 v. 3) were done using matched pairs t-tests for continuous quantitative response variables. The Rao-Scott Chi-Square test of equal proportions was used to test the null hypothesis of equal distribution between times for binary outcomes. In all cases, observations were used only if the participant had valid responses at both relevant time points.

Partner Site Focus Groups. This research activity aimed to understand centers' experiences participating in the formative evaluation, as well as facilitators and challenges to implementing the various formative evaluation research activities. The research team emailed the directors and key formative evaluation contacts at each partnering site to invite them to participate in either a focus group or individual interview discussion session—depending on their preference and availability—and to schedule the session(s). Each discussion session was guided by at least two research team members using a standardized, semi-structured guide (see Appendix A6). The guide was comprised of questions pertaining to (1) participants' experience implementing the formative evaluation research activities at their center, (2) facilitators and challenges of the

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formative evaluation process, and (3) recommendations for modifying and expanding the evaluation protocol. Prior to each discussion session, the research team sent scheduled participants an email reminder with both the consent form and a list of questions. At the beginning of each discussion session, a member of the research team reviewed the consent form and sought verbal consent. All of the discussion sessions took place in December 2023 virtually over Zoom and were digitally audio-recorded. The recordings were supplemented by research team member notes taken during the discussion sessions.

Five focus groups were conducted with a total of 12 participants, and between two and four participants in each focus group. Each of the six partnering sites were represented in these focus groups. Two sites had one representative, three sites had two representatives, and one site had four representatives who participated in this research activity.

All transcripts were de-identified and uploaded to Dedoose for data analysis. An initial codebook was developed based on the guiding research questions, a semi-structured guide, and a review of the data. Two members of the research team independently coded each of the transcripts using a combined inductive and deductive content analysis approach. After all transcripts were double-coded, the two coders met to discuss the final codebook and to collapse, remove, and hierarchically sort codes as needed.

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Chapter 3: Evaluability Assessment Key Findings

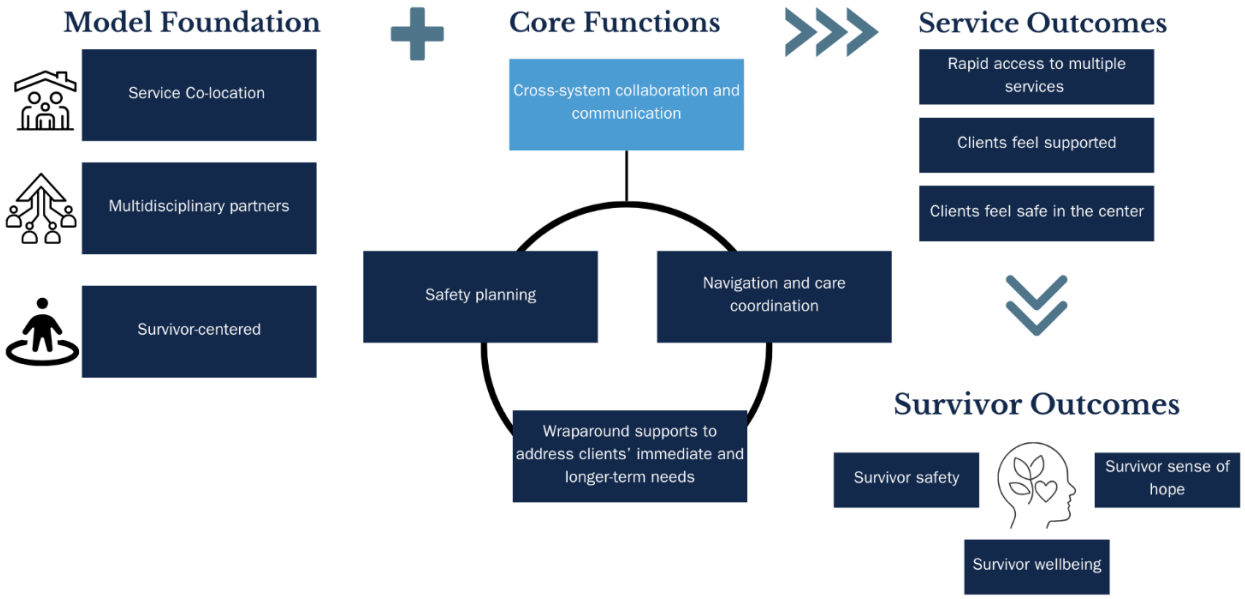
3.1 Core and Adaptive Components of Cross-Sectoral Approaches

This section describes core and adaptive components based on findings from the three evaluability assessment research activities—document review, affiliate interviews, and client-survivor interviews—as well as feedback from the partnering sites. Findings from this assessment informed the development of the practice and research materials used during the formative evaluation stage of the project.

3.1.1 Theory of Change. The theory of change is based on the document review, affiliate interview, and client-survivor interview findings. The following is a narrative summary of the theory of change illustration of co-located CSAs presented in Figure 3.1.1 (Appendix B1):

Multi-disciplinary, co-located, and survivor-centered services increase survivor safety, wellbeing, and hope through robust collaboration and communication that enhances safety planning, service navigation and coordination, and wraparound care to ensure clients have rapid access to services and feel supported and safe.

Figure 3.1.1 Integrated Theory of Change: Co-Located Service Agencies for IPV/SV



As depicted in Figure 3.1.1, the model is built on three foundational elements: (1) co-location, (2) two or more multidisciplinary partners, (3) providing survivor-centered services. These foundational elements, coupled with robust collaboration between co-located partners, lay the groundwork for core functions that are consistent across sites: navigation and care coordination, safety planning, and wraparound care to address clients' immediate and longer-term needs. Together, these activities are intended to improve service outcomes such as clients feeling supported and safe in a center where they have rapid access to multiple survivor-centered services, ultimately enhancing survivor outcomes of safety, hope, and well-being. In this theory of change, the central assumption underlying the model is that the co-location of multi-

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disciplinary partners provides the opportunity for more enhanced collaboration and communication across partners compared to a standalone model that may provide the same type of activities (e.g., safety planning, wraparound supports, care navigation). Consequently, collaboration is the primary function of the co-located CSA service model.

3.1.2 Logic Model. The integrated logic model in Figure 3.1.2 below (Appendix B2) was developed from affiliate interviews, client-survivor interviews, document reviews, and meetings with partner sites. Although program implementation varies across sites, this logic model focuses on elements that are applicable to most or all of the sites and represent the core functions and features of the program. Where appropriate, adaptive components of the model are described.

Inputs. Inputs are the resources necessary for operating an IPV/SV co-located center. Across partner sites, inputs were categorized into six types of resources: (1) physical space, (2) center personnel, (3) onsite partners, (4) funding, (5) training, and (6) infrastructure and committees. In terms of physical space, consistent attributes across sites were that the space was safe, secure, and confidential. Beyond these attributes, other aspects of the physical space varied by site, including but not limited to (a) whether the space was owned or rented, (b) whether partners had designated space at the center, (c) whether features of the physical space (e.g., layout, décor, comfort items) were trauma-informed, and (d) whether the space was centrally located or accessible by public transit systems. In terms of personnel, each site had a director and either a coordinator or navigator role that focused on coordination of care across partners. There was large variation across centers in other types of roles, which was largely dependent upon the site's programming (e.g., elder abuse, child trauma). For this study, co-location was defined as having two or more partner organizations that were co-located at a given site, either full-time or part-time. Although every site included two or more co-located partners, the two types of organizations consistent across sites were domestic violence and sexual violence services. The remaining co-located partners across centers varied by type, including law enforcement, legal advocates, the Department of Social Services, and more (see Appendix B2 for additional examples). Funding also varied across sites, with center budgets comprised of grants from public or private entities, county or city government, state government, and donations. All sites provided training to staff, but training varied by center, including model orientation and confidentiality training. Lastly, in terms of infrastructure and committees, some centers were led by county agencies, and others were led by non-profit organizations. Additionally, each center had different types of standing committees, including a VOICES committee (i.e., survivor committee), executive committee, and advisory committee.

Program Activities. Three main program activities were consistent across centers. First, navigation and care coordination refers to the onsite support services staff provided to ensure that the needs of clients during the intake process are, to the degree possible, met during the course of their visit. Given the multiple needs of clients and multiple providers onsite, this activity appears to be central to the model. A second core component or activity is safety planning, which is closely related to the final core activity, which involves providing wraparound care to address clients' immediate and longer-term needs. Taken together, these activities or core components mean that staff and co-located partners are using a wraparound approach to address clients' immediate safety planning and crisis needs while also focusing on longer-term goals. Services to address these needs look differently across centers and can include financial and material

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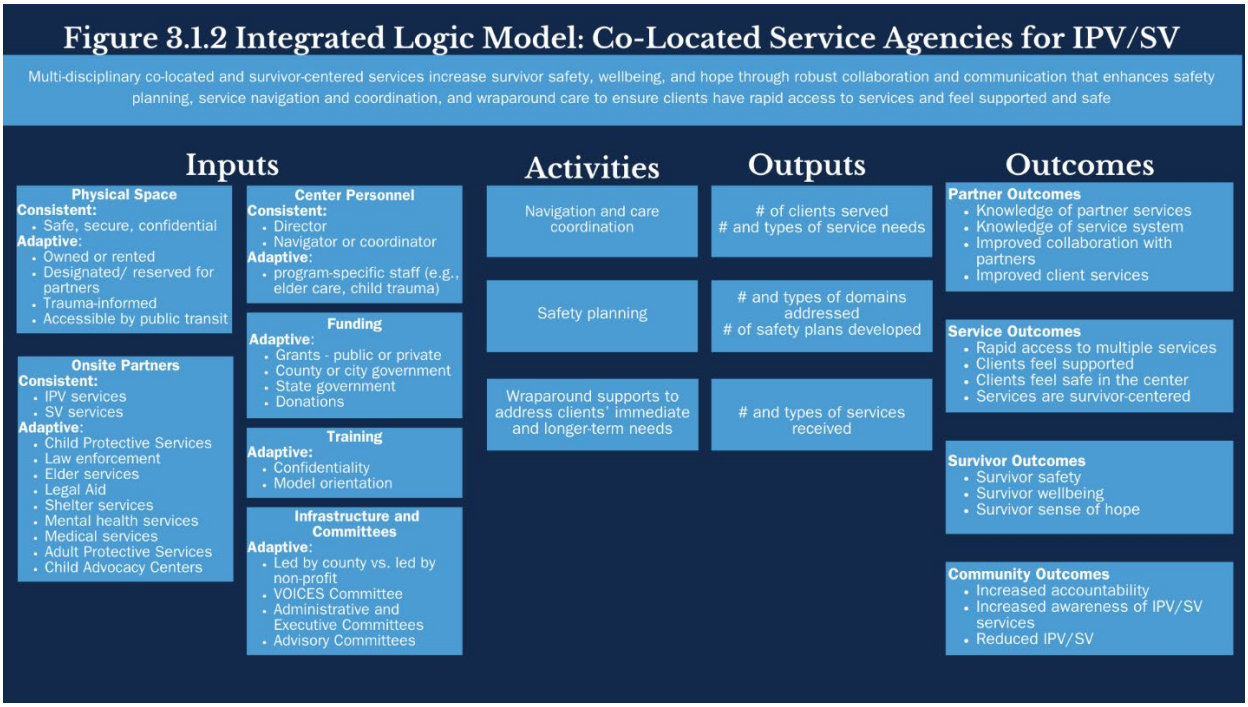
assistance, shelter and housing, medical services, and more. Although the specific structure of these activities may vary across centers, these broad activity categories or functions of the model appear to be consistent across centers.



Program Outputs. In the absence of a logic model for each of the centers, there is little information about how partner sites connected each of their activities to measurable outputs. Nonetheless, Figure 3.1.2 presents examples of potential measurable outputs for the above-named program activities. For example, navigation and care coordination could be measured by the number of clients served and the number and type of service needs shared at intake. Outputs for safety planning could include the number and types of domains addressed in the safety plan and the number of safety plans developed. Lastly, the output for wraparound support could examine the number and types of services provided to clients. This list of outputs is not exhaustive, and there are likely many more that could depict the delivery of the co-located CSA activities.

Program Outcomes. With this type of complex and inter-organizational model, there are a number of multi-level outcomes that this programming can impact. Consequently, outcomes named in the interviews and document review are divided into four broader categories. First, this model of co-location and collaboration can change **partner outcomes**, specifically partner knowledge about the services offered and the service system broadly, improved collaboration with other partners, and subsequently improved client services. A second set of outcomes, **service outcomes**, can include clients' rapid access to multiple types of resources. Additionally, clients may feel supported and safe at the center, particularly if the center and its services are survivor-centered. Further, in terms of **client outcomes**, the model aims to improve survivors' safety, wellbeing, and sense of hope. Finally, on a **community level**, these co-located models aim to increase accountability (e.g., offender accountability), increase awareness about IPV/SV

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services, and reduce the overall rate of IPV/SV. Although some of these outcomes will vary by center, these appear to be consistent across sites and are reasonably linked to the program activities named above, meaning that we can expect the program activities to have an impact on these outcomes.

3.1.3 Summary of Core and Adaptive Components of Cross-Sectoral Approaches. The integrated theory of change across centers was: "Multi-disciplinary co-located and survivor-centered services increase survivor safety, wellbeing, and hope through robust collaboration and communication that enhances safety planning, service navigation and coordination, and wraparound care to ensure clients have rapid access to services and feel supported and safe." This theory of change describes the centrality of collaboration, the functions at the core of co-located service models, and how these functions relate to organizational and survivor outcomes. Although there is consistency in the model's function across centers, the form that these functions take can vary. In other words, centers may adapt or tailor their specific activities to the context and resources of the center (e.g., specific co-located partners, physical space, type of funding, and priorities). This consistency in function and variation in form is depicted in the logic model that contains both core elements of the model as well as its adaptive components. Notably, outcomes of these co-located models are multi-level, such that inputs or resources paired with the activities result in changes in partner relationships, services delivery, survivors, and communities. Consequently, evaluation methods for programs will necessarily be complex and multilevel.

When considering these findings, there are notable limitations to consider. Findings for the theory of change and logic model are descriptive in nature and are not correlated with model effectiveness. That is, understanding the degree to which the form of the co-located model impacts service and client outcomes is unknown. Additionally, the logic model is largely theorized, meaning that centers did not have their own logic models that depicted the relationship between program activities. Rather, the research team developed a draft of logic models across centers and aggregated these elements into one model. Consequently, details of program variation in implementation are not shown in the figure. Further, because the model is based on aggregated information, the relationship between activities, outputs, and outcomes is largely theoretical in that programs are not necessarily tracking the activities and measuring outcomes as depicted in the model.

3.2 Best Strategies for Evaluating Cross-Sectoral and Co-Located Centers

This section describing promising methods and approaches for evaluating cross-sectoral and co-located centers is based on document review, affiliate interview, and client-survivor interview findings. These findings informed the research materials, methods, and approaches used as part of the formative evaluation.

3.2.1 Research and Evaluation with Survivors at Co-located Centers. The document review, affiliate interviews, and client-survivor interviews all had findings related to research and evaluation with survivors and co-located centers. Although the document review identified center efforts to conduct research and evaluation with survivors (e.g., survivor feedback surveys), the findings presented below come primarily from the affiliate and client-survivor interviews.

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Survivor Participation in Research. Survivor participants discussed various reasons why they might participate in a research study focused on evaluating an IPV/SV co-located center. For example, participants discussed wanting to help. This sentiment encompassed wanting to (a) contribute to research, (b) educate others about IPV/SV and the experiences of survivors, (c) help the co-located center (e.g., give back), (c) help other survivors, (d) increase funding for their local co-located center and funding to open more co-located centers, (e) improve their local co-located center and its services, and (f) improve policy. Some survivor participants identified their availability as a reason why they would participate in research. Survivor participants also described the potential for personal benefits that might be associated with participating in research (e.g., being compensated, being connected to researchers for potential future collaborations, enjoying being a part of the research, sharing their experiences, and turning their experience into a positive). In addition, survivor participants mentioned reasons related to the characteristics of a study, such as confidentiality and being associated with a reputable funder or university.

Survivor participants also described reasons why they would not participate in research. One reason was not having a thorough understanding of the research study (e.g., not knowing if it was a valid study, not knowing what participation would entail, not understanding the purpose of the study or how findings would be used). Survivor participants also shared concerns regarding confidentiality would keep them from participating. Personal characteristics that might keep a survivor from participating include being shy, having limited availability, and not feeling ready to talk about their experiences. Survivor participants also mentioned that interacting with researchers who were described as biased, disrespectful, or hostile would be a reason not to participate in research. Study characteristics such as being burdensome (e.g., too long of a survey, too many sessions, too much time) and lacking in flexibility (e.g., not being able to choose participation time or location) were also presented by participants as reasons not to participate in a research study. Moreover, survivor participants noted that they would not participate if they felt that participation would be triggering. Notably, several survivor participants stated that “nothing” would keep them from participating in a study about IPV/SV co-located centers.

Challenges to Engaging Survivors in Research. Affiliate participants discussed various challenges to recruiting and engaging survivors in research about co-located centers, particularly when receiving crisis services. Affiliates shared that when their centers previously undertook efforts to collect data from clients, few completed follow-up surveys or surveys left in waiting rooms. Some affiliate participants also noted provider-related barriers to engaging survivors in research, including concerns about recruiting clients when in crisis, concerns about potential negative feedback, and limited capacity to collect data from clients. Affiliate participants also noted that clients receiving services at a co-located center do not always know the specific staff or partner organization they worked with at a given visit, making it challenging to collect and interpret data about their experiences accessing services. Affiliate participants also raised concerns related to collecting data from clients after leaving the center (e.g., lack of client response, safety concerns if still with an abusive partner) and recognizing the delicate balance between not recruiting when a client is in crisis and not waiting so long that recollection is lost.

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Survivor Recruitment. Survivor participants shared varied preferences related to recruitment. Regarding the recruiter, some survivor participants preferred being recruited by staff from the co-located center (43.3%, *n* = 13) or someone known and trusted (6.7%, *n* = 2), whereas others preferred being recruited by a researcher not affiliated with the co-located center (10.0%, *n* = 3). However, some survivor participants (26.7%, *n* = 8) shared that they did not have a preference and would feel comfortable being recruited by center staff or an unaffiliated researcher. Affiliate participants also identified potential recruiters, including a familiar person, a service provider, an onsite researcher, and a peer survivor.

Survivor participants described their preferred recruitment strategies, including (a) email (70.0%, *n* = 21), (b) in-person (10.0%, *n* = 3), (c) mail (6.7%, *n* = 2), (d) newsletter (3.3%, *n* = 1), (e) social media (20.0%, *n* = 6), (f) telephone (30.0%, *n* = 9), and (g) text message (23.3%, *n* = 7). Survivor participants also shared strategies that they personally would not prefer, or that they thought might not be effective, including (a) email (6.7%, *n* = 2); (b) flyers (13.3%, *n* = 4); (c) social media (16.7%, *n* = 5); (d) and telephone/voicemail, particularly if from someone unknown (20.0%, *n* = 6). Affiliate participants similarly recommended email, telephone, flyers, social media, and television commercials; cold calls and letters were discouraged.

Survivor participants shared their perceptions regarding the timing of recruitment. Preferences varied and included: (a) < one month after seeking services (e.g., before leaving the building, immediate, next day; 20.0%, *n* = 6), (b) 1–2 months (23.3%, *n* = 7), (c) 3–6 months (16.7%, *n* = 5), 6–11 months (26.7%, *n* = 8), and 12 months + (20.0%, *n* = 6). Other responses included anytime (6.7%, *n* = 2); it depends (6.7%, *n* = 2); not the same day, next day, or immediately after initially seeking services (13.3%, *n* = 4); and when no longer in crisis or receiving services (13.3%, *n* = 4). Affiliate participants noted that timing would depend on the survivor and the data collection strategy (e.g., they would need to wait less time after seeking services to recruit for a survey but longer to recruit for an interview). General time frames provided by affiliate participants included at the end of their initial visit to the center, after the court process is over, when no longer in crisis and receiving services; more specific time frames included 1 month after seeking services, 3-6 months, and 1 year.

Survivor Data Collection. Survivor participants had wide-ranging preferences regarding data collection strategies, including (a) focus group, format not specified (20.0%, *n* = 6); (b) focus group, virtual (3.3%, *n* = 1); (c) interview, format not specified (50.0%, *n* = 15); (d) interview, in-person (6.7%, *n* = 2); (e) interview, phone (23.3%, *n* = 7); (f) interview, virtual (23.3%, *n* = 7); (g) survey, general (40.0%, *n* = 12); (h) survey, online (6.7%, *n* = 2); and (i) survey, paper (10.0%, *n* = 3). Affiliate participants also discussed various data collection strategies, including surveys (e.g., client satisfaction survey, exit survey), interviews, focus groups, and follow-up telephone calls. Below, participant-identified pros and cons of the various data collection strategies are described.

Overall, survivor and affiliate participants noted that interviews can be cathartic as they provide the opportunity to share one's experiences and be heard. Compared to other data collection strategies, survivor and affiliate participants shared that interviews can lead to richer data and be perceived as more confidential and personal. Affiliate participants also noted that interviews can address challenges with reading and writing, make it possible to read tone, and can be helpful

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with marginalized populations more accustomed to storytelling than taking surveys. However, survivor and affiliate participants also noted that interviews, in general, can be burdensome, overwhelming, re-traumatizing, and triggering. In addition to mentioning that scheduling can be challenging, survivor participants shared that survivors may worry that they will be misunderstood or that they will forget to share something important. Further, some survivors may not feel comfortable participating in an interview.

In-person interviews were perceived as more personal than other interview formats (e.g., phone or video); however, survivor participants also felt that some survivors might not be comfortable communicating in person and face-to-face. Survivor and affiliate participants shared a number of benefits for interviews conducted virtually or by phone, including being more comfortable (e.g., can be in their own space) and convenient (e.g., can care for children, can take the interview anywhere, easy to coordinate) than in-person interviews. Nonetheless, phone interviews were described as not personal. Survivor and affiliate participants also shared that virtual interviews may be challenging depending on survivors' access to a private space and technology, as well as their level of comfort communicating via a computer screen.

In discussing the benefits and limitations of focus groups, survivor participants mentioned that focus groups could lead to more in-depth responses because (a) participants are able to think about their possible responses to the focus group questions as others share and (b) participants can expand on others' responses. Focus groups were also described as cathartic and helpful, given that such participation would enable participants to connect with and hear from other survivors. However, survivor and affiliate participants also described potential challenges to focus groups, including (a) being biased given group dynamics (e.g., groupthink, over- or under-participation), (b) being difficult to schedule, (c) being less confidential and anonymous than other data collection strategies, and (d) being potentially triggering or re-traumatizing. Survivor participants also mentioned that there might be survivors who are not comfortable sharing in a group setting.

In general, survivor and affiliate participants shared that surveys can be beneficial because of the following factors: (a) anonymity and confidentiality afforded by surveys, (b) consistency of data across participants, and (c) convenience (e.g., able to think about and re-read questions, can complete anytime and anywhere, can take your time or complete immediately, less time consuming than other strategies). Further, surveys may be less triggering than other forms of data collection, and surveys may also be helpful for survivors who are introverted or not comfortable speaking about their experiences. Nonetheless, participants also shared challenges with surveys. For example, survivor participants noted potential barriers, including language, length, and literacy, as well as lack of access to technology for online surveys. In addition to noting that surveys are generally not perceived as personal, survivor and affiliate participants explained that someone would need to be interested and motivated to complete the survey, and if they complete it at all, it may not be done in a timely manner. Other challenges included the inappropriateness of the survey questions and response options, as well as the inaccuracy of actual responses.

Recommendations for Research and Evaluation with Survivors. Survivor and affiliate participants shared recommendations for enhancing people's comfort and motivation to participate in research. These recommendations included: (a) conducting data collection in a

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comfortable and private location (and for telephone/virtual data collection, being mindful of camera placement and considering ways to minimize background noise and echoes), (b) considering strategies for maximizing anonymity, confidentiality, and safety, (c) engaging co-located center staff in recruitment, (d) providing reasonable and non-coercive compensation as well as other research supports (e.g., childcare, food, interpretation, toys for children, transportation), (e) reducing burden on survivors, (f) sharing key recruitment information (e.g., purpose, relevance, and importance of the study; benefits of participation; connection to funder, sponsor, university; duration of participation and wait it entails; how findings will be used; how confidentiality will be addressed interview questions; timeline), (g) waiting until survivors have received services and are more removed from their experiences of abuse, and (h) offering survivors control over their participation (e.g., options for data collection strategies and scheduling).

Participants also shared recommendations for data collection. Regarding interviews, survivor and affiliate participants recommended that researchers share the interview questions in advance, and affiliates recommended conducting in-person interviews at the center. For focus groups, a survivor participant recommended that researchers conduct individual interviews with survivors before inviting them to participate in a focus group, whereas affiliates recommended scheduling focus groups following support groups. In terms of surveys, survivor participants recommended that researchers share the survey with survivors at the center and that researchers provide options for completing the survey (e.g., in-person, online, and paper; self-administered and assisted); affiliates recommended being mindful of survey length, including open-ended questions, and conducting surveys at multiple timepoints.

In addition, survivor and affiliate participants shared recommendations for trauma-informed interviewing strategies and for responding to distress in the context of research participation. Recommendations for not re-traumatizing survivors included: (a) asking open-ended questions, (b) avoiding asking for details about the trauma or abuse and instead focusing on services and healing, (c) avoiding the use of invalidating or victim-blaming language, (d) being mindful of self and environment (e.g., not interrupting participants), (e) ensuring participants are far enough along in their healing, and (f) prefacing data collecting by acknowledging that participation is voluntary and that participants can share as much or as little as they feel comfortable. Recommendations for responding to distress varied, and a couple of participants noted that it would depend on the survivor and context. Potential strategies included being supportive and compassionate, embracing the distress, checking in with the participant, connecting the participant with service providers, engaging in de-escalation and grounding tactics, empathizing, listening actively, providing options (e.g., discontinuing participation, skipping questions, taking a break), providing space to talk or process, re-directing, and remaining professionally detached and stoic if the participant shares something shocking. Survivor participants also offered key phrases that researchers should avoid when responding to distress. These phrases included “calm down,” “everything will be okay,” “it’s okay,” “I’m sorry,” “I understand what you are going through,” “I get it,” “I know where you are coming from,” and “life goes on.”

3.2.2 Research and Evaluation in Co-located Centers. The findings presented below, which are related to research and evaluation in co-located centers, come from the affiliate interviews and document reviews.

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Co-located Centers' Capacity for Research and Evaluation. Overall, affiliate participants reported that co-located center staff and partners have limited capacity for engaging in research and evaluation. To address this challenge, some affiliates and documents highlighted established collaborations and partnerships between centers and university researchers as an existing and effective means of increasing capacity. Further, forming such partnerships between centers and researchers was provided as a recommendation to increase capacity.

Design and Data Collection Strategies. Affiliate participants identified design and data collection challenges. For example, participants noted that it can be difficult to provide anonymous or confidential feedback when a center is small (e.g., not many employees or partners). Additionally, participants reported that it is "hard to track" if the success of a client is related to the client's engagement with the center or if their success is influenced by outside services and support. Affiliate participants also shared existing design and data collection practices, including data platforms, data sharing, and data collection strategies. Reported data platforms include Apricot and Osnium (though challenges were noted with extracting data from Osnium and using the platform to track outcome metrics). Examples of data sharing included exploring centralized data platforms, having one partner maintain the data (e.g., create reports and scramble/de-identify the data), and leveraging a general and universal (or blanket) release of information (ROI) form. Affiliate participants also reported the use of various data collection strategies at their centers, including data collection with clients (see prior section on research and evaluation with survivors), one-week census, partner data requests, use of referral forms to collect data, focus groups with the VOICES committee, and tracking of informal feedback. Document review also identified different types of evaluations employed by the centers, including needs assessments, process evaluations, and outcome evaluations, using both cross-sectional and longitudinal designs and collecting data from multiple sources (i.e., administrative data, partner agencies, providers, and clients).

Affiliate participants had various recommendations related to design and data collection. Participants recommended the inclusion of "as much data from many different perspectives" when evaluating co-located centers. Relying on partners and providers for data was highlighted as an important element so that survivors are not overburdened. Many participants suggested conducting an initial or ongoing needs assessment to ensure that co-located services and partners are aligned with the mission/vision of the center and the needs of the community. Participants also suggested conducting a one-week census to gain a better understanding of clients and service provision. Further, participants recommended conducting a multi-site outcome evaluation and comparing co-located centers to child advocacy centers and stand-alone domestic violence/sexual assault organizations.

Measurement and Key Constructs. Affiliate participants described challenges to determining and measuring success across centers. In particular, participants noted that (1) center partners might define success in different ways and (2) centers located in different geographical areas likely serve varying client populations with unique needs. Thus, success may look different across centers and communities.

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Affiliate participants also discussed existing constructs and measures used by their centers, including client and provider satisfaction with the center, experiences at the center, and services at the center; criminal legal system indicators (e.g., number of domestic violence protection orders [DVPOs], number of high lethality case reviews and related outcomes, and lethality assessment information); perception of law enforcement; and service outputs. Reported service outputs include (1) tracking clients' service/intakes, including demographics, the number of clients coming to appointments and/or enrolling in services, and the number of children receiving services; (2) tracking partners and the providers that clients meet with, including the type of services utilized, the number of visits, and the type and number of resources provided; (3) and referral sources to the center and the number of referrals between co-located partners; and (4) service gaps. The document review confirmed existing practices of measuring provider satisfaction and perceptions, criminal legal system indicators (i.e., legal outcomes), and collaboration, and also identified efforts to measure client hope, safety, support, and well-being.

In addition, affiliate participants provided recommendations on important constructs and measures to consider in research and evaluation with co-located centers, including (1) service accessibility and barriers, (2) client satisfaction and key outcomes, (3) information on co-location (e.g., number and type of co-located partners in the center, number and type of co-located partners who have left the center, number and type of co-located staff), (4) collaboration outputs and outcomes, (5) community outputs and outcomes, (6) partner and provider satisfaction (e.g. perceptions of benefits and success of the center), and (7) service outputs. Examples of key client outcomes shared by participants include criminal legal system outcomes (e.g., number of arrests, number of DVPOs and dismissals, number of police calls, number of successful prosecutions); family outcomes (e.g., child reunification); interpersonal violence outcomes (e.g., IPV/SV incidents, safety, whether the client left the abusive partner); mental health outcomes (e.g., anxiety, depression, trauma symptoms); well-being outcomes (e.g., empowerment, hope, sense of security, sense of support), and self-identified outcomes (e.g., service needs and goals met).

Affiliates also provided numerous examples of collaboration outputs and outcomes, including the number of shared clients (e.g., number of clients that saw each/all partners, number of clients that used each all/services, number of partners/providers and services accessed by clients); client perceptions of collaboration; client success stories and challenges; collaboration and partnership assessment/functioning tool (e.g., Milwaukee tool); the number of meetings held, conferences attended, and committees convened, along with minutes and the list of participating partners (including the type of partner organization); nature of collaboration (e.g., authentic, equitable, mutually beneficial); documentation of the number and type of partner contacts; partner knowledge of the center, partners, services, and IPV/SV; partner/staff experiences with collaborative projects and conflict resolution; partner/staff perceptions about benefits, partners, and partner relationships; partner/staff understanding about partner roles and services; relationships among partners.

Community outputs and outcomes recommendations included the number of community events and attendees; community knowledge of IPV/SV, center, and available services; community safety and violence; homicides; poverty; prosecution and conviction rates. Affiliates also had a number of recommendations regarding service outputs, some of which corresponded to their center's existing practices: demographics and number of clients serviced (e.g., first-time clients,

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clients that have stayed and engaged in services, return clients); the type of meeting and number of times partners and providers met (e.g., the type and number of services used and resources provided); referrals including the number and source of referrals to the center, the number of referrals between co-located partners, the number of referrals to community partners, the number of referrals followed up on, the number of referrals not followed up on and why, and the workflow through the center (e.g., follow clients' path through center).

Data Collection from Center and Partners. Affiliate participants shared various challenges to collecting center and partner data, including data and evaluation concerns (e.g., questions about data accuracy and quality, questions about who holds or owns the data), variation in partners' data and evaluation practices (e.g., collect different types of data, define and measure key constructs differently, have different funder-related data requirements, do not prioritize data and evaluation in the same way), and partner and staff reluctance to collect and share data (e.g., certain partners do not share data, it can be difficult to partners complete surveys or provide data in a timely manner, inter-organizational competition for funding disincentivizes data sharing, partners and staff not perceiving data and evaluation as important, and time constraints and competing demands). Participants stressed the importance of confidentiality but also noted how confidentiality can impact data collection and evaluation. In particular, participants noted the need to balance confidentiality with data-informed decision-making. Participants noted differing confidentiality constraints and interpretations across partners that can make it challenging to maintain and navigate confidentiality, particularly with personally identifiable information. Participants also noted that partners often have different data systems and platforms and that many centers do not have a centralized data system.

Affiliate participants provided a number of recommendations to address these challenges and enhance efforts to collect center and partner-related data. In particular, participants discussed efforts to create buy-in and synergy around data collection, including conveying the importance of data and evaluation, engaging partners in data evaluation and planning, incentivizing partner data collection and sharing, having a memoranda of understanding (MOU) with partners related to data and evaluation, holding meetings to create a common language, discussing current data practices and capacity, and making collective decisions regarding data and evaluation (e.g., defining key constructs). Participants also discussed the importance of being clear and transparent about evaluation activities, focusing on data that all partners can collect, making data and evaluation as easy as possible (e.g., using data already being collected, determining how partners report out their data, and incorporating that into data requests), gathering data that will be used, and sharing data back with partners after conducting center-related analysis. Participant recommendations related to data collection and evaluation processes included examining data already being collected and developing a plan for additional data needs, having the director prompt and remind partners about data and evaluation, and having one person at the center and each partner organization responsible for data and evaluation.

Strategies for enhancing data sharing included using mutual/blank ROI forms that explain why and how data will be shared and sharing anonymous and de-identified data (e.g., overall statistics, aggregated data, data linked through client IDs). Participants also provided recommendations related to data systems and platforms, including creating formal templates in Excel, using the same data system and platform across partners, and using a centralized data

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system and platform. Notably, some participants shared concerns about the potential implications of centralized data systems, particularly if subpoenaed.

3.2.3 Summary and Limitations of Best Strategies for Evaluating Cross-Sectoral and Co-Located Centers. Research and evaluation of CSAs and co-located centers require various sources of data, including center data, partner data, and client data. Examples of center and partner data include information on co-location, collaboration, and service delivery; provider satisfaction, perspectives, and experiences; service outputs; and criminal legal system indicators. Client data examples include information on service accessibility and barriers, needs and goals met, client satisfaction, and client outcomes (e.g., violence victimization, sense of safety, mental health, support, empowerment, hope). Notably, engaging in research and evaluation of this complex model can be challenging. Overall challenges for centers and partners to engage in research and provide data include limited capacity, concerns related to confidentiality, variation in partners' data and evaluation practices, data systems and platforms, and definitions of success, and a general reluctance to share data. It can also be challenging to engage clients in research and evaluation, as they are generally seeking co-located services in a moment of crisis.

Despite these challenges, Phase 1 findings identified a number of recommended best practices for conducting research and evaluation of CSAs and co-located centers. To address capacity, participants recommended developing center-researcher collaborations, creating a position in the center and each partner organization responsible for data and evaluation, and making engagement and participation in research as easy as possible (e.g., using available data whenever possible). Another recommendation was to create buy-in and synergy around research and evaluation by involving centers and partners early in the planning stage and using this time to make collective decisions around common language and data collection practices. Participants also recommended clarity and transparency about evaluation activities, only gathering data necessary to answer the evaluation questions, and sharing findings with partners. In terms of engaging clients in research and evaluation, participants recommended providing flexibility and control over research participation (e.g., use of multiple recruitment strategies with key information, use of multiple data collection strategies, offering options when possible) while maximizing confidentiality and safety, reducing burden, and offering compensation and research supports (e.g., childcare and transportation).

Findings related to best practices for conducting research and evaluation of this IPV/SV service model should be considered in light of study limitations and, in particular, selection bias. Documents included in the review were selected by our partnering sites. Similarly, leaders and contacts at our partnering sites identified affiliates to recruit for this research activity and also shared study information with potential survivor participants. Further, once invited to participate in an interview, affiliates and survivors had to self-select to participate (e.g., there may be meaningful differences between those who elected to participate and those who did not). It is also possible that our interview guide and codebook were not comprehensive and, therefore, missed important questions, themes, and categories. Nonetheless, the research team used multiple strategies to enhance rigor, including inviting EAG members to review the interview guides, having numerous team discussions regarding the codebook, using triangulation of data sources, involving multiple coders, conducting both inductive and deductive coding, memoing

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and leaving an audit trail and conducting negative case analysis. Thus, these findings were used to develop the research materials tested in the formative evaluation phase of the project.

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Chapter 4: Formative Evaluation Key Findings

4.1 Implementation Findings

The implementation-related objectives of the study focused on three evaluation questions: What services and supports do clients seek from co-located centers (i.e., demand), What services and supports do clients receive from co-located centers (i.e., dose), and What components of co-located centers can be adapted to the local context and what must be uniform across centers (i.e., adaptive fidelity). Four research activities were used to address these evaluation questions: (1) a review of annual programmatic data, (2) an examination of client-level service needs using a service navigation log, (3) an exploration of partner collaboration using a survey about inter-organizational collaboration, and (4) an assessment of adaptive fidelity using an adaptive fidelity self-assessment tool. For additional details about measures and data collection methods, see Chapter 2.

4.1.1 Service Demand and Dose. There were two data collection activities used to assess demand (i.e., what services clients sought) and dose (i.e., what services clients received) of services—the annual programmatic data activity and the client-level-service need activity.

Annual Programmatic Data Findings. Table C1.1 (Appendix C1) presents the aggregate center and service indicator findings. Overall, centers provided a majority of the aggregate center and service data requested; however, gaps in reported data varied by the center as well as the source and operationalization of data points. All of the centers provided data regarding the number of organizations and people reached by center outreach and education efforts. Overall, the centers reached 351 organizations and 11,458 people. Aggregate data regarding DV and SV calls varied by the center: one center combined their DV and SV calls (n = 3,484), five centers provided the number of DV calls received on the crisis line by their DV partner (n = 10,338), and three centers provided the number of crisis line calls received by their SV partner (n = 909). In terms of aggregate data about DV and SV advocacy services (n = 3,549), five centers shared the number of clients receiving DV advocacy services by their DV partner (n = 26,206), and four provided the number of clients receiving SV advocacy services by their SV partner (n = 1,995).

All of the centers provided the number of clients housed in a shelter (n = 2,156) and the total number of shelter/hotel nights provided to clients (n = 62,139). Notably, the manner in which shelter/hotel night data was provided varied across centers. For example, centers may have merged shelter and hotel nights into one category or provided these data separately. All of the centers provided mental health data, representing 279 clients referred for mental health services and 180 who received mental health services. Four centers provided data regarding the number of patients examined by a Sexual Assault Nurse Examiner (SANE nurse; n = 1,423), of which one indicated the number represented both center clients and hospital patients.

Table C1.2 (Appendix C1) presents the aggregate criminal legal system indicator findings. Fewer data were available for court-related processes. For example, although five centers provided the number of DVPOs filed in the prior year, inclusive of 50Bs and 50Cs (i.e., DVPO and civil no-contact order, respectively; n = 9,251), only one center provided the number of cases heard in court in the prior year for DV (n = 2,196), SV (n = 52), elder abuse (n = 0), and other (i.e., stalking, n = 86), and no center provided the number of cases heard in court that year for child

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maltreatment. In terms of legal support, all of the centers shared the number of DV cases referred (n = 2,075), five provided the number of DV cases opened by their legal partners (n = 1,717), and four provided the number of cases closed by their legal partners (n = 1,235). All of the centers provided the number of DV calls responded to by at least some of their law enforcement partners (n = 62,200), of which five provided the number of calls resulting in charges/arrests (n = 4,488). Four centers provided the number of rape/sexual assault calls responded to by their law enforcement partners (n = 923), of which three centers reported the number of such calls resulting in charges (n = 76).

Four centers provided the number of charges processed in 2022 in the areas of child abuse (n = 232), sex offense charges (n = 14), crimes against nature (n = 11), indecent exposure (n = 51), statutory underage (n = 39), and forcible rape (n = 18); whereas three provided the number of charges of child neglect (n = 2), DV (n = 23), and child molestation (n = 0). Four centers provided the number of law incident records with arrests for DV (n = 7,087); three provided information regarding records with arrests for child abuse (n = 28), child neglect (n = 4), sex offenses (n = 30); and one provided the number of arrests of elder abuse (n = 3), child molestation (n = 9), crimes against nature (n = 0), indecent exposure (n = 5), statutory underage (n = 0), and forcible rape (n = 2).

Four centers provided the number of DVPOs (including 50Bs and 50Cs) received by the Sheriff's Department in 2022 (n = 6,773), and five provided the number of DVPOs served by the Sheriff's Department that year (n = 5,428).

Client-level Service Need Findings. Each of the centers selected a timeframe in which to pilot test the service navigation log that anonymously tracked services needed and received among clients coming to the center during the selected time period. Across centers' pilot periods, 760 logs were completed. The number of service logs completed by each center ranged from 27 to 284, and these differences in the number of logs completed reflect the size of the center, typical center census (i.e., how many clients a center sees in a given week), and the length of the pilot testing period (e.g., 3 weeks vs. 6 weeks). Table C2.1 in Appendix C2 presents visit information. Most of the visits were either initial visits (n = 320) or returns for services (n = 309), and a smaller number of visits were for scheduled appointments (n = 141). The vast majority of services requested during the pilot phase were for domestic violence (n = 550), followed by stalking (n = 170), child abuse or neglect (n = 69), sexual assault or abuse (n = 54), and elder abuse or neglect (n = 24). These findings were consistent across centers, depending on the services available at the center. In addition, nearly all visits were completed in person; however, one of the six centers routinely provided both remote and in-person options for engagement.

Tables C2.2 and C2.3 in Appendix C2 present findings on requested services and service provision (i.e., whether provided by the navigator, onsite partner, or offsite partner), respectively. Across the 760 visits, the top five services requested were information about options and resources (n = 448), safety planning (n = 313), crisis counseling and emotional support (n = 226), assistance completing a 50B protective order for themself (n = 225), and case coordination and partner follow-up (n = 146). Of these top five services and supports, nearly all were addressed onsite by either the center navigator or an onsite partner. For example, of the 313 visits pertaining to safety planning, 201 were addressed by a center navigator, and 148 were addressed

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by another onsite partner. This pattern of addressing service requests by either the center navigator or another onsite partner (as opposed to offsite partners) was consistent across service types (see Table C2.3 in Appendix C2).

Across service types, there was some variation in whether the service was addressed by a center navigator, onsite partner, or offsite partner (see Figures C2.1 through C2.8 in Appendix C2). For example, center navigators addressed 98% of requests for danger assessments and 87% of requests for information about options and resources (see Figure C2.1 in Appendix C2). On the other hand, 71% of requests for assistance completing a 50B protective order for the client, 62% of requests for assistance completing a 50B protective order for the child, 80% of requests for escorts to court, and 69% of requests for following up on a reported incident were addressed by co-located partners, namely court and law enforcement (see Figures C.2.2, C2.3, and C2.6 in Appendix C2). The responsibility of addressing certain service requests (e.g., crisis counseling, housing services, child protective services reporting, care coordinating, parenting support) appeared to be shared by either the center navigator or an onsite partner.

Summary and Limitations of Demand and Dose Findings. In terms of service demand, most visits were for domestic violence, and of those, most clients sought information about their options and requested safety planning and crisis support. These trends were consistent across centers. In terms of the dose of the services—meaning the degree to which service demands were met by center personnel—nearly all service needs were addressed onsite by a center navigator or an onsite partner. This pattern of addressing needs onsite was largely consistent across centers and is aligned with the core elements of the model.

In terms of limitations, there was wide variation in the aggregate data collected from partners, including whether or not the data were available, how the indicators were defined, and how the data were aggregated (e.g., combining DV calls with SV calls versus reporting on both call types separately). Consequently, interpreting aggregate data across centers has limited value. However, using this type of data collection longitudinally for one agency may be useful as long as the data collection methods and definitions are held constant over time.

Although the service navigation log was a more direct assessment of clients' needs and more straightforward to interpret, comparisons across centers should not be made given variations in both the centers' typical census and the length of the pilot period. Additionally, using service requests as a measure of client needs has significant limitations. Specifically, people tend to seek services if they know a service is provided by an organization. Consequently, lower numbers of service requests for a specific type of service may also indicate that community members may not know the service is available. Lastly, demand and dose are indicators of services sought and received and should not be conflated with measures of effectiveness or quality.

4.1.2. Adaptive Fidelity. To examine adaptive fidelity, the research team used two data collection activities. The first was a collaboration survey that examined characteristics of co-location and relationships between partner agencies to describe collaboration across centers, which was identified as the core function of the co-located model. The adaptive fidelity self-assessment focused on examining variation in the activities of the model (i.e., adaptation),

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including co-located partners, services and supports, and infrastructure or processes across centers.

Partner Collaboration Findings. Table C3.1 (Appendix C3) presents findings on co-location characteristics. A majority of all respondents reported either having a designated private office at the center or designated desk space; however, designated space varied by center, with 29% of respondents from one center reporting having a private space compared to 70% of respondents from another center. Other forms of co-location involved sharing space with other co-located partners (17%, $n = 20$) or finding a space upon arrival (17%; $n = 20$). In terms of time spent onsite at the center, 43% ($n = 51$) reported that they spent 25% of their time or less onsite, 37% ($n = 44$) reported that they spent at least 75% of their time onsite, 9% ($n = 11$) reported spending 26% to 50% of their time onsite, and another 9% ($n = 11$) reported spending 51% to 75% of their time onsite. This pattern was consistent across centers except for one where 71% of respondents reported spending less than half of their time onsite, and over a quarter reported at least 75% ($n = 5$) of their time spent onsite.

The findings of the Partnership Assessment Tool are shown in Table C3.2 (Appendix C3). Respondents showed high endorsement of most activities, with highest average scores as follows: organizing partnership activities ($M = 4.07$; $SD = 1.02$); providing orientation for partners ($M = 4.01$; $SD = 0.93$); combining perspectives, resources, and skills of partners ($M = 3.99$; $SD = 1.01$); coordinating communication among partners ($M = 3.97$; $SD = 1.06$); and recruiting diverse people and organizations into the partnership ($M = 3.96$; $SD = 0.94$). These patterns of endorsement were consistent across centers with no notable differences. Table C3.3 (Appendix C3) presents findings on the perceived benefits and drawbacks of partnership in the co-located center. Respondents indicated the ability to have a greater impact than you could on your own (71%, $n = 85$), development of valuable relationships (71%, $n = 85$), the ability to address an important issue (70%, $n = 83$), and enhanced ability to meet the needs of clients (69%, $n = 82$)as benefits of collaboration. Fewer respondents endorsed the drawbacks of the partnership, and those that were endorsed appeared to be center-specific. For instance, reports of aggravation and frustration, insufficient credit given to contributing to accomplishments, and conflict between job and partnership work varied across centers.

Organizational-level analyses (i.e., the unit of analysis is the organization and not the respondent) were used to examine how knowledgeable partners were about the services that other co-located partners provided, ranging from *Not at all* (1) to *Extremely* (5). Across centers, respondents' average self-report score of their knowledge about center partners was 3.82 ($SD = 1.05$), and these average scores ranged by the center from 3.68 ($SD = 1.26$) to 4.61 ($SD = 0.58$). Respondents were also asked to rate how confident they were in their ability to make appropriate referrals to partner organizations at their center using a scale from *Not at all* (1) to *Extremely* (5). Across centers and partners, the average score was 3.94 ($SD = 1.17$), and these average scores ranged by center from 3.68 ($SD = 1.31$) to 4.87 ($SD = 0.37$). These findings are presented in Table C3.4 (Appendix C3).

Findings about communication, guidance, and trust are presented in Table C3.5 (Appendix C3). Respondents were asked to report on their frequency of communication within the last 3 months with each of the partners in their center on a scale ranging from monthly or less (1) to almost

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daily (4). Across centers and partners, the average self-report score was 2.29 (*SD* = 1.03), indicating weekly to biweekly communication with partners, and these scores ranged across centers from 2.17 (*SD* = 1.05) to 2.52 (*SD* = 0.84). Of those who had communicated with a given partner within the last three months, partners reported that they received guidance from other partners on a biweekly basis (*M* = 2.08; *SD* = 1.04), and these scores ranged slightly from biweekly (*M* = 1.94; *SD* = 1.06) to biweekly or weekly (*M* = 2.52; *SD* = 0.85). Across centers, partners reported giving other co-located partners guidance on a biweekly basis (*M* = 2.00; *SD* = 1.00), and this average ranged across centers from biweekly (*M* = 1.86; *SD* = 0.94) to biweekly or weekly (*M* = 2.61; *SD* = 0.73). Lastly, based on a scale from 1 to 6, respondents were asked to rate their trust that partner organizations would respond to survivors in ways that make them feel supported. On average and across centers, partners' scores were 4.99 (*SD* = 0.99), and these scores ranged from 4.71 (*SD* = 1.10) to 5.40 (*SD* = 0.75). Notably, higher average scores on trust also had a smaller standard deviation, indicating consistently higher scores across respondents, compared with larger standard deviations for the lower average scores, indicating potential outliers among respondents.

Adaptive Fidelity Self-Assessment Findings. Table C4.1 (Appendix C4) shows the partners co-located across the various centers. Core partners co-located in all the centers include domestic violence advocates and some type of law enforcement personnel (i.e., police department personnel and/or sheriff's office personnel). Although not co-located in all the centers, common partners include mental health professionals and civil legal service providers. Variation in co-location exists among other types of partners such as rape crisis advocates, human trafficking advocates, medical personnel, district attorneys and civil attorneys, victim-witness program personnel, domestic violence shelter staff, social service agency staff members, and child welfare agency social workers. None of the centers reported having city or county public assistance workers co-located in their center.

Table C4.2 (Appendix C4) reports on participants' perceptions of how essential it is for different partners to be co-located in centers serving IPV/SV survivors, as well as their perceptions on whether the way these partners are co-located (e.g., part-time, full-time) can vary across centers and still be effective. Over 75% of participants found the following partners' co-location to be extremely essential/essential to ensuring center effectiveness: rape crisis advocates, domestic violence advocates, human trafficking advocates, police department personnel, sheriff's office personnel, district attorney and city attorneys, victim-witness program personnel, child welfare agency social workers, mental health professionals, and civil legal service providers. Nonetheless, participants shared that the way partners co-locate can vary, particularly for medical personnel, district attorneys and city attorneys, victim-witness program personnel, domestic violence shelter staff, social service agency staff members, county health department staff, city or county public assistance workers, and mental health professionals.

Table C4.3 (Appendix C4) presents the various co-located services and supports available across the partnering centers. All of the centers reported having the following co-located services: information about options and resources, danger assessments and/or strangulation assessment, photo documentation of visible injury, case coordination, safety planning, assistance completing 50Bs and 50Cs, victim's compensation applications, address confidentiality program, violence prevention education and outreach, court preparation and accompaniment, protection order

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referral for representation, crisis counseling/emotional support, mental health counseling, and peer-support or support groups.

As presented in Table C4.4 (Appendix C4), most services were identified as extremely essential or essential. Of those, there were three services identified as "extremely essential" by 10 of the 11 participants: information about options and resources, danger assessments and/or strangulation assessment, and safety planning. Two services were identified as "extremely essential" by only five participants: medical care and guardianship/power of attorney. Moreover, the majority of participants reported that the way medical care, guardianship/power of attorney, parenting support resources, immigration services, and human trafficking services are co-located can vary across communities and still be effective. Additional information about perceptions of essential services and variation is listed in Table C4.4 (Appendix C4).

Table C4.5 (Appendix C4) presents the infrastructure and processes implemented across the partnering centers. All or most of the centers had the following infrastructure and processes: central location, centralized intake process, collaborative infrastructure with cross-agency leaders, MOU or memoranda of agreement (MOA), and regular partner meetings. Table C4.6 (Appendix C4) shows that the infrastructure and processes perceived as extremely essential/essential included capacity-building activities across partners, central location, centralized intake process, client navigation by a designated person, collaborative infrastructure with cross-agency leaders, confidentiality agreements between co-located partners, MOU or MOA, high-risk lethality teams, regular partner meetings, and a VOICES committee of client-survivors. Notably, participants also reported that the way various infrastructure or processes—whether led by county government or a non-profit, partner capacity building activities, shared calendar, and shared database—are implemented can look different across communities and still be effective.

Summary and Limitations of Adaptive Fidelity Findings. Although centers varied in the types and number of partners that were co-located at the center, there was overall consistency in the types and comprehensiveness of services provided. This is true even among centers with fewer partners onsite and suggests that center staff and onsite partners fill a variety of roles. Across co-located partners, co-located services, and infrastructure, there was some conflicting information for various items. For example, one person from a center may report that a forensic exam is not a co-located service, whereas another person from the same center may report that it is. It is unclear why these discrepancies occurred, but the emergence of differences in perspectives is a relevant finding.

There was wide variation in how partners co-located at the centers, including part-time and full-time co-location, whether the partner had designated desk space or a private office, and how much time they spent co-located, with most participants reporting either 75% or more of their time or 25% or less of their time. A majority of the participants saw the value and benefits of collaboration and partnership, and few reported drawbacks. There was wider variation across centers in terms of frequency of communication and providing and receiving guidance from partners and some variation in participants' degree of trust that a partner organization would be supportive in response to clients' needs. Although there is significant consistency in services offered, there is wider variation in the co-located partners at the center and the relationships

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between organizations. Understanding how model effectiveness varies with partner co-location, service adaptations, and collaborative relationships is outside the scope of the study, but it presents an opportunity for future research and evaluation. Collaboration is a critical component of the model and is measurable and modifiable. Consequently, if collaboration is linked to model effectiveness, the quality of collaboration itself can be a target for intervention. Additionally, tools like the collaboration survey used for this study can be used longitudinally, and these results can identify organizational and center-based strategies for enhancing partnerships.

In terms of limitations, it is important to note the degree to which a service seemed essential or modifiable was based on individual perspectives and could be influenced by their opinions about their own model (i.e., biased perspective) and a reluctance to suggest that services provided at the center may not be essential to the model. Consequently, there may be an inflation of services that participants deem essential to the model, evidenced by the high number of endorsements for each service type. Additionally, perceptions of essentialness are up to the participant to define. There could be varying degrees of how essentialness was conceptualized. Likewise, the question about whether a service can look differently across centers and still be effective was broad and could include any adaptation.

Lastly, the sampling frame is sensitive to bias—centers provided a list of partners based on who they believe is core to the functioning of the partnership. How the center selected the sample can impact the findings in a number of ways. First, centers could cast a wide net and include a number of partners and their staff members who are integrally involved and marginally involved. Thus, elements of the survey, such as trust, may be harder to assess among those peripherally involved. Likewise, it is possible that partners were more selective in choosing who to include and could have limited to those who were deemed “close” or trusted, which may impact scoring.

4.2 Client Outcome Findings

A total of 41 clients enrolled in the study and completed the timepoint 1 (TP1) survey at baseline. Enrolled participants were seeking services at one of five co-located centers partnering with the research team on this activity. Of these 41 enrolled participants, 28 (68.3%) completed the timepoint 2 (TP2) 3-month follow-up survey, and 24 (58.5%) completed the timepoint 3 (TP3) 6-month follow-up survey. At all three timepoints, the majority of surveys were completed in English (TP1 = 95.1%; TP2 = 96.4%; TP3 = 95.8%).

4.2.1 Service Needs. Table C5.1 (Appendix C5) presents findings related to participants’ service needs. Examination of participants’ reported needs over time demonstrated a statistically significant increase from TP1 to TP2 in the percentage of participants reporting a need for seasonally appropriate clothing or shoes (TP1: 34.6.%, TP 2: 61.5%, $p < 0.05$) and personal hygiene items (TP1: 32.0%, TP2: 60.0%, $p < 0.05$), From TP1 to TP3 for dental care needs (TP1: 10.5%, TP3: 47.4%, $p < 0.05$), and from TP1 to TP2 and TP1 to TP3 for medical care needs (TP1: 15.4%, TP2: 38.5%, $p < 0.05$; TP1: 15.0%, TP3: 50.0%, $p < 0.05$). There was a statistically significant decrease from TP1 to TP2 in the percentage of participants reporting a need for help filing criminal charges (TP1: 28.0%, TP2: 8.0%, $p < 0.05$) and someone to go with them to court (TP1: 45.8%, TP2: 8.3%, $p < 0.01$). Further there was a statistically significant decrease from TP1 to TP2 and from TP1 to TP3 in the percentage of participants reporting a need to speak with an advocate or crisis counselor about their situation and available options/services (TP1: 88.9,

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TP2: 44.4, $p < 0.01$; TP 1: 85.0%, TP3 = 35.0, $p < 0.05$), personal safety (TP1: 85.2%, TP2: 40.7%, $p < 0.01$; TP1: 80.0%, TP3: 35.0%, $p < 0.05$), safety of their child(ren) (TP1: 64.0%, TP2: 36.0%, $p < 0.05$; TP1: 65.0%, TP3: 30.0%, $p < 0.05$), and obtaining a restraining order for themselves (TP1: 65.4%, TP2: 19.2%, $p < 0.01$; TP1: 55.0%, TP3: 15.0%, $p < 0.05$). When examining need composites using sum scores for different categories of need, there was a statistically significant decrease from TP1 to TP2 and TP1 to TP3 in the average number of reported IPV and SV needs (TP1: $M = 3.31$, TP2: $M = 1.85$, $p < 0.01$; TP1; $M = 3.14$, TP3: $M = 1.52$, $p < 0.01$) and law enforcement and legal needs (TP1: $M = 2.27$, TP2: $M = 0.73$, $p < 0.01$; TP1; $M = 2.20$, TP3: $M = 0.90$, $p < 0.05$), and an increase from TP1 to TP3 in medical needs (TP1; $M = 0.50$, TP3: $M = 1.35$, $p < 0.05$).

There were no statistically significant differences across timepoints in whether participants received help from the center for their reported needs or their level of satisfaction with the support provided by the center. Notably, there were few participants who responded to each of these questions given survey logic (i.e., participants only reported on help received for identified needs, and participants only reported on satisfaction for needs being addressed by the center).

4.2.2 Perceptions of Center and Staff. Table C5.2 (Appendix C5) presents findings related to participants' perceptions of the center and staff, with higher scores representing more positive perceptions. There were statistically significant decreases from TP1 to TP2 and from TP1 to TP3 in participants' average responses to the following statements: staff offered choices (TP1: $M = 3.76$, TP2: $M = 3.40$, $p < 0.05$; TP1: $M = 3.75$, TP3: $M = 3.42$, $p < 0.01$), and staff believed that decisions about my life were mine to make (TP1: $M = 3.80$, TP2: $M = 3.40$, $p < 0.05$; TP1: $M = 3.79$, TP3: $M = 3.42$, $p < 0.05$). There were statistically significant decreases from TP1 to TP3 for the statements: I was easily able to access services I need (TP1: $M = 3.54$, TP3: $M = 3.21$, $p < 0.05$), the services I received helped me make decisions about my next steps (TP1: $M = 3.63$, TP3: $M = 3.17$, $p < 0.01$), I felt safe at the center (TP1: $M = 3.83$, TP3: $M = 3.58$, $p < 0.05$), I felt respected by staff (TP1: $M = 3.87$, TP3: $M = 3.61$, $p < 0.05$), and I feel like my confidentiality was honored by staff (TP1: $M = 3.83$, TP3: $M = 3.58$, $p < 0.05$). Despite these decreases over time, both TP2 and TP3 participants' average responses ranged between agree and strongly agree.

4.2.3 Experiences of Victimization, Impact, and Injuries. Findings related to participants' experiences of IPV and SV victimization are presented in Table C5.3 (Appendix C5). Participants demonstrated a statistically significant decrease from TP1 to TP2 and from TP1 to TP3 in the average number of reported incidents of psychological IPV (TP1: $M = 11.14$, TP2: $M = 2.07$, $p < 0.001$; TP1: $M = 10.38$, TP3: $M = 1.92$, $p < 0.001$), stalking (TP1: $M = 8.18$, TP2: $M = 1.64$, $p < 0.01$; TP1: $M = 8.29$, TP3: $M = 1.38$, $p < 0.01$), any IPV (TP1: $M = 33.29$, TP2: $M = 9.21$, $p < 0.001$; TP1: $M = 31.88$ TP3: $M = 9.13$, $p < 0.001$), and any IPV or SV (TP1: $M = 33.61$, TP2: $M = 9.54$, $p < 0.001$; TP1: $M = 31.92$, TP3: $M = 9.21$, $p < 0.001$). There was also a statistically significant decrease from TP1 to TP2 in financial IPV (TP1: $M = 6.86$, TP2: $M = 1.79$, $p < 0.05$), and from TP1 to TP3 in physical IPV (TP1: $M = 3.21$, TP3: $M = 0.50$, $p < 0.05$). There were no statistically significant differences across time related to injuries or health conditions sustained as a result of participants' victimization experiences.

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4.2.4 Sense of Safety. Table C5.4 (Appendix C5) presents findings related to sense of safety, with smaller scores representing a greater sense of safety. There were statistically significant improvements from TP1 to TP3 and from TP 2 to TP3 in participants' average responses to the following statements: I have a good idea about what kinds of support for safety that I can get from people in my community (TP1: $M = 2.58$, TP3: $M = 2.00$, $p < 0.05$; TP2: $M = 2.64$, TP3: $M = 1.95$, $p < 0.01$); community programs and services provide support I need to keep safe (TP1: $M = 2.82$, TP3: $M = 2.41$, $p < 0.05$; TP2: $M = 3.20$, TP3: $M = 2.35$, $p < 0.01$); and overall, I feel safe (TP1: $M = 2.67$, TP3: $M = 1.96$, $p < 0.01$; TP2: $M = 2.59$, TP3: $M = 1.91$, $p < 0.01$). There were also statistically significant improvements from TP1 to TP3 and from TP2 to TP3 in participants' scores on the internal tools subscale (TP1: $M = 2.57$, TP3: $M = 2.24$, $p < 0.01$; TP2: $M = 2.53$, TP3: $M = 2.18$, $p < 0.05$), the expectations of support subscale (TP1: $M = 2.59$, TP3: $M = 2.24$, $p < 0.05$; TP2: $M = 2.69$, TP3: $M = 2.15$, $p < 0.05$), and the overall sense of safety scale (TP1: $M = 2.56$, TP3: $M = 2.24$, $p < 0.01$; TP2: $M = 2.50$, TP3: $M = 2.19$, $p < 0.05$).

4.2.5 Sense of Hope. Table C5.5 (Appendix C5) presents findings related to participants' sense of hope, with higher scores representing a greater sense of hope. There were statistically significant increases from TP1 to TP3 and TP2 to TP3 for participants' average responses to the following statement: I meet the goals that I set for myself (TP1: $M = 5.58$, TP3: $M = 6.21$, $p < 0.05$; TP2: $M = 5.45$, TP3: $M = 6.27$, $p < 0.05$). There were also significantly significant improvements from TP1 to TP3 for the statement indicating that participants have been pretty successful in life (TP1: $M = 5.67$, TP3: $M = 6.13$, $p < 0.05$), and from TP2 to TP3 for the statement indicating there are lots of ways around any problem (TP2: $M = 5.68$, TP3: $M = 6.45$, $p < 0.05$) and participants' average hope scale scores (TP2: $M = 45.50$, TP3: $M = 49.91$, $p < 0.05$).

4.2.6 Client Outcome Summary. Participants had positive perceptions and experiences receiving services at the centers. Overall, participants felt safe at the center and believed the services were helpful and easy to access. Additionally, participants believed that the staff offered choices, were respectful, honored their confidentiality, and believed that decision-making belonged to the client. Participants also reported changes in their needs from intake to follow-up, including an increase in basic needs (e.g., clothing, shoes, personal hygiene items) and medical needs (e.g., medical and dental care), and a decrease in law enforcement needs (e.g., help filing criminal charges; help with divorce, custody, or will; court accompaniment) and IPV/SV needs (e.g., advocacy, safety, restraining order). Despite the decrease in IPV/SV needs, about a third of participants reported still having IPV/SV-related needs at their 6-month follow-up.

In addition, participants reported improvements in their experiences of violence victimization, sense of safety, and sense of hope. Participants demonstrated decreases in their experiences of physical IPV, psychological IPV, financial IPV, stalking, any IPV, and any IPV or SV. Whereas statistically significant changes in financial abuse were evident between baseline and 3-month follow-up, significant decreases in physical IPV were not apparent until 6-month follow-up. These findings suggest that it might take longer to experience changes in experiences of physical IPV victimization. Participants also experienced continuous improvements in their perceptions of overall safety, internal safety tools (i.e., safety-related goals and confidence in one's ability to reach those goals), and expectations of support (i.e., belief one has the support needed to increase safety) from baseline to 3-month follow-up and from 3-month follow-up to 6-month follow-up,

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as well as an increase in their overall sense of hope from 3-month follow-up to 6-month follow-up.

Findings from this activity should be considered in light of limitations, including relatively small sample size and attrition across time points. Moreover, sample sizes for each center and for specific variables were too small to allow for statistical comparisons and analyses. Self-selection—at the time of enrollment and each subsequent follow-up—is another important consideration, as there might be meaningful differences between those clients who participated in the study and completed surveys and those who did not (e.g., differences in violence victimization, severity, needs, safety). Other limitations include the number of statistical analyses employed (i.e., the potential increase in Type 1 error) and the lack of a comparison group. Despite these limitations, the client outcome activity demonstrated the research team's ability to recruit and follow up with clients in crisis seeking services from a co-located center. Moreover, preliminary findings from this exploratory activity suggest that the partnering co-located centers were perceived positively by clients, and clients experienced improvements in violence victimization, safety, and hope.

4.3 Lessons Learned and Feasibility Focus Group Findings

This section on feasibility is informed by overall lessons learned as well as findings from focus groups with leaders and key contacts at our partnering centers.

4.3.1. Overall Feasibility. Overall, partnering centers found the formative evaluation to be feasible. Factors that enhanced the formative evaluation's feasibility included being flexible (e.g., adapting timelines based on center needs), engaging in ongoing communication with partnering centers, trying to minimize burden (e.g., traveling to partnering sites, sending calendar invites for meetings), modeling various research activities after existing center practices, and starting the formative evaluation with an onsite activity. In terms of challenges, partnering center leaders and contacts felt the formative evaluation was overwhelming at first, given the difficulty of understanding the multiple research activities. Additional challenges included (1) the timing and duration of the various activities (e.g., gaps between research activities, multiple activities occurring at the same time), (2) leadership and staff capacity (e.g., staff burden, change in leadership, staff turnover, staff on leave), and (3) the unpredictability and nature of crisis work. Further, centers in earlier stages of implementation experienced more difficulty fully participating in all of the formative evaluation activities.

Recommendations for enhancing the overall formative evaluation included engaging in efforts to increase center staff and partner buy-in in the evaluation early on in the process. In these efforts and throughout, it is critical to provide clear information about the formative evaluation, research activities, and participation. Strategies for improving communication included creating a centralized place to store project information for all partnering centers, using different communication strategies, offering monthly check-ins, and sharing an overarching figure depicting the project phases, activities, and timeline. It would also be helpful to consider shortening some of the activity durations. Presented below are lessons learned and findings regarding the feasibility of the specific formative evaluation.

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4.3.2. Annual Programmatic Data. Centers provided aggregate annual programmatic data for many of the center, service, and criminal legal system indicators. Notably, there was more complete data for indicators related to center outreach and education, crisis calls, advocacy, shelter, mental health services, legal referrals, DVPOs, and law enforcement related to DV. Information on indicators already being tracked by the centers or their partners (particularly if based on similar reporting calendars) was more easily attained by the research team. Additional facilitators included center staff dedicated to data management, activity information, and troubleshooting provided by the research team.

Several challenges were identified pertaining to this research activity. Some of the requested data was not easily accessed. For example, data on indicators related to sexual violence cases (e.g., SV crisis calls and advocacy, law enforcement related to SV), SANE, court cases, charges, and legal support were more difficult to obtain. Potential reasons include determining who holds the data, staff transitions, timing of the data request (e.g., courts were changing their filing system), specificity of the requested data, lack of timely responses from partners, and discomfort or concerns related to sharing data. Another challenge was inconsistency in the manner in which indicators were defined and operationalized across centers. Therefore, even if two centers reported information on the same indicator, it is possible that the data are not directly comparable. For some indicators (e.g., patients examined by partnering Nurse Examiner), centers provided data specific to their center clients; however, others also included information for partner clients that may not have been seen as part of their center model. Moreover, missing data could represent various different scenarios, including the data being unavailable because (a) the center does not include the related partner (e.g., legal partner, SANE partner), (b) the data were not available or collected, and/or (c) the data are available but were not reported by the center or their partner.

Future efforts to gather aggregate annual programmatic data across centers, particularly centers within a particular state, could benefit from several recommendations. This activity identified the benefit of focusing on indicators already being collected by centers or their partners. Therefore, it may be helpful to collaborate with all partnering centers in advance to develop data collection positions, tools, processes, and infrastructure that would allow centers and their partners to collect such information as part of typical operations. This would allow for clarification and consistency across centers in terms of how indicators are defined and operationalized. Another recommendation would be to make use of existing state-level data. For example, a research team could partner with the Administrative Office of the Courts (AOC) to obtain and analyze relevant court-level data for counties served by co-located centers.

4.3.3. Client-Level Service Need. A key challenge to collecting client-level service need data using the study-developed service navigation log (SNL) was the staff's capacity to engage in this activity in the context of crisis work. Notably, this was the most time-intensive formative evaluation activity for center staff. Given the nature of crisis work, staff, at times, forget to complete the SNL or would be too busy to complete it at the moment and would have to complete it later in the day. Research partners indicated that although they hoped this activity would provide the opportunity to pause and reflect, there was limited capacity to use the activity and related data for internal review and reflection. Research partners also identified challenges related to the SNL tool itself, including (1) unclear service need categories and provision options,

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(2) the lack of consistency between the SNL and center records made it difficult to complete the tool at a later time, and (3) a desire for the tool to include identifiable information to use for the purpose of service delivery and quality assurance. Despite these challenges, a number of factors enhanced the feasibility of this research activity, including efforts of the research team to clarify the activity and ease the burden (e.g., dropping off/picking up the SNLs and lock boxes, facilitating meetings/training with leadership and staff, providing flexibility regarding the process for completing the SNLs). Several research partners appreciated the SNL instructions and definitions page and found the tool to be user-friendly (e.g., categories were easy and helpful). Additional facilitators identified by research partners included keeping the logs in an accessible location and checking in with staff to remind them to complete the SNLs. Recommendations for future evaluation efforts include adding completion of the SNL to staff checklists, shortening the duration of the SNL implementation period (e.g., one week), revising the SNL for clarity (e.g., having a key for the different service categories with examples), considering ways to collect information on timing and duration of service delivery, providing additional training and technical assistance support, and identifying additional ways the SNL activity could be mutually beneficial for the research team and partnering centers.

4.3.4. Partner Collaboration. Several challenges were identified pertaining to the staff collaboration survey research activity. Throughout the process of participant recruitment and based on partner feedback, it became evident that the sampling frame was unclear. The sampling frame was developed by inviting partnering site leadership to identify staff and core partners to participate in the collaboration survey, but it was not always clear to our partners who exactly should complete the survey. Further, some potential participants invited to complete the survey were confused about the request and unsure about whether they should participate, given their role and relationship to the center. Another challenge pertained to the survey itself. Notably, the survey included minimal open-ended questions or response options and did not include a "not applicable" category, making it challenging for participants to answer questions about unfamiliar partners. Further, some survey participants who worked at multiple centers found it difficult to respond to the multiple centers separately. Participation was also identified as a challenge. Some of our research partners shared that despite the collaboration survey being implemented during a typically less busy time of the year, staffing issues (e.g., staff transitions and turnover, staff on leave) impacted their center's capacity to participate fully in this activity. Some of our research partners also shared concerns about limited responses from their external partners, particularly since they could not easily walk across the office to remind these colleagues to complete the survey.

Although there were challenges related to this activity, there were also facilitators that made implementation and participation easier for our partnering centers. Facilitators identified by our research partners included: (1) elements of the data collection protocol (e.g., working directly with the center coordinator to implement the collaboration survey, having centers email their partners about the collaboration survey in advance of the research team's recruitment email and providing related language, sending reminders, having a set deadline, offering opportunities for troubleshooting), (2) the online nature of the survey (i.e., clear and easy to complete at one's own convenience), (3) the center having strong relationships with their partners, and (4) the activity offering an opportunity to pause and reflect.

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Recommendations for enhancing this data collection activity for future evaluation efforts include (1) enhancing clarity regarding the sampling frame and ensuring it is comprehensive and inclusive of all relevant center staff and partners, (2) revising the survey to incorporate more open-ended questions and "not applicable" response options, and (3) combining the survey for staff who work across multiple centers. For centers that engage in regular evaluation activities, it would be helpful to integrate the collaboration survey with other existing staff surveys and to consider the frequency of survey administration (e.g., every other year).

4.3.5. Adaptive Fidelity Self-Assessment. Initially, our team had planned to examine adaptive fidelity by inviting center directors and partner lead representatives to complete the study-developed adaptive fidelity self-assessment tool and participate in a guided group assessment process. However, to reduce the burden and enhance feasibility, this activity was modified to invite only the center directors and key formative evaluation contacts at each partnering site to complete the adaptive fidelity self-assessment survey online. Although our research partners identified potential limitations of this modification (e.g., fewer participants and responses, limited ability to introduce new topics and ideas to the larger group, less immediate impact), they also identified numerous benefits (e.g., reduced burden, online survey is more accessible, challenging to schedule group meetings, participants had the necessary knowledge to complete the survey for their center).

Nonetheless, several challenges pertaining to this research activity were identified. For example, some research partners felt the survey was repetitive, whereas others noted that the response options and survey format could be challenging depending on the center's model (e.g., centers with multiple locations and centers with fewer onsite partners). Notably, some research partners felt the survey was straightforward and applied to a variety of co-located center models. Recommendations for future evaluation efforts include (1) revising the adaptive fidelity self-assessment survey to include more open-ended questions, (2) combining the survey for staff who work across multiple centers or center locations, and (3) expanding the sampling frame to gather multiple perspectives on the center model.

4.3.6. Client Outcome Survey. This study identified facilitators and challenges for both partnering centers and clients pertaining to the client outcome survey research activity. Elements that enhanced feasibility for the partnering centers involved scheduling data collection days with the research team, clear eligibility criteria, and a recruitment process that modeled the existing service process (i.e., asking the client if they would like to speak with a member of the research team, and if yes, then bringing the member of the research team to the client), and overall posing a low burden on center staff. However, challenges included staff buy-in and support, limited space for onsite data collectors, capacity for participating in this research activity (e.g., staff turnover, staff on leave), remembering to recruit, and the unpredictability and nature of crisis work (e.g., fast-paced, difficulty predicting on which days they will serve more clients, slow year for one center), and center model (e.g., appointments only). Factors that enhanced feasibility for clients included having onsite, bilingual data collectors and compensating clients for their participation, whereas challenges included data collectors not always being on-site, data collection only being available in English and Spanish, and eligibility requirements excluding some interested clients. Moreover, the initial visit to a co-located IPV/SV center can be stressful

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and overwhelming, leading some clients to be too exhausted or rightfully concerned with more pressing needs to engage in this research activity.

Recommendations for enhancing this activity in future research include (1) engaging center and advocacy staff early on to build buy-in and support and address any concerns, (2) using existing center data to schedule onsite data collection on potentially busier days, (3) problem solving around space availability for onsite data collectors and enhancing data collectors' onsite visibility, (4) continuing client compensation and increasing language capacity, and (5) considering additional options for baseline survey completion (e.g., incorporating survey into center intake, not requiring clients to complete the baseline survey in-person at the time of their initial visit).

4.3.7. Feasibility Summary. Overall, the formative evaluation was feasible as the six partnering centers involved in the formative evaluation were able to participate in all of the implementation activities and the client outcome activity. Key challenges focused on capacity, timing, duration, and the nature of crisis work. Nonetheless, participants recommended several strategies to enhance feasibility, including (1) fostering center, partner, and staff buy-in and support early on; (2) using flexible evaluation designs and data collection methods; (3) engaging in clear and ongoing communication using multiple strategies (e.g., meetings, phone calls, emails); and (4) minimizing data collection burden (e.g., model activities after existing practice and data, reduce the duration of data collection activities). Other recommendations included revising data collection tools to enhance clarity, including more comprehensive and open-ended response options (e.g., service navigation log, collaboration survey, adaptive self-assessment tool), and ensuring sampling frames are clear (i.e., participating centers have a clear understanding of who should be participating in each research activity) and include multiple perspectives (e.g., collaboration survey sampling frame, adaptive fidelity self-assessment sampling frame). Participants also recommended that staff involved in recruitment and data collection receive training and technical assistance support. Finally, participants recommended that client data collection include compensation (e.g., gift cards) and the capacity to offer data collection activities in multiple languages.

Feasibility focus group findings should be considered in light of several limitations. Only directors and key contacts at the partnering centers were invited to participate in these focus groups. It is possible that others involved in the various research activities—including partners, staff, and clients—may have had other perspectives regarding the feasibility of the formative evaluation activities. Notably, some of the participants shared the focus group questions with staff in advance and were able to solicit and incorporate their feedback into their focus group responses. Another limitation is that participants were asked to reflect back on activities that occurred months prior, with the retrospective nature of this activity likely impacting memory and recall. It is also possible that participants were not comfortable sharing more critical feedback directly with members of the research team. To address these concerns, focus group facilitators provided a summary of each activity, used prompts to help with recollection, and directly requested more critical feedback on challenges related to the formative evaluation and each of the specific activities. Additional strategies used to enhance rigor include having numerous team discussions regarding the codebook, involving multiple coders, conducting both inductive and deductive coding, memoing and leaving an audit trail and conducting negative case analysis.

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Further, the feasibility focus group findings were supplemented by lessons learned by the research team throughout the formative evaluation.

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Chapter 5: Key Takeaways

5.1 Observations about Model Implementation

5.1.1 It's not just *whether* a partner is co-located but *how*. If co-location (and, by extension, collaboration) is the key function of these centers, the form that this function can take may vary widely. Understanding how this variation impacts outcomes was outside the scope of this study. However, this is a relevant topic to explore, given the cost of space (either new construction or rented) and the degree to which potential partners would be able to co-locate a portion of their staff's time. For instance, if reserving space at a center for a designated number of hours each week is just as effective as having a designated office space for a full-time co-located partner, then centers may be able to rent or build smaller spaces and have fewer costs. However, this flexibility in the form co-location takes may only apply to certain partners and activities. For example, having access to 50Bs during all operating hours may be essential, and a full-time designated office may be necessary.

5.1.2 The number and type of co-located partners vary, but service offerings do not. Although the number of partners per center varied widely, the number and type of services that centers offered were consistent. This finding leads us to consider whether which partner is co-located is as important as what service is co-located. Consequently, it is possible that centers may choose to have a smaller number of co-located partners based on their local context, as long as the core services are provided onsite within a timely manner. Additional research needs to be conducted to determine whether there are differences between larger co-location models and smaller co-location models in terms of client outcomes, particularly when these models offer the same types of services.

5.1.3 Knowledge about co-located partners and referral processes should be consistently high. From a theoretical perspective, there was some unexpected variation in self-report regarding knowledge about other co-located partners and understanding of their referral processes. These findings suggest that co-location alone and the proximity to and collaboration with others may not be enough to foster knowledge about center partners, referral protocols, and related processes. There are additional factors that may impact individuals' sense of knowledge about co-located partners, such as the individual's length of time at the center, the comprehensiveness and complexity of a given center's model, variability in schedules of part-time co-located partners, and the number of co-located partner organizations and their staff. Given these findings, additional attention could be paid to managing the co-location partnership. This may be particularly relevant for large co-located centers that have more partnering organizations and/or more individuals co-located onsite. Further, given turnover rates among all partner types, an ongoing focus on building knowledge and reinforcing referral protocols is critically important, even among centers that have been established for several years.

5.2 Observations about Survivor Outcomes

For each of the observations below, readers should keep in mind the small sample size and the fact that clients came from different centers. Consequently, there are significant limitations in the degree to which these findings can be generalized to the co-located service model generally or to any one center specifically. Nevertheless, these findings represent trends that are important to consider.

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5.2.1 Centers should consider changes in clients' needs at different timepoints. One takeaway from the outcome evaluation findings is that clients' needs vary over time after the initial visit. These findings can provide useful information to centers about service priorities at the time of the first visit and then subsequently at follow-up. For example, knowing that a greater percentage of clients report a need for clothing and personal hygiene items within 3 months may help the center prepare for re-engaging at follow-up. This attention to differences in client needs at different timepoints also appears in the data pertaining to client perceptions of the center and staff. For most categories, there was a notable decrease in perceptions of staff and center (e.g., items related to self-efficacy and agency in the process, accessibility of services, and feeling like services helped survivor make decisions), with mean scores decreasing significantly from timepoint 1 to timepoint 2 or timepoint 3. Given the small sample size, generalizing this finding to any center or a specific service is not possible; however, it identifies an area for future consideration and examination.

5.2.2 Experiences of victimization declined significantly. Aggregated across centers, survivors reported a significant decline in physical, psychological, and financial IPV, as well as stalking. Further, any IPV or IPV/SV declined significantly both between Timepoint 1 and Timepoint 2 and between Timepoint 1 and Timepoint 3. Although these findings cannot be attributed to the co-location service model alone, this is a substantial finding and a promising trend, providing some evidence that timely access to services can reduce victimization. During these same time periods, survivors' self-reported sense of safety also improved. Given limitations in the design and the data, these findings warrant further examination with larger sample sizes.

5.2.3 Clients may be feeling more hopeful at follow-up. Between Timepoints 1, 2, and 3, survivors' sense of hope increased. Taking into consideration the findings that a sense of safety also improved during this same time period, this finding preliminarily suggests that a sense of safety and hope may be correlated. Centers that have not already adapted programming on hope and integrated this into foundational program components may consider doing so (despite the limitations in the study), given the potential for hope to be a protective factor in a survivor's healing journey.

5.3 Observations about Research and Evaluation

5.3.1 Engaging clients in research and evaluation during the intake period is feasible. Overall, the formative evaluation was feasible as the six centers were able to participate in client recruitment at the time of the initial visit, and external data collectors were able to enroll and complete baseline surveys with clients from five of the centers. Additionally, the research team was able to follow up with clients over six months, although there was some expected attrition. There were notable challenges to engaging clients in research and evaluation, including determining when the best time to approach the client within the overall flow of service delivery at the time of the visit. Additionally, the nature of survivor-centered crisis work means that any research and evaluation-related activities are secondary to the current needs of the client. Consequently, discretion should be used in how to approach clients about potentially engaging in research and evaluation. Additionally, centers should consider what data are being collected as part of routine practice and whether these data can be incorporated into an overall evaluation approach to reduce the direct burden on clients. Additionally, when selecting any data collection

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approach, centers and future evaluators should build on flexibility. For example, it may be possible for clients to complete a hard copy or web-based survey. Additionally, evaluators should consider whether the surveys must be completed at the time of service or whether they could be completed by the client after they leave the center. Overall, these considerations should balance the burden on the client and center with study rigor.

5.3.2 Collecting implementation-related data alongside outcome data is important. It is important to consider any outcome evaluation data alongside service and programmatic data pertaining to implementation. Although understanding whether a client's sense of safety or experiences of victimization improved is crucial, it is also important to collect service data. Collecting service-related data will provide important information about whether clients' needs are being met, what types of needs clients have, and what service gaps exist. Programmatic and service data can also provide information about the timeliness of access to services, a critical component of the co-located service model. These service-related outcomes can also be linked to outcome data in a larger-scale study that examines the relationship between service dose (i.e., the number and type of services received) and outcomes (e.g., sense of safety, hope, victimization). This type of analysis can provide valuable insights into how co-located service models impact client-level outcomes.

5.3.3 Resource-intensive challenges will hamper widescale rigorous evaluation. The purpose of this project was to determine the evaluability of co-located centers, particularly within the context of larger-scale rigorous evaluations that may aim to either compare across models or examine change in outcomes within a center. There are a number of factors that can inhibit this type of rigorous evaluation that should be considered from the outset. First, center partners and center staff should develop consistent definitions of terms, both in narrative and data form. Although fundamental to evaluation, this task is challenging given that each center partner represents a larger external organization with its own standards and definitions, some of which may be driven by legislation or funding sources. In cases where a single unifying definition may not be possible, centers, partners, and evaluators should define the terms their organizations must follow and specify how the data are operationalized and measured. For evaluations that seek to examine impact across centers or to compare outcomes of centers to, for example, standalone IPV/SV agencies, this challenge will be particularly important to address. In these cases, evaluators should follow the same recommendation to first clearly define terms and understand how existing data are collected. Another challenge is the lack of data integration. A majority of centers do not have an integrated database that includes partner data and center data. The lack of data integration creates a burden on agency partners when, for example, aggregate annual reporting is due. Having integrated data systems will not only allow for ongoing data collection and reporting but also aid in information sharing and care coordination. An integrated data system will also lead to better tracking of services requested, services provided, and client outcomes. A third challenge is the centers' capacity for evaluation and data collection activities. It is possible that some centers may have staff resources to assist with or lead evaluations. These centers will likely have an increased ability to collect, analyze, and interpret data, as well as develop and share reports. This capacity may suffice for routine program evaluation activities. However, enhanced resources will likely be needed for a large-scale rigorous evaluation that aims to compare models or rigorously assess the impact of a single model. Multi-site evaluations

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or research studies will require significant resources to engage centers, develop protocols, and use longer-term engagement time for collecting client outcome data.

5.3.4 Approaches, strategies, and conditions that can foster evaluation. Although there are various challenges to conducting a rigorous evaluation of co-located centers, there are a number of factors that can foster an environment for evaluation. First, evaluators should aim to reduce the burden on agency staff, clients, and any other partners who may be contributing to the data collection protocol. Strategies to reduce burden can include streamlining data collection methods to include multiple topics and questions into a single instrument, limiting the questions and topics to only those that are necessary, and building in flexibility to evaluation methods (e.g., adapting the length and duration of implementation activities, offering clients' options for data collection strategies). Additionally, including client incentives (e.g., gift cards) and research supports (e.g., childcare, transportation) may help to increase participation. Another factor that aids in evaluation is center engagement. Notably, all participating centers were interested and invested in the evaluation. Having this type of engagement from centers can help to make the evaluation successful and more feasible, assuming engaged partners are also providing input into the process. Lastly, having the evaluation completed by an external evaluator was helpful for some of the centers, particularly those who did not already have evaluation partners or designated staff to lead evaluation activities. In lieu of internal evaluators, it is possible for centers to engage academic partners to assist with program evaluation activities or consider contracting with a consultant. Options for engaging external evaluators will be dependent on center funding resources.

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List of Appendices

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Appendix A

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Appendix A1: List of Service Indicators

Service Indicator
• How many domestic violence protective orders were filed during 2022? • In 2022, how many cases were heard in court for each type of case: (a) Domestic violence, (b) Sexual assault, (c) Elder abuse, (d) Child maltreatment, (e) Other
• How many domestic violence calls did your law enforcement agency respond to in 2022? • How were these calls identified in the data? • How many domestic violence calls to your law enforcement agency resulted in charges being filed in 2022?
• How many rape/sexual assault calls did your law enforcement agency respond to in 2022? • Of the rape/sexual assault calls your law enforcement agency responded to, how many resulted in charges being filed?
• How many patients were examined by Nurse Examiners partnering with the co-located center in 2022?
• How many agencies and organizations did the agency provide domestic violence outreach and education to in 2022? • Approximately how many people were reached through these outreach and education efforts in 2022? • How many calls were received by the domestic violence crisis line in 2022? • How many clients received domestic violence advocacy services in 2022?
• How many victims of domestic violence and their children were housed in the domestic violence partner's shelter services in 2022? • How many shelter nights were provided in 2022? For the purposes of this study, shelter nights are defined as the number of nights clients stayed in the agency's emergency shelter program. If your agency does not have an emergency shelter program, please note that here. • How many nights in a hotel were provided for clients needing emergency shelter in 2022?
• How many agencies and organizations did the agency provide sexual violence outreach and education to in 2022? • Approximately how many people were reached through these outreach and education efforts in 2022? • How many calls were received by the sexual violence crisis line in 2022? • How many clients received advocacy services related primarily to sexual assault in 2022?
• How many clients were referred to the mental health agency by the co-located center in 2022? • Of those who were referred, how many clients received services?
• How many agencies and organizations did the co-located center provide outreach and education to in 2022? • Approximately how many people were reached through these outreach and education efforts in 2022? • How many victims did the co-located center serve in 2022?
• How many domestic violence cases were referred for legal support by the co-located center in 2022? • Of those referred by the co-located center, how many domestic violence cases were opened by the legal organization in 2022? • Of those referred by the co-located center and opened by the legal organization, how many domestic violence cases were closed?
• How many charges were processed in the following areas in 2022: (a) Child abuse, non-assaultive, (b) Child neglect, non-assaultive, (c) Domestic incidents, (d) Sex offenses (total)
• How many charges were processed for the following types of sex offenses in 2022: (a) Child molestations, (b) Crimes against nature/sodomy, (c) Indecent exposure, (d) Statutory underage, (e) Forcible rape
• How many law incident records with arrests for various domestic violence, sexual assault, child maltreatment, and elder abuse incidents occurred in 2022: (a) Child abuse, non-assaultive, (b) Child neglect, non-assaultive, (c) Domestic incidents, (d) Sex offenses (total)
• How many law incident records with arrests for different sex offenses occurred in 2022: (a) Child molestations, (b) Crimes against nature/sodomy, (c) Indecent exposure, (d) Statutory underage, (e) Forcible rape
• How many domestic violence protective orders were received by the Sheriff's Department in 2022? • Of the domestic violence protective orders received in 2022, how many were served?

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Appendix A2: Service Navigation Log

Instructions

Review the following definitions and instructions for each column and then complete the form for any client seen. Please do not include the client's name or any other identifying information about them. Be sure to include the center name, date, and the approximate time the client checked in and checked out. Once the form is completed, place it in the [specify by agency].

Information about the visit:

Point of entry: How did the client become connected to the Center (e.g., crisis line, walk-in, court)
Initial visit: Check this box if it's the client's first time visiting the Center (i.e., first time completing new client intake sheet).
Returned for continued services: Check this box if the client has returned for ongoing services.
Scheduled appointment: Check this box if the client has returned to complete a scheduled appointment with one of the onsite partners.
In-person: Check this box if the client is in-person (i.e., not connecting remotely via video or phone)
Remote/virtual: Check this box if the client is meeting via video or phone (i.e., not in person)
Services type requested: Check which category of services were requested includes any service the client has asked for.

Information about service needs and referrals:

Service requested: Check the box for any specific service that the client requested as part of this visit. If a staff member recommended a service and the client agreed to be connected, check that box as well.
Provided by navigator/intake specialist: Check the box if the navigator or intake specialist provided the service.
Onsite partner – provided: Check this box if the service was provided by a partner that was onsite during the client's visit.
Onsite partner – scheduled: Check this box if the service was scheduled with an onsite partner for a later date/time.
Onsite partner – referred: Check this box if the service was connected to an onsite partner to be scheduled for a later date/time.
Offsite partner – provided: Check this box if the service was provided by a partner that was offsite during the client's visit.
Offsite partner – scheduled: Check this box if the service was scheduled with an offsite partner for a later date/time.
Offsite partner – referred: Check this box if the service was connected to an offsite partner to be scheduled for a later date/time.

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Service Navigation Log								
Information About the Visit								
Center Name:			**Point of Entry:**					
Today's Date:			**Check-in Time:**			**Checkout Time:**		
☐ **Initial Visit** ☐ **Returned for Continued Services** ☐ **Scheduled Appointment**						☐ **In-Person** ☐ **Remote/Virtual**		
Service Type Requested: ☐ **Domestic Violence** ☐ **Sexual Assault/Abuse** ☐ **Child Abuse/Neglect** ☐ **Elder Abuse/Neglect** ☐ **Stalking/Harassment** ☐ **Other:**								
Information About Service Needs and Referrals								
Services	**Service Requested**	**Provided by Navigator/ Intake Specialist**	**Onsite Partner**			**Offsite Partner/ Resource**		
			Provided	**Scheduled**	**Referred**	**Provided**	**Scheduled**	**Referred**
Intake & Needs Assessment								
Information about Options and Resources	☐	☐	☐	☐	☐	☐	☐	☐
Danger Assessment	☐	☐	☐	☐	☐	☐	☐	☐
Strangulation Assessment	☐	☐	☐	☐	☐	☐	☐	☐
Photo Documentation of Visible Injury	☐	☐	☐	☐	☐	☐	☐	☐
Permission for High-Risk Case Review	☐	☐	☐	☐	☐	☐	☐	☐
Case Coordination – Partner Follow Up	☐	☐	☐	☐	☐	☐	☐	☐
Advocacy Services								
Safety Planning	☐	☐	☐	☐	☐	☐	☐	☐
Emergency Temporary Housing/Shelter Services	☐	☐	☐	☐	☐	☐	☐	☐
Assistance Completing a 50B Protective Order for Self	☐	☐	☐	☐	☐	☐	☐	☐
Assistance Completing a 50B Protective Order for Child(ren)	☐	☐	☐	☐	☐	☐	☐	☐
Assistance Completing a 50C	☐	☐	☐	☐	☐	☐	☐	☐
Victim's Compensation Application	☐	☐	☐	☐	☐	☐	☐	☐
Address Confidentiality Program	☐	☐	☐	☐	☐	☐	☐	☐
Court-Based Services								
First Appearance Victim Statement	☐	☐	☐	☐	☐	☐	☐	☐
Court Preparation – Civil	☐	☐	☐	☐	☐	☐	☐	☐
Court Preparation – Criminal (e.g., Victim Impact Statement)	☐	☐	☐	☐	☐	☐	☐	☐

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Court Accompaniment – Civil	☐	☐	☐	☐	☐	☐	☐	☐
Court Accompaniment – Criminal	☐	☐	☐	☐	☐	☐	☐	☐
Civil/Legal Services								
Custody Consultation	☐	☐	☐	☐	☐	☐	☐	☐
Divorce/Separation Consultation	☐	☐	☐	☐	☐	☐	☐	☐
Other Civil Legal Consultation	☐	☐	☐	☐	☐	☐	☐	☐
Protective Order Consultation	☐	☐	☐	☐	☐	☐	☐	☐
Protective Order Referral for Representation	☐	☐	☐	☐	☐	☐	☐	☐
Guardianship/Power of Attorney	☐	☐	☐	☐	☐	☐	☐	☐
Health & Emotional/Wellness Services								
Medical Care	☐	☐	☐	☐	☐	☐	☐	☐
Crisis Counseling/Emotional Support	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health Counseling for Self	☐	☐	☐	☐	☐	☐	☐	☐
Mental Health Counseling for Child(ren)	☐	☐	☐	☐	☐	☐	☐	☐
Peer Support	☐	☐	☐	☐	☐	☐	☐	☐
Support Group Referral	☐	☐	☐	☐	☐	☐	☐	☐
Law Enforcement								
Follow Up on Reported Incident	☐	☐	☐	☐	☐	☐	☐	☐
File New Police Report	☐	☐	☐	☐	☐	☐	☐	☐
Assistance Filing Private Warrant(s)	☐	☐	☐	☐	☐	☐	☐	☐
Escort to Court – Civil or Criminal	☐	☐	☐	☐	☐	☐	☐	☐
Social Services								
Child Protective Services Report – Filed or Follow Up	☐	☐	☐	☐	☐	☐	☐	☐
Adult Protective Services Report – Filed or Follow Up	☐	☐	☐	☐	☐	☐	☐	☐
Economic Services	☐	☐	☐	☐	☐	☐	☐	☐
Housing Services	☐	☐	☐	☐	☐	☐	☐	☐
Childcare Assistance	☐	☐	☐	☐	☐	☐	☐	☐
Specialized Services for Vulnerable Populations								
Care Management/Coordination – Aging Adults	☐	☐	☐	☐	☐	☐	☐	☐
Care Management/Coordination – Children/Families	☐	☐	☐	☐	☐	☐	☐	☐
FJC Specialized Youth Program	☐	☐	☐	☐	☐	☐	☐	☐

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Maternal Health Education/Support	☐	☐	☐	☐	☐	☐	☐	☐
Parenting Support Resources	☐	☐	☐	☐	☐	☐	☐	☐
Extracurricular Program Connections	☐	☐	☐	☐	☐	☐	☐	☐
Immigration Services	☐	☐	☐	☐	☐	☐	☐	☐
Human Trafficking Services	☐	☐	☐	☐	☐	☐	☐	☐
Other Services Requested								
	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐	☐	☐

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Appendix A3: Collaboration Survey

Section 1: Respondent Information

Thank you for agreeing to participate in this survey. You have been asked to participate in this survey because you provide services at one of our partnering organizations. This first section asks you to identify the center where you provide services, your primary role at the center, and about how much time you spend there.

Q1. From the list below, please select the center where you provide services. If you personally provide services at more than one center, at the end of this survey you will have a chance to select an additional center.

1. [Center 1]
2. [Center 2]
3. [Center 3]
4. [Center 4]
5. [Center 5]
6. [Center 6]

Q2. Who is your employer? In other words, from which agency or organization does your paycheck come?

Q3. Please select the option that best describes your **primary role** at [Center Name].

1. Administrator or supervisor of the co-located center (e.g., FJC director, site director or manager)
2. Administrator or supervisor of a co-located partner organization
3. Direct client care/contact (e.g., service coordination, therapy, law enforcement investigation, CPS investigation, safety assessment, other direct services)
4. Other, please specify:

Q4. Do you have a designated office or desk space at [Center Name]?

1. Yes, I/my organization has a private office
2. Yes, I/my organization has desk space
3. No, but I/my organization uses shared office or desk space that is available upon arrival
4. No, I/my organization does not have office or desk space available to us, whether dedicated or made available upon arrival
5. Other, please specify:

Q5. On average, what percentage of your work time do you spend **onsite** at [Center name]?

1. Less than 25%
2. 26% to 50%
3. 51% to 75%
4. 75% to 100%

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Q6. Which of the following best describes your current position/area of practice?

1. Administrator
2. Attorney
3. Childcare provider
4. Child advocacy center staff
5. Child protective services staff
6. Court clerk/professional
7. DV/SA advocate
8. Elder abuse specialist
9. Housing specialist
10. Human trafficking specialist
11. Law enforcement
12. Medical provider
13. Mental health provider
14. Navigator/intake
15. Other, please specify:

Q7. How many years have you worked at [Center Name]? For partial years, please use decimals (e.g., 1.5 for 1 year and 6 months).

Section 2: Knowledge of Partners

In this section, you will be asked about your knowledge of the services provided by partnering organizations at the center and whether you feel confident about your ability to make appropriate referrals to them.

Q8. How knowledgeable are you about the services this organization provides to clients at [Center Name]?

	Not at all	Slightly	Somewhat	Moderately	Extremely
Org 1					
Org 2					
Org 3					
Org 4					
Org 5					

Q9. How confident are you in your ability to make appropriate referrals to this partner organization at [Center Name]?

	Not at all	Slightly	Somewhat	Moderately	Extremely
Org 1					
Org 2					
Org 3					
Org 4					
Org 5					

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Section 3: Relationship Information

The following set of questions asks you about your collaboration with organizations that are core partners at your center. For the purpose of this study, core partners are defined as partners who are essential to the mission and functioning of [Center Name]. Please remember that your answers are confidential and will not be shared with center partners.

Q10. Over the past three months, have you communicated with the following organizations? For the purposes of this study, communication is defined as contact in the form of in-person, video, telephone, or email discussions that are mutual and bidirectional.

	This is my organization	Yes	No, but I needed to	No, because I did not need to
Org 1				
Org 2				
Org 3				
Org 4				
Org 5				

Q11. Over the **past 3 months**, how frequently have you communicated with staff members from each organization listed below?

	Almost daily	Weekly	Couple times a month	Monthly or less
Org 1				
Org 2				
Org 3				
Org 4				
Org 5				

Q12. Over the **past 3 months**, how frequently has a staff member from each organization listed below provided you with guidance, relevant information, or consultation regarding a case?

	Almost daily	Weekly	Couple times a month	Monthly or less
Org 1				
Org 2				
Org 3				
Org 4				
Org 5				

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Q13. Over the **past 3 months**, how frequently have you given guidance, relevant information, or case consultation to staff from each organization listed below?

	Almost daily	Weekly	Couple times a month	Monthly or less
Org 1				
Org 2				
Org 3				
Org 4				
Org 5				

Q14. I trust this organization to respond to survivors in ways that make them feel supported.

	This is my organization	Totally True	Mostly True	Somewhat True	Somewhat Untrue	Mostly Untrue	Completely Untrue
Org 1							
Org 2							
Org 3							
Org 4							
Org 5							

Q15. To the best of your knowledge, are there operating procedures or protocols that define how you should interact or collaborate with organizations that are part of the center (e.g., MOU/MOA or other protocol)?

- Yes
- No
- I don't know

Section 4: Partnership Assessment Tool

The following set of questions asks you about activities that foster partnership within the center, such as practices, behaviors, and language that convey partnership between organizations that are part of the [Center name].

Q16. Please indicate your level of agreement with the following statements.

	Center staff and partners…	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
a	Taking responsibility for partnership					
b	Inspire or motivate people involved in the partnership					
c	Empower people involved in the partnership					

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	Center staff and partners…	Strongly Disagree	Disagree	Neither Disagree Nor Agree	Agree	Strongly Agree
d	Communicate the vision of the partnership					
e	Work to develop a common language within the partnership					
f	Foster respect, trust, inclusiveness, and openness in the partnership					
g	Create an environment where differences of opinion can be voiced					
h	Resolve conflict among partners					
i	Combine perspectives, resources, and skills of partners					
j	Help partnership be creative and look at things differently					
k	Recruit diverse people and organizations into the partnership					
	Coordinate communication among partners					
l	Coordinate communication with people and organizations outside the partnership					
m	Organize partnership activities including meetings and activities					
n	Apply for and managing grants and funds					
o	Prepare materials that inform partners and help them make timely decisions					
p	Perform secretarial duties					
q	Provide orientation to new partners as they join the partnership					
r	Evaluate the progress and impact of the partnership					
s	Minimize the barriers to participation in the partnership's meeting and activities (i.e., holding meetings in convenient times and places)					

Q17. Please note which of the following benefits arise from being a part of [Center Name]:

- ☐ Enhanced ability to address an important issue
- ☐ Development of new skills
- ☐ Heightened public profile
- ☐ Increased utilization of expertise or services
- ☐ Acquisition of useful knowledge about services, programs, or people in the community
- ☐ Enhanced ability to affect public policy
- ☐ Development of valuable relationships
- ☐ Enhanced ability to meet the needs of your constituency or clients
- ☐ Ability to have a greater impact than you could have on your own
- ☐ Ability to make a contribution to the community
- ☐ Acquisition of additional financial support

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☐ Other, please specify: _____

Q18. Please note which of the following drawbacks arise from being a part of [Center Name]

☐ Diversion of time and resources away from other priorities and obligations
☐ Insufficient influence in partnership activities
☐ Viewed negatively due to association with other partners or the partnership
☐ Frustration or aggravation
☐ Insufficient credit given for contributing to the accomplishments of the partnership
☐ Conflict between job and partnership's work
☐ Other, please specify: _____

Thank you for your time and participation in this survey. If you have any questions about the project after completing the survey, you are welcome to contact [co-PI name], a member of the research team, at the following email [email address].

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Appendix A4: Adaptive Fidelity Self-Assessment

Purpose of this Self-Assessment

In this self-assessment, we are asking about the core components of co-located models for intimate partner violence and sexual violence (IPV/SV) services as well as whether and how these components can be adapted across centers. The self-assessment asks about three different aspects of your co-located center: (1) agency partners, (2) services offered, and (3) process and infrastructure to support the center's operations.

Section 1: Respondent Information

Question 1: Please identify the center where you provide services.

- Masked location 1
- Masked location 2
- Masked location 3
- Masked location 4
- Masked location 5
- Masked location 6

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Section 2: Agency Partners

Question 2A: The following table lists the co-located partners that, according to the Alliance for HOPE International, comprise typical partners at family justice centers and multi-agency centers. For each potential partner listed, please answer the following questions using the response options provided.

Type of organization	**Is the partner co-located?** 1= Yes, full time 2= Yes, part-time 3= No, but they engage with us in service coordination 4= No, and they don't engage with us in service coordination 5= Not a partner organization	**How essential is this partner's co-location in ensuring the effectiveness (i.e., improved client outcomes) of your center?** 1= Not essential 2= Slightly essential 3= Moderately essential 4= Essential 5= Extremely essential	**Do you think the way this organization partners with a co-located center (e.g., full-time co-location vs. part-time co-location vs. timely coordination in lieu of co-location) could look differently in other communities and still be effective?** 1= Yes 2= No 3= I'm not sure
Rape crisis advocates			
Domestic violence advocates			
Human trafficking advocates			
Police department personnel			
Sheriff's office personnel			
Medical personnel			
District attorneys and city attorneys			
Victim-witness program personnel			
Domestic violence shelter service staff			
Social service agency staff members			
Child welfare agency social workers			
County health department staff			
City or county public assistance workers			
Mental health professionals			
Civil legal service providers			
Other partner, please specify			
Other partner, please specify			
Other partner, please specify			
Other partner, please specify			

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Question 2B: In your perspective, what makes some partners' co-location essential in ensuring the effectiveness of your center?

Question 2C: Consider the partners whose involvement could vary across centers without negatively impacting effectiveness. Please describe how their partnership might look differently across centers.

Section 3: Center Services

Question 3A: The following table lists types of services and supports that some communities offer in their co-located center serving IPV/SV survivors. For each service or support listed, please answer the following question using the response options provided.

Type of service or support	**Is this service or support co-located?** 1= Yes, this is provided by center staff or a co-located partner 2= No, this is not provided by center staff or a co-located partner	**How essential is this service or support's co-location in ensuring the effectiveness (i.e., improved client outcomes) of your center?** 1= Not essential 2= Slightly essential 3= Moderately essential 4= Essential 5= Extremely essential	**Do you think the way this service or support is implemented (or delivered) could look different in other communities and still be effective** 1= Yes 2= No 3= I'm not sure
Intake & Needs Assessment			
Information about Options and Resources			
Danger Assessments and/ or Strangulation Assessment			
Photo Documentation of Visible Injury			
Permission for High-Risk Case Review			
Case Coordination – Partner Follow Up			
Advocacy Services			
Safety Planning			
Emergency Temporary Housing/Shelter Services			
Assistance Completing a 50B Protective Orders			
Assistance Completing 50Cs			
Victim's Compensation Applications			
Address Confidentiality Program			

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Type of service or support	**Is this service or support co-located?** 1= Yes, this is provided by center staff or a co-located partner 2= No, this is not provided by center staff or a co-located partner	**How essential is this service or support's co-location in ensuring the effectiveness (i.e., improved client outcomes) of your center?** 1= Not essential 2= Slightly essential 3= Moderately essential 4= Essential 5= Extremely essential	**Do you think the way this service or support is implemented (or delivered) could look different in other communities and still be effective** 1= Yes 2= No 3= I'm not sure
Violence Prevention Education and Outreach			
Court-Based Services			
Court Preparation – Civil or Criminal			
Court Accompaniment – Civil or Criminal			
Civil/Legal Services			
Civil Legal Consultation			
Criminal Legal Consultation			
Protective Order Referral for Representation			
Guardianship/Power of Attorney			
Health & Emotional/Wellness Services			
Medical Care			
Forensic Exams			
Crisis Counseling/Emotional Support			
Mental Health Counseling (for client and/ or children)			
Peer Support or Support Groups			
Law Enforcement			
File New Police Report			
Assistance Filing Private Warrant(s)			
Social Services			
Economic Services			
Housing Services			
Childcare Assistance			
Assistance with material goods (food, water, diapers, toothpaste, menstrual care products, etc..)			

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Type of service or support	**Is this service or support co-located?** 1= Yes, this is provided by center staff or a co-located partner 2= No, this is not provided by center staff or a co-located partner	**How essential is this service or support's co-location in ensuring the effectiveness (i.e., improved client outcomes) of your center?** 1= Not essential 2= Slightly essential 3= Moderately essential 4= Essential 5= Extremely essential	**Do you think the way this service or support is implemented (or delivered) could look different in other communities and still be effective** 1= Yes 2= No 3= I'm not sure
Specialized Services for Vulnerable Populations			
Care Management/Coordination – Aging Adults			
Care Management/Coordination – Children/Families			
FJC Specialized Youth Program			
Parenting Support Resources			
Immigration Services			
Human Trafficking Services			
Other Services or Supports			
Other, please specify			
Other, please specify			
Other, please specify			

Question 3B: In your perspective, what makes some services and supports essential in ensuring the effectiveness of your center?

Question 3C: For services and supports that could vary across communities, please describe how the service or support could look differently across centers.

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Section 4: Center Infrastructure and Operations

Question 4A: The following table lists infrastructure and process components that some communities include in their co-located center serving IPV/SV survivors. For each infrastructure or process listed, please answer the following questions.

Type of infrastructure or process	**Does your center implement this infrastructure or process?** 1= Yes, this is implemented at my center 2= No, this is not implemented, but will be implemented in the future 3= No, this is not implemented, and we do not have plans to implement it in the future	**How essential is this infrastructure or process in ensuring the effectiveness (i.e., improved client outcomes) of your center?** 1= Not essential 2= Slightly essential 3= Moderately essential 4= Essential 5= Extremely essential	**Do you think the way this infrastructure or process is implemented could look differently in other communities and still be effective?** 1= Yes 2= No 3= I'm not sure
Co-located center led by county government			
Co-located center led by non-profit			
Capacity building activities across partners (e.g., cross-agency trainings)			
Centrally located center			
Centralized intake process			
Client navigation by a designated person			
Collaborative infrastructure with cross-agency leaders			
Confidentiality agreements between co-located partners			
Memoranda of understanding (MOU) or memoranda of agreement (MOA)			
High-risk lethality teams			
Regular meetings across partners			
Shared calendar			
Shared database			
VOICES committee			

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Type of infrastructure or process	**Does your center implement this infrastructure or process?** 1= Yes, this is implemented at my center 2= No, this is not implemented, but will be implemented in the future 3= No, this is not implemented, and we do not have plans to implement it in the future	**How essential is this infrastructure or process in ensuring the effectiveness (i.e., improved client outcomes) of your center?** 1= Not essential 2= Slightly essential 3= Moderately essential 4= Essential 5= Extremely essential	**Do you think the way this infrastructure or process is implemented could look differently in other communities and still be effective?** 1= Yes 2= No 3= I'm not sure
Other, please specify			
Other, please specify			
Other, please specify			
Other, please specify			

Question 4B: In your perspective, what makes some infrastructure or processes essential in ensuring the effectiveness of your center?

Question 4C: For infrastructure or processes that could vary across communities, please describe how they could look differently across centers.

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Appendix A5: Client Outcome Survey (Intake/Baseline)

Formative and Evaluability Assessment of Cross-Sectoral Approaches for Intimate Partner and Sexual Violence:

Client Outcome Survey Paper Version (Timepoint 1)

Before you start this survey, we would like to remind you that: (1) your participation is voluntary, (2) you can skip any questions you do not want to answer, and (3) you can stop your study participation at any time.

You can reach a member of our team at cfraga@email.unc.edu

Thank you for participating in our research!

- Please note the participant ID number provided to you by the member of our research team. _____

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Section 1:
Service Needs and Center Experiences

Please indicate the Center from which you were recruited to participate in this study?

- ☐ Alamance County Family Justice Center
- ☐ Buncombe County Family Justice Center
- ☐ Charlotte/Mecklenburg Survivor Resource Center
- ☐ Hope United Survivor Network
- ☐ Guilford County Family Justice Center: Greensboro Location
- ☐ Guilford County Family Justice Center: High Point Location
- ☐ Safelight Family Advocacy Center
- ☐ Bridges to Hope Family Justice Center of Forsyth County

Instructions: Below is a list of needs that people sometimes require help with. Please indicate whether each item in the list is a need for you, whether the center is helping you to address this need, and your level of satisfaction.

Basic Needs	Check here if this is a need for you	Check here if the Center is helping you address this need currently	If the Center is helping you with this need, indicate your level of satisfaction
Safe place to live short-term	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Safe place to live long term	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied

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Food	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Seasonally appropriate clothing and/or shoes	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Personal hygiene items (e.g., toothpaste, toothbrush, soap)	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Infant supplies (e.g., diapers, formula)	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Childcare	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Pet care	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Transportation (e.g., taxi, vouchers)	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied

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Help getting my belongings (e.g., after leaving partner, getting kicked out, being evicted)	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Domestic or Sexual Violence Specific Needs	**Check here if this is a need for you**	**Check here if the Center is helping you address this need currently**	**If the Center is helping you with this need, indicate your level of satisfaction**
Speak with an advocate or crisis counselor about my situation and available options/services	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Personal safety	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Safety of my child(ren)	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Talk with peers that have similar experiences (e.g., peer support group)	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Learn more about domestic or sexual violence by attending group classes	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied

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Employment and Financial Needs	Check here if this is a need for you	Check here if the Center is helping you address this need currently	If the Center is helping you with this need, indicate your level of satisfaction
Help with employment	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Financial or cash assistance	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Help signing up for benefits	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Medical Needs	**Check here if this is a need for you**	**Check here if the Center is helping you address this need currently**	**If the Center is helping you with this need, indicate your level of satisfaction**
Medical care (e.g., assessment, check-up, prescriptions)	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Dental care	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Vision care	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied

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Someone to come with me to medical visits (e.g., emergency room, visit to complete rape kit or strangulation kit)	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Behavioral Health Needs	**Check here if this is a need for you**	**Check here if the Center is helping you address this need currently**	**If the Center is helping you with this need, indicate your level of satisfaction**
Mental health services or counseling for myself	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Mental health services or counseling for my child(ren)	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Substance use services or counseling for myself	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Substance use services or counseling for my child(ren)	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Law Enforcement and Legal Needs	**Check here if this is a need for you**	**Check here if the Center is helping you address this need currently**	**If the Center is helping you with this need, indicate your level of satisfaction**
Restraining order for myself	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied

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			☐ Completely Dissatisfied
Restraining order on behalf of my child(ren)	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Help filing criminal charges	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Help filing for a divorce, getting custody of my child(ren), and/or changing my will	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Help with mediation	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Someone to come with me to court	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Speak with law enforcement about an on-going case or investigation	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Culturally Specific Needs	**Check here if this is a need for you**	**Check here if the Center is helping you address this need currently**	**If the Center is helping you with this need, indicate your level of satisfaction**

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Language interpretation and/or translation services	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
American Sign Language services	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Help with immigration concerns (e.g., legal)	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Help identifying a culturally-specific or faith community	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied
Help identifying a program to learn English	☐	☐	☐ Completely Satisfied ☐ Satisfied ☐ Neither Satisfied nor Dissatisfied ☐ Dissatisfied ☐ Completely Dissatisfied

Instructions: If you have any other needs not captured in the list above, please share them here and note whether the center is helping you address these needs.

_____

_____

_____

_____

_____

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Instructions: If you indicated that you were in some way dissatisfied with the help the Center is providing to address your needs, please share more details about why you were dissatisfied and how you could be better supported. Your feedback will help the Center improve the services they provide future clients. As a reminder, your responses are confidential and will not in any way influence the services that you receive from the Center.

_____
_____
_____
_____
_____

Instructions: Sometimes people may face barriers that can make it difficult to have their needs met. What are some barriers that you experience? Please select all that apply.

- ☐ Center's hour of operation
- ☐ Center's location
- ☐ Childcare
- ☐ Transportation
- ☐ Other, please specify here: _____
- ☐ None or not applicable

Instructions: The following questions have to do with the services and support you have received from this Center and the various staff that you interacted with while seeking and receiving services. We want your honest opinion, whether positive or negative. Please select the response that best reflects whether you agree or disagree with the following statements.

Center	Strongly Agree (4)	Agree (3)	Disagree (2)	Strongly Disagree (1)
I felt safe at the Center	☐	☐	☐	☐
The Center was inviting and clean	☐	☐	☐	☐
The Center was accessible	☐	☐	☐	☐

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My children were well cared for while we were at the Center	☐	☐	☐	☐
My wait at the Center was reasonable, and staff kept me updated throughout	☐	☐	☐	☐
I was easily able to access services I needed	☐	☐	☐	☐
The services I received helped me make decisions about my next steps	☐	☐	☐	☐
I believe the services I received will help address my goals	☐	☐	☐	☐
Staff	**Strongly Agree (4)**	**Agree (3)**	**Disagree (2)**	**Strongly Disagree (1)**
Staff supported my decisions	☐	☐	☐	☐
Staff made sure that services are right for what I need	☐	☐	☐	☐
Staff offered choices	☐	☐	☐	☐
Staff helped me to shape goals that work for me	☐	☐	☐	☐
Staff believed that decisions about my life were mine to make	☐	☐	☐	☐
I felt respected by the staff	☐	☐	☐	☐
I feel like my confidentiality was honored by the staff	☐	☐	☐	☐

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Section 2: Victimization

Instructions: The following questions ask about different forms of interpersonal violence victimization, including physical violence, psychological abuse, sexual abuse, financial abuse, legal abuse, and stalking. For each type of violence victimization, we provide some examples. People who have experienced a given type of violence may not experience all the examples listed; likewise, it is possible that some may have experiences not represented by the examples provided.

Please indicate how many times you experienced each of the main categories of violence victimization in the past 3 months. We recognize that some instances of violence may include multiple types of abuse, such as physical, psychological and sexual abuse at one time. In such instances, count the specific incident in each of the types of abuse that apply.

How often in the past 3 months have you experienced **physical violence from an intimate partner** (i.e., current/former partner, current/former spouse)?

> *Some examples of **physical violence** include your partner twisted your arm; your partner threw something at you that could hurt; your partner pushed or shoved you; your partner used a knife or gun on you; your partner punched or hit you; your partner choked or strangled you with their hands, a belt, a tie, or other means (i.e., your partner applied pressure to your neck that blocked your airflow in some way); your partner slammed you against a wall; your partner beat you up; your partner slapped you; your partner burned or scalded you on purpose; your partner kicked you; and your partner withheld medical support, treatment, and/or medications.*

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- ☐ Never
- ☐ Once
- ☐ Twice
- ☐ 3-5 times
- ☐ 6-10 times
- ☐ 11-20 times
- ☐ More than 20 times
- ☐ This has happened, but not in the past 3 months

How often in the past 3 months have you experienced **psychological abuse from an intimate partner** (i.e., current/former partner, current/former spouse)?

*Some examples of **psychological abuse** include your partner insulted or swore at you; your partner called you fat or ugly; your partner threatened you or others with violence; your partner threatened to harm or kill you or someone else; your partner threatened to harm or kill themselves; your partner destroyed something belonging to you; your partner shouted or yelled at you; your partner was jealous or suspicious of your friends; your partner interfered with your relationships (either in-person or virtually); your partner isolated or tried to isolate you; your partner used your children to manipulate you; your partner tried to keep you from doing things for yourself; your partner tried to make you feel crazy; your partner had you falsely involuntarily committed; your partner blamed you for their problems; your partner posted unflattering images or messages online; your partner made posts online to hurt you; your partner monitored your social media accounts; and your partner asked questions of you online or demanded your passwords to access information.*

- ☐ Never
- ☐ Once
- ☐ Twice
- ☐ 3-5 times
- ☐ 6-10 times
- ☐ 11-20 times
- ☐ More than 20 times
- ☐ This has happened, but not in the past 3 months

How often in the past 3 months have you experienced **sexual abuse from an intimate partner** (i.e., current/former partner, current/former spouse)?

*Some examples of **sexual abuse** include your partner repeatedly touched your private parts (or parts typically covered by a bathing suit) without your consent; your partner made you have sex without a condom or birth control; your partner insisted on sexual activity when you did not want to, including oral and anal sex; your partner used threats or violence (i.e., strangulation) to make you have sex/sexual activity, including oral and anal sex; and your partner used force (i.e., holding you down) to make you have sex/sexual activity, including oral or anal sex.*

- ☐ Never
- ☐ Once

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- ☐ Twice
- ☐ 3-5 times
- ☐ 6-10 times
- ☐ 11-20 times
- ☐ More than 20 times
- ☐ This has happened, but not in the past 3 months

How often in the past 3 months have you experienced **financial abuse from an intimate partner** (i.e., current/former partner, current/former spouse)?

*Some examples of **financial abuse** include your partner made you ask them for money; your partner demanded to know how money was spent; your partner monitored your spending or bank account; your partner kept financial information from you; your partner made important financial decisions without talking to you first; your partner interfered with your job; your partner interfered with your public assistance/benefits; your partner spent the money you needed for rent or other bills; your partner had you on an allowance; your partner threatened to withhold financial support if you left them; and your partner did things to ruin your credit.*

- ☐ Never
- ☐ Once
- ☐ Twice
- ☐ 3-5 times
- ☐ 6-10 times
- ☐ 11-20 times
- ☐ More than 20 times
- ☐ This has happened, but not in the past 3 months

How often in the past 3 months have you experienced **legal abuse from an intimate partner** (i.e., current/former partner, current/former spouse)?

*Some examples of **legal abuse** include your partner threatened or actually used the court to take custody of your children away; your partner threatened or actually used the court to get unsafe access to your children; your partner threatened or actually used the court just to punish you; your partner threatened deportation or actually called ICE (Immigration and Customs Enforcement); your partner threatened or made false allegations to CPS (child protection services); your partner took you to court repeatedly; your partner was dishonest about your character, mental health, or parenting to professionals on your case; your partner took a false restraining order out on you; your partner had wrongful or retaliatory charges taken out on you; your partner told professionals on your case that you were trying to harm their relationship with the children; and your partner threatened or took you to court to take control of all assets.*

- ☐ Never
- ☐ Once
- ☐ Twice
- ☐ 3-5 times
- ☐ 6-10 times
- ☐ 11-20 times

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☐ More than 20 times

☐ This has happened, but not in the past 3 months

How often in the past 3 months have you experienced **stalking from an intimate partner** (i.e., current/former partner, current/former spouse)?

*Some examples of **stalking** include your partner called, texted, or emailed you multiple times against your wishes; your partner tried to get information about you from others; your partner drove by, showed up uninvited, or waited at places they thought you would be; your partner followed you or watched you from a distance; your partner broke into your home; your partner accessed your accounts without your permission; your partner put tracking or recording devices into your car or phone; your partner monitored your whereabouts using social media or other means (i.e., text, email); and your partner created fake accounts to contact you or track your location.*

☐ Never
☐ Once
☐ Twice
☐ 3-5 times
☐ 6-10 times
☐ 11-20 times
☐ More than 20 times
☐ This has happened, but not in the past 3 months

How often in the past 3 months have you experienced **sexual abuse from a friend, acquaintance, or stranger** (i.e., someone other than an intimate partner)?

***Sexual abuse from a friend, acquaintance, or stranger** includes any attempted or actual sexual activity (e.g., fondling, kissing, removing your clothes, oral sex, vaginal penetration, anal penetration) without your consent (whether by manipulation, coercion, or physical force).*

☐ Never
☐ Once
☐ Twice
☐ 3-5 times
☐ 6-10 times
☐ 11-20 times
☐ More than 20 times
☐ This has happened, but not in the past 3 months

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Section 3:
Severity

****Only complete this section if you indicated that you experienced any type of victimization within the prior 3 months in Section 2 of this Survey. If not, skip to Section 4****

Instructions: The following questions ask about the potential impact of experiencing interpersonal violence victimization. Please indicate how many times you experienced each of these things in the past 3 months.

	Never (0)	Once (1)	Twice (2)	3-5 times (3)	6-10 times (4)	11-20 times (5)	More than 20 times (6)	This has happened, but not in the past 3 months
I had a sprain, bruise, or small cut	☐	☐	☐	☐	☐	☐	☐	☐
I had a broken bone	☐	☐	☐	☐	☐	☐	☐	☐
I felt physical pain that still hurt the next day	☐	☐	☐	☐	☐	☐	☐	☐
I passed out, blacked out, or lost consciousness from physical violence or related pain (e.g., being hit on the head, being strangled or chocked)	☐	☐	☐	☐	☐	☐	☐	☐
I had a concussion	☐	☐	☐	☐	☐	☐	☐	☐
I experienced sexual and/or reproductive concerns(e.g., genital pain, abnormal bleeding, tearing, STIs, unplanned pregnancy)	☐	☐	☐	☐	☐	☐	☐	☐
I experienced emotional symptoms because of stress (e.g., excessive worry, fear, sadness, hopelessness)	☐	☐	☐	☐	☐	☐	☐	☐

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	Never (0)	Once (1)	Twice (2)	3-5 times (3)	6-10 times (4)	11-20 times (5)	More than 20 times (6)	This has happened, but not in the past 3 months
I experienced physical symptoms because of stress (e.g., trouble sleeping, upset stomach)	☐	☐	☐	☐	☐	☐	☐	☐
I experienced an increase in my drinking or drug use to cope with stress	☐	☐	☐	☐	☐	☐	☐	☐
I was encouraged to see a doctor or medical professional	☐	☐	☐	☐	☐	☐	☐	☐

Instructions: The following questions ask about the potential impact of experiencing interpersonal violence victimization. Please indicate whether you experienced each of these things in the past 3 months.

	Yes	No
Loss of hearing	☐	☐
Loss of vision	☐	☐
Brain injury	☐	☐

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Section 4:
Sense of Safety

Instructions: You may be facing a variety of different challenges to safety. When we use the word safety in the next set of questions, we mean safety from physical or emotional abuse you have experienced from another person. Please select the response that best describes how you think about your and your family's safety right now. When responding to these questions, it is fine to think about your family's safety along with your own if that is what you usually do.

	Never True (1)	Sometimes True (2)	Half the Time True (3)	Mostly True (4)	Always True (5)
I can cope with whatever challenges come at me as I work to keep safe.	☐	☐	☐	☐	☐
I have to give up too much to keep safe	☐	☐	☐	☐	☐
I know what to do in response to threats to my safety	☐	☐	☐	☐	☐
I have a good idea about what kinds of support for safety that I can get from people in my community (friends, family, neighbors, people in my faith community, etc.)	☐	☐	☐	☐	☐
I know what my next steps are on the path to keeping safe	☐	☐	☐	☐	☐
Working to keep safe creates (or will create) new problems for me	☐	☐	☐	☐	☐
When something doesn't work to keep safe, I can try something else	☐	☐	☐	☐	☐
I feel comfortable asking for help to keep safe	☐	☐	☐	☐	☐
When I think about keeping safe, I have a clear sense of my goals for the next few years	☐	☐	☐	☐	☐

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	Never True (1)	Sometimes True (2)	Half the Time True (3)	Mostly True (4)	Always True (5)
Working to keep safe creates (or will create) new problems for people I care about	☐	☐	☐	☐	☐
I feel confident in the decisions I make to keep safe	☐	☐	☐	☐	☐
I have a good idea about what kinds of support for safety I can get from community programs and services	☐	☐	☐	☐	☐
Community programs and services provide support I need to keep safe	☐	☐	☐	☐	☐
Overall, I feel safe	☐	☐	☐	☐	☐

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Section 5:
Well-being

Instructions: Read each item carefully. Using the scale shown below, please select the response that best describes YOU.

	Definitely False	Mostly False	Some-what False	Slightly False	Slightly True	Some-what True	Mostly True	Definitely True
I can think of many ways to get out of a jam	☐	☐	☐	☐	☐	☐	☐	☐
I energetically pursue my goals	☐	☐	☐	☐	☐	☐	☐	☐
I feel tired most of the time	☐	☐	☐	☐	☐	☐	☐	☐
There are lots of ways around any problem	☐	☐	☐	☐	☐	☐	☐	☐
I am easily downed in an argument	☐	☐	☐	☐	☐	☐	☐	☐
I can think of many ways to get the things in life that are important to me	☐	☐	☐	☐	☐	☐	☐	☐
I worry about my health	☐	☐	☐	☐	☐	☐	☐	☐
Even when others get discouraged, I know I can find a way to solve the problem	☐	☐	☐	☐	☐	☐	☐	☐
My past experiences have prepared me well for my future	☐	☐	☐	☐	☐	☐	☐	☐
I've been pretty successful in life	☐	☐	☐	☐	☐	☐	☐	☐
I usually find myself worrying about something	☐	☐	☐	☐	☐	☐	☐	☐
I meet the goals that I set for myself	☐	☐	☐	☐	☐	☐	☐	☐

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Section 6:
Demographics

Instructions: To understand who participated in this study, we now invite you to answer a few questions about yourself. Please know that your individual information will be treated with confidentiality and not shared outside our research team. Also, no individual's data will be identified.

***What is your age in years*_____**

What is your gender identity? For instance, some people identify as woman, man, nonbinary, transgender, or another gender.

_____

What is your sexual orientation? For example, some people identify as heterosexual (i.e., straight), gay, lesbian, bisexual, pansexual, asexual, or another sexual orientation.

_____

What is your race/ethnicity (Please check all that apply to you)

- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Hispanic or Latino/Latina/Latinx/Latine
- ☐ Middle Eastern or Northern African (MENA)
- ☐ White
- ☐ Another race/ethnicity not listed, please specify here: _____
- ☐ Prefer not to answer

What is/are your preferred or primary language(s)? _____

What is your country of origin? _____

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How many children do you have, and how old are they?

_____

What is your relationship status TODAY? (Please check all that apply)

- ☐ Married
- ☐ In a relationship (living together)
- ☐ In a relationship (not living together)
- ☐ Divorced
- ☐ Separated
- ☐ Widowed
- ☐ Single
- ☐ Other, please specify here: _____
- ☐ Prefer not to answer

If you are in a relationship TODAY, is your partner the same person you were with when you sought help from the Center?

- ☐ Yes
- ☐ No
- ☐ Prefer not to answer
- ☐ Not applicable

What is your highest level of education?

- ☐ Completed Grade 5
- ☐ Completed Grade 8
- ☐ Completed Grade 11
- ☐ Completed High School
- ☐ Completed GED
- ☐ Completed Some College/Technical School Coursework
- ☐ Completed College/Technical School Degree
- ☐ Completed Some Graduate Coursework
- ☐ Completed Graduate Degree
- ☐ Other, please specify here: _____
- ☐ Prefer not to answer

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How, if at all, are you currently employed? (Please check all that apply to you)

- ☐ Full-Time Employment
- ☐ Part-Time Employment (i.e., less than 30 hours per week)
- ☐ Occasional Employment/Informal Employment
- ☐ Unemployed
- ☐ Self-Employed
- ☐ Home-Maker (e.g., unpaid caregiving)
- ☐ Retired
- ☐ Other, please specify here: _____
- ☐ Prefer not to answer

What type of health insurance do you have? (Please check all that apply to you)

- ☐ No health insurance
- ☐ Private Health Insurance (HMO/PPO from your/your spouse's job)
- ☐ Medicaid/Medicare
- ☐ Other Government Insurance
- ☐ Other, please specify here: _____
- ☐ Prefer not to answer

Thank you for taking time to complete this survey. We appreciate you sharing your experiences, perceptions, and opinions with our team. Please reach out if you have any questions or comments to share. You can reach a member of our team at xxx@email.unc.edu

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Appendix A6: Partner Site Focus Group Guide

Center:
Date:
Start time:
End time:
# of participants:
Facilitator:
Note taker:

Question	Notes & Observations	Notable Direct Quotes
1. Challenges and facilitators: The purpose of the overall research project was to test the feasibility of doing an evaluation across multiple co-located service centers and to see what may be possible for a subsequent rigorous evaluation. As part of the project, we conducted a number of different evaluation activities to collect different types of data from partners and clients. Specifically, we collected process-related data to help us understand how centers implement their programs. We also collected outcome-related data to learn about clients' experiences and outcomes after receiving center services. To start, we're going to ask you about each of the evaluation activities. Some of these may not apply to you so no need to respond about each activity. We will name the activity and would like for you to think about what you were asked to do for that evaluation activity, what were some of the challenges that came up, and what were some things that made it easier for your center and partners to participate? **1a. Collaboration Survey**		

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Question	Notes & Observations	Notable Direct Quotes
As part of the project, we asked you and other staff members to complete the collaboration survey. Think about the collaboration survey, what were some of the challenges that came up? What were some things that made it easier for your center and partners to participate in the collaboration survey? [Team to add center-specific follow-up prompts based on observations from this activity.] **1b. Aggregate annual data** As part of the project, we asked you and other staff members to provide annual programmatic data. Thinking about the annual programmatic data, what were some of the challenges that came up? What were some things that made it easier for your center and partners to provide annual programmatic data? [Team to add center-specific follow-up prompts based on observations from this activity.] **1c. Service log** We also asked center staff to complete an anonymous service log. Can you explain your center's process for completing the service navigation log activity?		

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Question	Notes & Observations	Notable Direct Quotes
Thinking about the service log, what were some of the challenges that came up? What were some things that made it easier for your center and partners to complete the service log? [Team to add center-specific follow-up prompts based on observations from this activity.] **1d. Adaptive fidelity** We asked that you participate in the adaptive fidelity self-assessment. Thinking about the self-assessment, what were some of the challenges that came up? What were some things that made it easier for your center to participant in the self-assessment? [Team to add center-specific follow-up prompts based on observations from this activity.] **1e. Client outcome survey** We also asked clients to complete an outcomes survey at 3 timepoints. And, we asked for your help with recruitment with this research activity. From your perspective, what were some of the challenges related to the client outcome survey component? What were some things that made it easier to implement the client outcomes survey component at your center?		

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Question	Notes & Observations	Notable Direct Quotes
[Team to add center-specific follow-up prompts based on observations from this activity.]		
2. Overall feasibility and burden: Thinking about the entire research project and the various evaluation activities together, how feasible was it for you and your organization to participate in this research project? You can think of feasibility in terms of your time and effort, the questions we were asking, etc.		
3. Recommendations: As mentioned, the purpose of the research project is to learn about what evaluation methods could work and what may not be a good fit, and to make recommendations for future evaluations. Keeping this in mind, what recommendations would you make to enhance the evaluation of co-located centers?		
4. Sustainability: What supports or resources do you think your center needs in order to sustain a program evaluation?		
5. Anything else: Is there anything else you want to share about the evaluation protocol?		

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Appendix B

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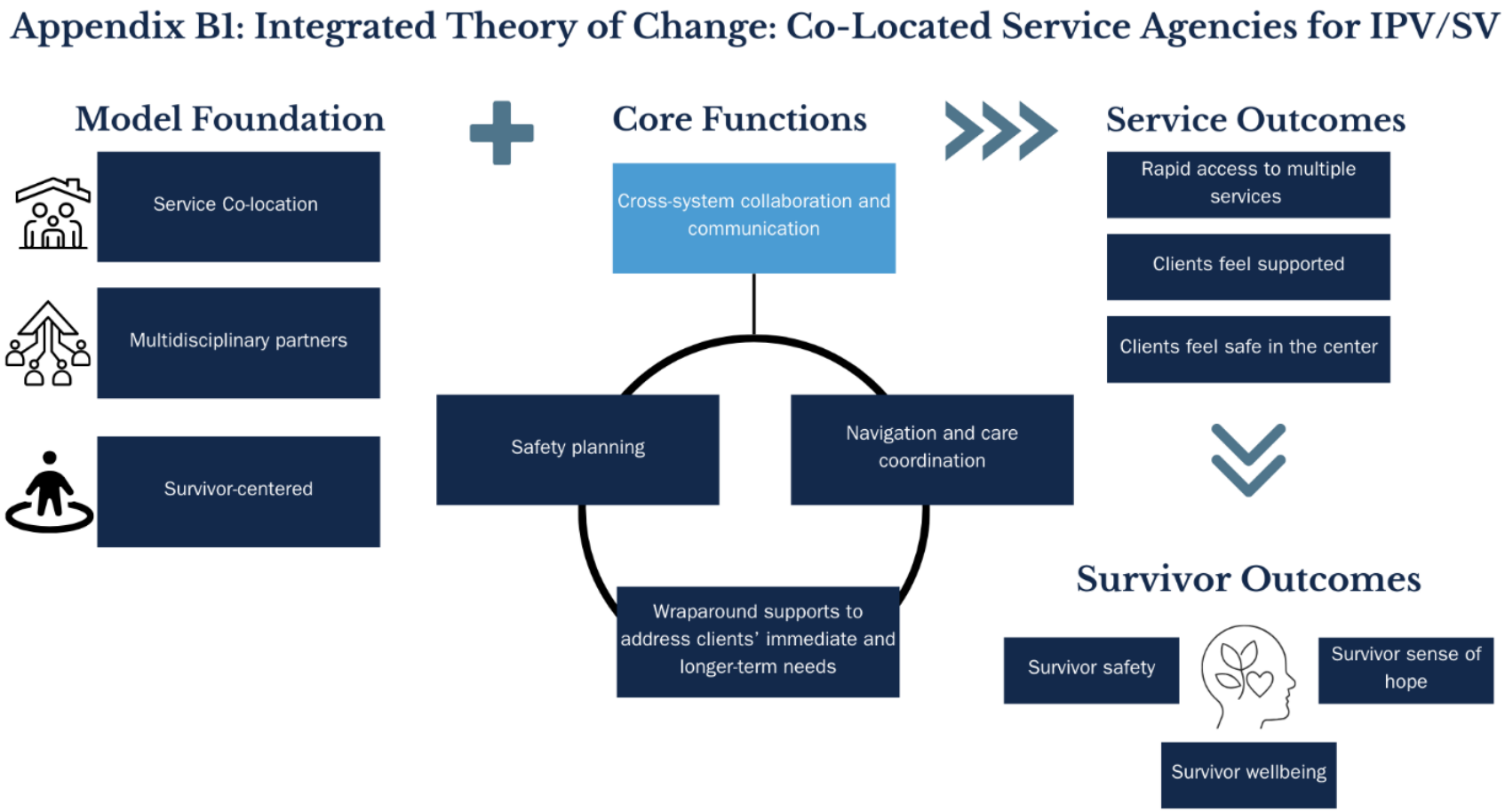
Appendix B1: Theory of Change



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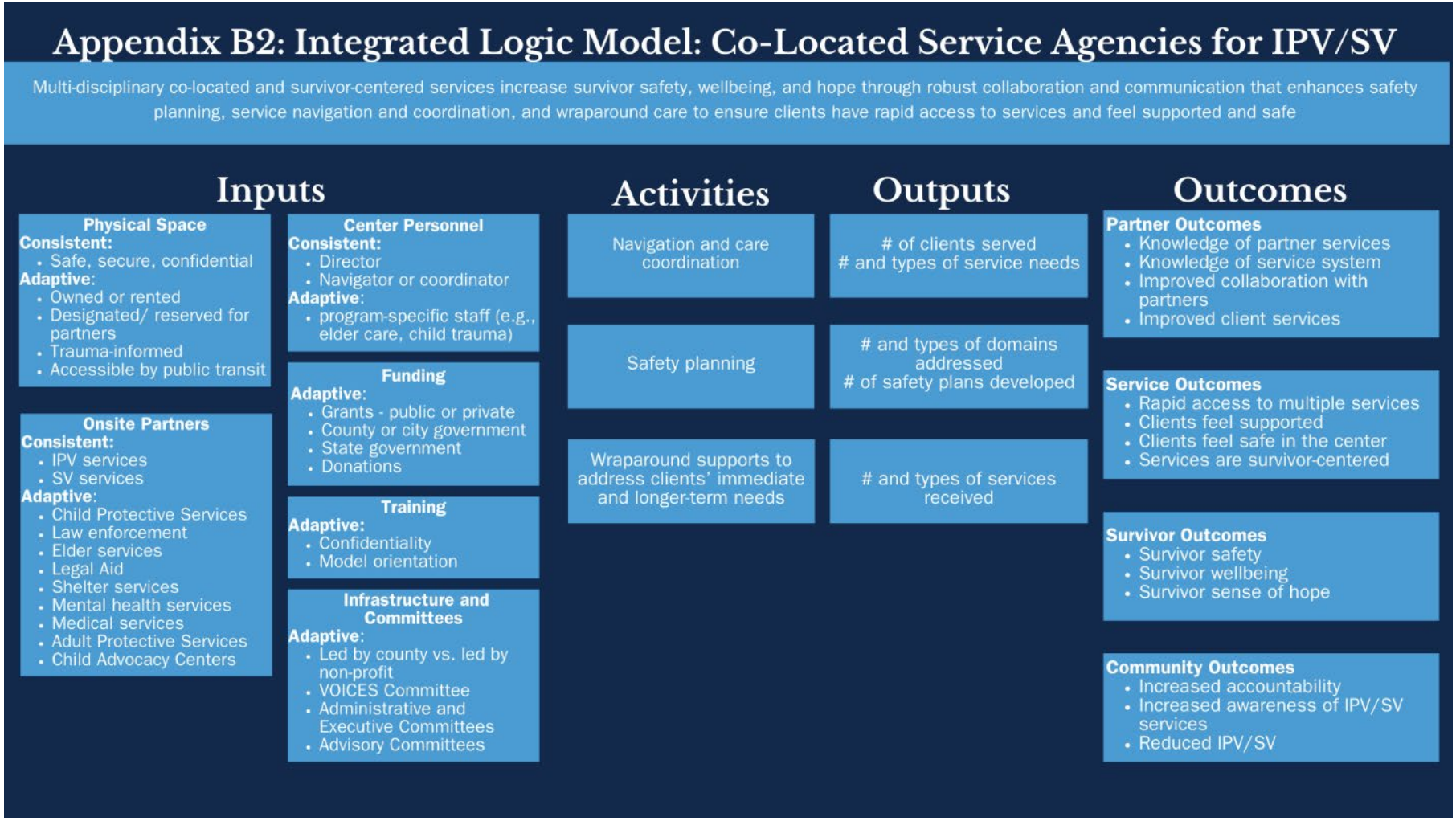
Appendix B2: Logic Model



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Appendix C

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Appendix C1: Annual Programmatic Findings

Table C1.1. Aggregate Data: Center and Service Data

Indicators	Total (*n*)	# Centers reporting (*n*)	# Centers not reporting (*n*)	Minimum (*n*)	Maximum (*n*)
Center-Specific Data					
# orgs outreached	351	6	0	0	129
# people outreached	11,458	6	0	0	5,750
# DV & SV calls received (combined)	3,484	1	5	3,484	3,484
# received advocacy services (combined)	3,549	4	2	364	1,744
DV Agency Data					
# calls received on crisis line	10,338	5	1	1,011	6,499
# clients receiving DV advocacy	26,206	5	1	893	11,132
# clients housed in shelter	2,156	6	0	69	923
# shelter/hotel nights	62,139	6	0	27	44,051
Sexual Violence Agency Data					
# crisis line calls received	909	3	3	121	788
# clients receiving SV advocacy	1,995	4	2	7	1,898
Mental Health Agency Data [7]					
# clients referred	279	6	0	0	138
# receiving services	180	6	0	0	120
SANE Data					
# patients examined	1,423	4	2	9	915

Note. [1] May not apply to all centers as some centers refer out for mental health services not captured by these data.

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Table C1.2. Aggregate Data: Criminal Legal System Data

Indicators	Total (*n*)	# Centers reporting (*n*)	# Centers not reporting (*n*)	Minimum (*n*)	Maximum (*n*)
Court Data					
# DVPOs (50Bs and 50Cs)	9,251	5	1	399	3,698
# DV	2,196	1	5	2,196	2,196
# SV	52	1	5	52	52
# Elder abuse	0	1	5	0	0
# Child maltreatment	—	0	6	—	—
# Other [1]	86	1	5	86	86
Legal Support Data					
# DV referred	2,075	6	0	0	574
# cases opened	1,717	5	1	0	940
# cases closed	1,235	4	2	0	931
Police Department Data					
# DV calls	62,200	6	0	2,519	12,110
# DV calls resulting in charges	4,488	5	1	102	1,383
# Rape/SV calls	923	4	2	76	496
# Rape/SV calls resulting in charges	76	3	3	19	32
Sherriff Department Data					
# Child abuse charges	232	4	2	18	121
# Child neglect charges	2	3	3	0	2
# DV charges	23	3	3	0	23
# Sex offense charges	14	4	2	1	10
# Child molestation charges	0	3	3	0	0
# Crimes against nature charges	11	4	2	0	11
# Indecent exposure charges	51	4	2	1	28
# Statutory underage charges	39	4	2	1	30
# Forcible rape charges	18	4	2	1	11
# Child abuse incidents	28	3	3	10	18
# Child neglect incidents	4	3	3	2	2
# DV incidents	7,087	4	2	23	6,789
# Sex offense incidents	30	3	3	0	30
# Elder abuse incidents	3	1	5	3	3
# Child molestation incidents	9	1	5	9	9
# Crimes against nature incidents	0	1	5	0	0
# Indecent exposure incidents	5	1	5	5	5
# Statutory underage incidents	0	1	5	0	0
# Forcible rape incidents	2	1	5	2	2
# DVPOs received (50Bs and 50Cs)	6,773	4	2	514	3,773
# DVPOs served (50Bs and 50Cs)	5,428	5	1	451	2,881

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Appendix C2: Client-Level Service Need Findings

Table C2.1. Service Navigation Log: Visit Information

Visit Information	Total (*n* = 760)	Minimum (*n*)	Maximum (*n*)
Type of Visit			
Initial visit	320	10	96
Returned for services	309	4	131
Scheduled appointment	141	1	55
Service Type Requested			
Domestic Violence	550	24	170
Sexual Assault/Abuse	54	0	20
Child Abuse/Neglect	69	1	29
Elder Abuse/Neglect	24	0	13
Stalking/Harassment	170	3	75
Other	63	0	51
Type of Engagement			
In-person	634	23	248
Remote	22	0	22

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Table C2.2. Service Navigation Log: Requested Services

Information about Options and Resources	Total (*n* = 760)	Minimum (*n*)	Maximum (*n*)
Intake & Needs Assessment			
Information about Options and Resources	448	13	158
Danger Assessment	193	9	44
Strangulation Assessment	12	0	4
Photo Documentation of Visible Injury	24	0	11
Permission for High-Risk Case Review	48	0	44
Case Coordination – Partner Follow Up	146	2	51
Advocacy Services			
Safety Planning	313	9	87
Emergency Temporary Housing/Shelter Services	35	0	9
Assistance Completing a 50B Protective Order for Self	225	0	97
Assistance Completing a 50B Protective Order for Child(ren)	64	0	27
Assistance Completing a 50C	14	0	7
Victim's Compensation Application	8	0	6
Address Confidentiality Program	8	0	4
Court-Based Services			
First Appearance Victim Statement	17	0	9
Court Preparation – Civil	135	0	65
Court Preparation – Criminal (e.g., Victim Impact Statement)	28	0	13
Court Accompaniment – Civil	116	0	38
Court Accompaniment – Criminal	58	0	21
Civil/Legal Services			
Custody Consultation	52	1	18
Divorce/Separation Consultation	35	0	14
Other Civil Legal Consultation	47	0	26
Protective Order Consultation	119	0	53
Protective Order Referral for Representation	86	0	35
Guardianship/Power of Attorney	4	0	4
Health & Emotional/Wellness Services			
Medical Care	11	0	4
Crisis Counseling/Emotional Support	226	3	59
Mental Health Counseling for Self	137	8	46
Mental Health Counseling for Child(ren)	21	1	6
Peer Support	49	0	40
Support Group Referral	46	0	22
Law Enforcement			
Follow Up on Reported Incident	94	1	41
File New Police Report	37	0	14
Assistance Filing Private Warrant(s)	18	0	9
Escort to Court – Civil or Criminal	51	0	39
Social Services			
Child Protective Services Report – Filed or Follow Up	56	1	20
Adult Protective Services Report – Filed or Follow Up	8	0	5
Economic Services	17	0	5
Housing Services	28	0	16

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Childcare Assistance	12	0	6
Specialized Services for Vulnerable Populations			
Care Management/Coordination – Aging Adults	6	0	4
Care Management/Coordination – Children/Families	16	0	8
FJC Specialized Youth Program	14	0	8
Maternal Health Education/Support	4	0	2
Parenting Support Resources	4	0	2
Extracurricular Program Connections	1	0	1
Immigration Services	7	0	4
Human Trafficking Services	1	0	1
Other Services Requested			
Other 1	129	2	43
Other 2	11	1	3
Other 3	2	0	2

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Table C2.3. Service Navigation Log: Service Provision

Information about Options and Resources	Provided by Navigator			Provided by Onsite Partner			Provided by Offsite Partner		
	Total (*n* = 760)	Min (*n*)	Max (*n*)	Total (*n* = 760)	Min (*n*)	Max (*n*)	Total (*n* = 760)	Min (*n*)	Max (*n*)
Intake & Needs Assessment									
Information about Options and Resources	388	13	140	74	0	23	1	0	1
Danger Assessment	189	9	42	7	0	3	0	0	0
Strangulation Assessment	3	0	2	5	0	2	2	0	1
Photo Documentation of Visible Injury	13	0	7	7	0	4	1	0	1
Permission for High-Risk Case Review	45	0	44	2	0	1	0	0	0
Case Coordination – Partner Follow Up	126	1	45	23	0	12	2	0	1
Advocacy Services									
Safety Planning	201	4	64	148	0	46	1	0	1
Emergency Temporary Housing/Shelter Services	10	0	6	21	0	7	1	0	1
Assistance Completing a 50B Protective Order for Self	42	0	15	160	0	68	1	0	1
Assistance Completing a 50B Protective Order for Child(ren)	9	0	4	40	0	22	0	0	0
Assistance Completing a 50C	8	0	4	3	0	3	0	0	0
Victim's Compensation Application	6	0	5	2	0	1	0	0	0
Address Confidentiality Program	4	0	3	2	0	1	0	0	0
Court-Based Services									
First Appearance Victim Statement	11	0	5	1	0	1	3	0	3
Court Preparation – Civil	70	0	46	98	0	53	0	0	0
Court Preparation – Criminal (e.g., Victim Impact Statement)	21	0	12	10	0	6	2	0	1
Court Accompaniment – Civil	15	0	7	97	0	35	0	0	0
Court Accompaniment – Criminal	10	0	7	7	0	3	0	0	0
Civil/Legal Services									
Custody Consultation	3	0	1	20	0	10	3	0	1
Divorce/Separation Consultation	2	0	1	16	0	11	1	0	1
Other Civil Legal Consultation	3	0	2	11	0	7	1	0	1
Protective Order Consultation	18	0	8	61	0	24	0	0	0
Protective Order Referral for Representation	7	0	3	33	0	13	0	0	0
Guardianship/Power of Attorney	0	0	0	1	0	1	0	0	0
Health & Emotional/Wellness Services									
Medical Care	0	0	0	4	0	2	1	0	1
Crisis Counseling/Emotional Support	135	0	51	84	1	38	1	0	1
Mental Health Counseling for Self	16	0	13	63	0	29	0	0	0
Mental Health Counseling for Child(ren)	2	0	1	4	0	3	0	0	0
Peer Support	0	0	0	43	0	37	1	0	1
Support Group Referral	15	0	11	11	0	4	1	0	1
Law Enforcement									
Follow Up on Reported Incident	27	0	15	65	1	33	0	0	0
File New Police Report	7	0	4	25	0	12	0	0	0
Assistance Filing Private Warrant(s)	10	0	5	7	0	4	0	0	0
Escort to Court – Civil or Criminal	6	0	3	41	0	38	0	0	0
Social Services									

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Child Protective Services Report – Filed or Follow Up	36	0	16	35	0	13	0	0	0
Adult Protective Services Report – Filed or Follow Up	4	0	3	6	0	4	0	0	0
Economic Services	1	0	1	10	0	3	0	0	0
Housing Services	10	0	4	11	0	7	0	0	0
Childcare Assistance	4	0	3	4	0	2	0	0	0
Specialized Services for Vulnerable Populations									
Care Management/Coordination – Aging Adults	2	0	2	3	0	2	0	0	0
Care Management/Coordination – Children/Families	5	0	3	9	0	4	0	0	0
FJC Specialized Youth Program	5	0	3	7	0	5	0	0	0
Maternal Health Education/Support	1	0	1	1	0	1	0	0	0
Parenting Support Resources	3	0	1	2	0	1	0	0	0
Extracurricular Program Connections	0	0	0	0	0	0	0	0	0
Immigration Services	2	0	1	2	0	2	1	0	1
Human Trafficking Services	0	0	0	0	0	0	0	0	0
Other Services Requested									
Other 1	49	0	21	59	0	21	6	0	5
Other 2	6	0	2	3	0	2	0	0	0
Other 3	2	0	2	0	0	0	0	0	0

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Figure C2.1. Service Navigation Log: Intake & Needs Assessment

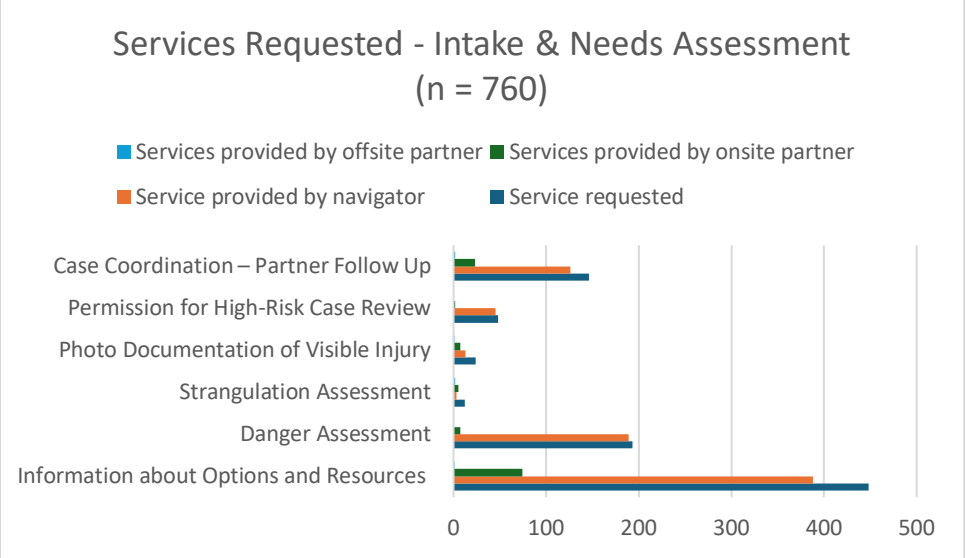

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Figure C2.2. Service Navigation Log: Advocacy Services

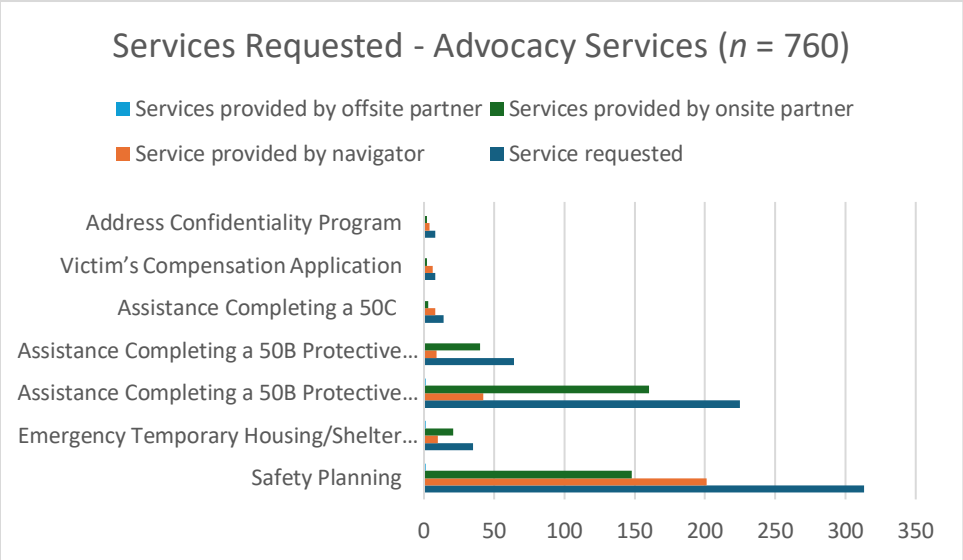

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Figure C2.3. Service Navigation Log: Court-Based Services

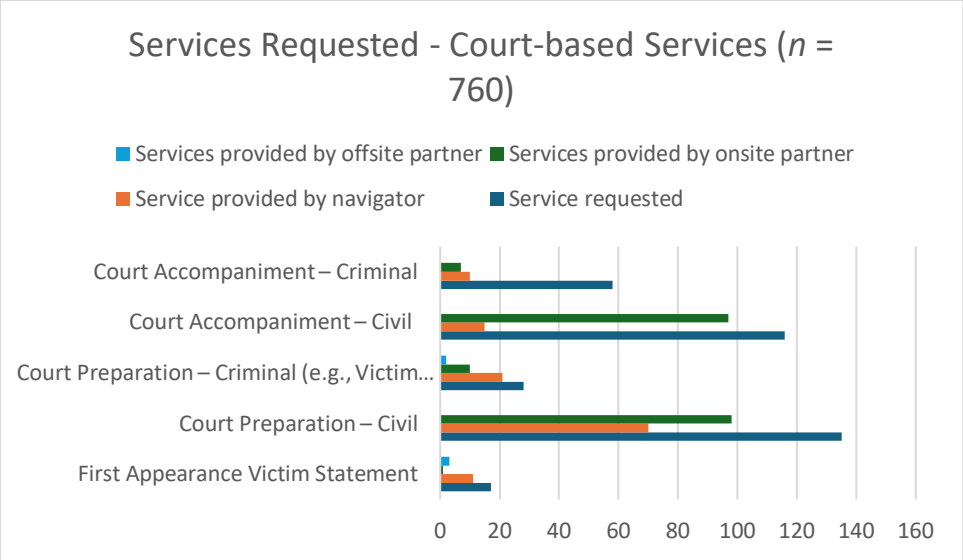

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Figure C2.4. Service Navigation Log: Civil/Legal Services

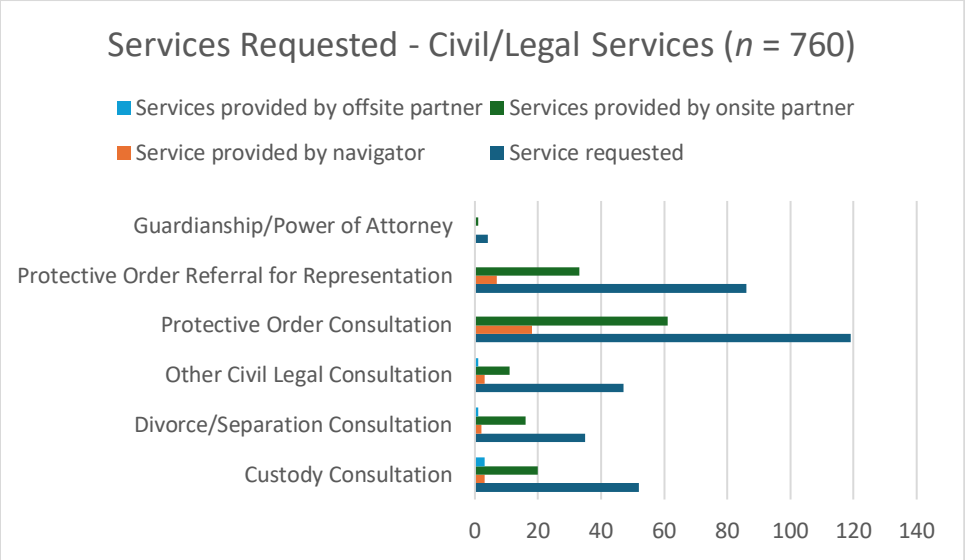

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Figure C2.5. Service Navigation Log: Health and Emotional Wellness Services

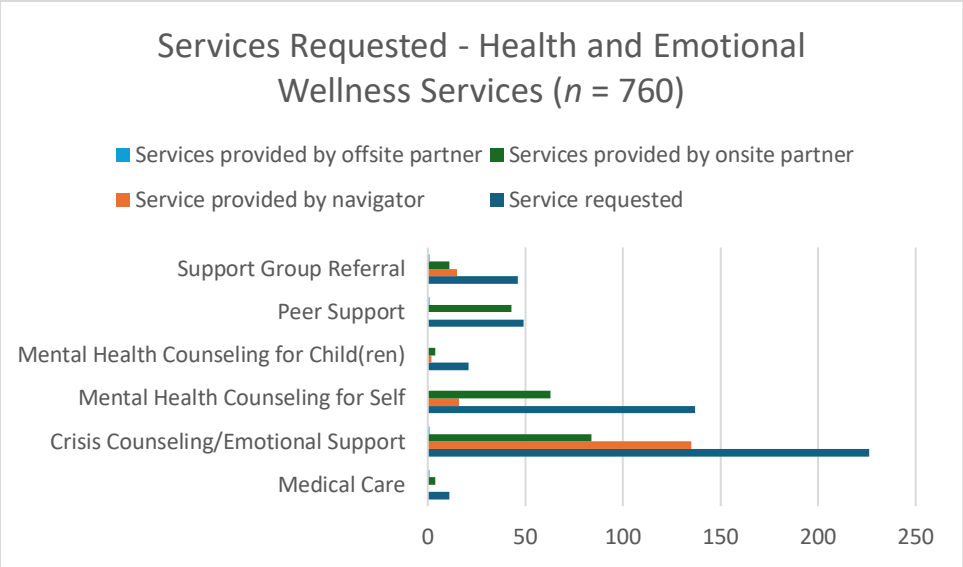

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Figure C2.6. Service Navigation Log: Law Enforcement

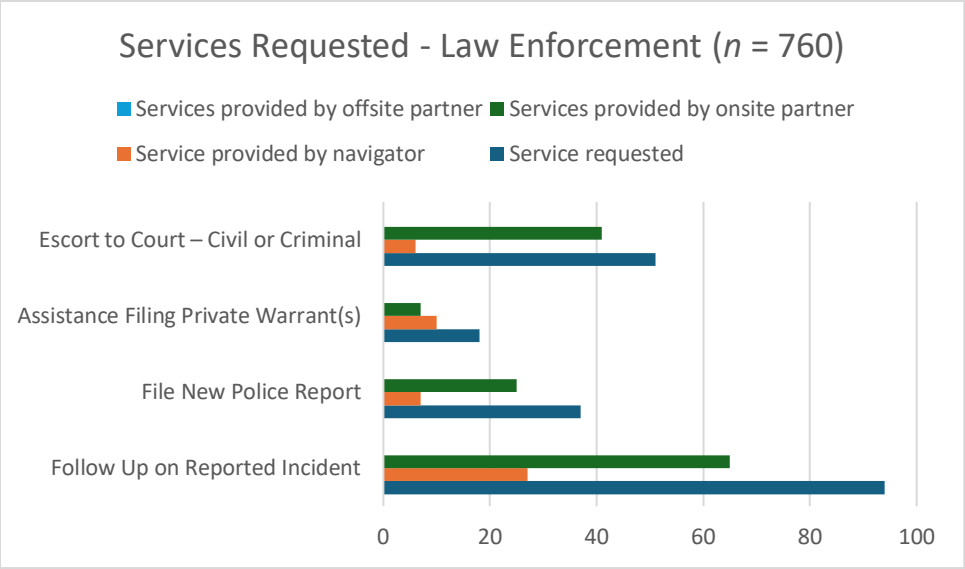

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Figure C2.7. Service Navigation Log: Social Services

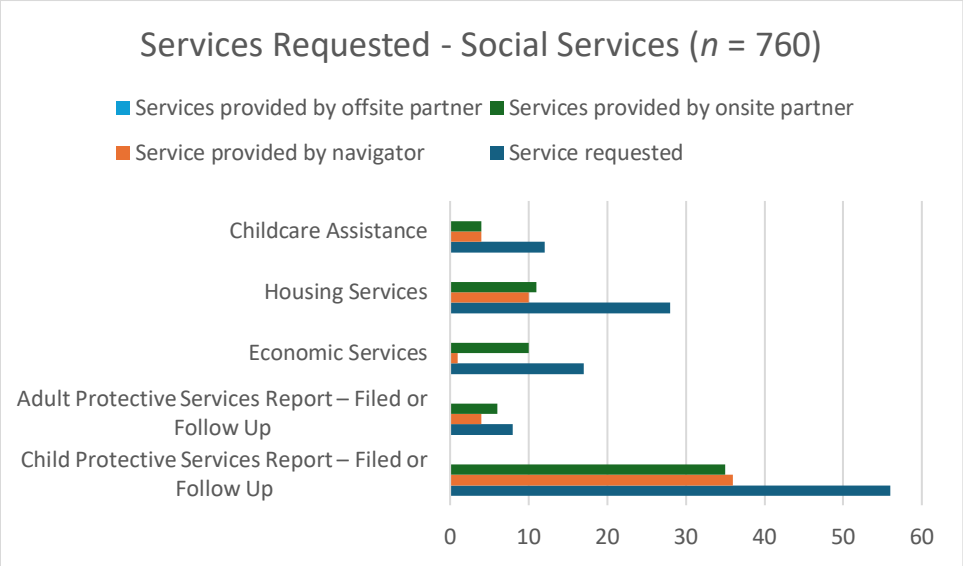

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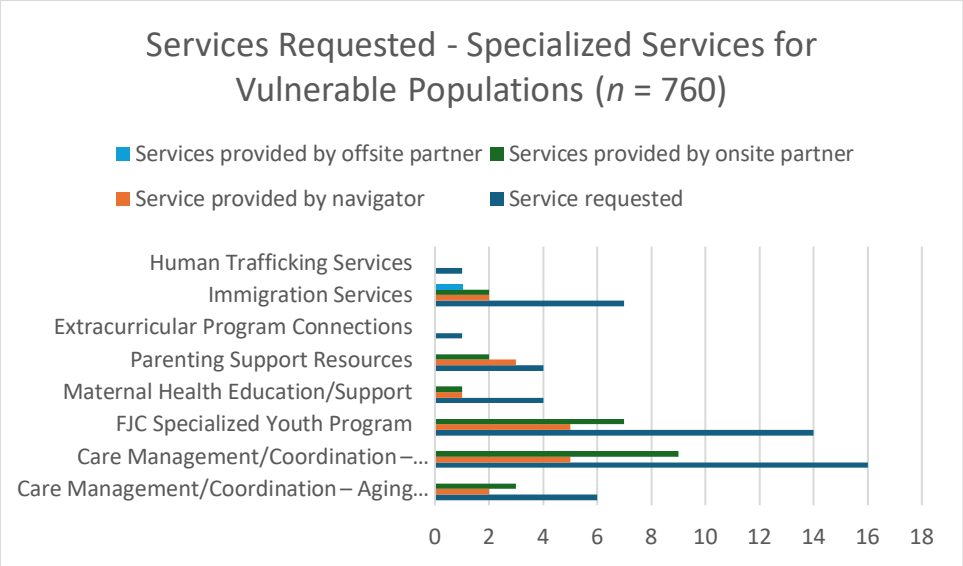
Figure C2.8. Service Navigation Log: Specialized Services for Vulnerable Populations



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Appendix C3: Partner Collaboration Findings

Table C3.1. Collaboration Survey: Co-location Characteristics

Item	Total *n*	Total %	Min %	Max %
Do you have a designated office or desk space at the center?				
Yes – private office	56	47.06	28.57	70.00
Yes – designated desk	20	16.81	0.00	28.57
No – shared office or desk space available upon arrival	20	16.81	0.00	29.03
No designated or shared space	14	11.76	4.17	31.25
Other, please specify	9	7.56	0.00	42.86
Respondents' average percentage of work time spent onsite at center[1]				
Less than 25% of my time	51	42.86	28.57	71.43
26% to 50% of my time	11	9.24	0.00	28.57
51% to 75% of my time	11	9.24	0.00	14.29
75% to 100% of my time	44	36.97	28.57	43.75

Note. [1] 2 missing observations.

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Table C3.2. Collaboration Survey: Partnership Assessment Tool

Center staff and partners...	Total *M* (*SD*)	Min *M* (*SD*)	Max *M* (*SD*)
Take responsibility for partnership	3.87 (1.08)	3.55 (1.18)	4.50 (0.55)
Inspire or motivate people involved in the partnership	3.79 (1.16)	3.48 (1.21)	4.29 (0.49)
Empower people involved in the partnership	3.72 (1.19)	3.48 (1.24)	4.33 (0.52)
Communicate the vision of the partnership	3.88 (1.10)	3.72 (1.19)	4.50 (0.55)
Work to develop a common language within the partnership	3.75 (1.20)	3.52 (1.32)	4.10 (0.57)
Foster respect, trust, inclusiveness, and openness in the partnership	3.73 (1.32)	3.45 (1.43)	4.71 (0.49)
Create an environment where differences of opinion can be voiced	3.77 (1.25)	3.45 (1.43)	4.57 (0.53)
Resolve conflict among partners	3.63 (1.11)	3.38 (1.37)	3.83 (0.98)
Combine perspectives, resources, and skills of partners	3.99 (1.01)	3.74 (1.20)	4.67 (0.52)
Help partnership be creative and look at things differently	3.83 (1.15)	3.59 (1.30)	4.50 (0.84)
Recruit diverse people and organizations into the partnership	3.96 (0.94)	3.69 (0.87)	4.17 (0.98)
Coordinate communication among partners	3.97 (1.06)	3.83 (0.41)	4.43 (0.79)
Coordinate communication with people and organizations outside the partnership	3.93 (1.03)	3.76 (1.18)	4.20 (0.92)
Organize partnership activities including meetings and activities	4.07 (1.02)	3.79 (1.17)	4.67 (0.52)
Apply for and manage grants and funds	3.81 (1.06)	3.55 (1.21)	4.10 (0.57)
Prepare materials that inform partners and help them make timely decisions	3.83 (1.03)	3.66 (1.20)	4.17 (0.41)
Perform secretarial duties	3.69 (1.03)	3.38 (1.20)	3.90 (0.74)
Provide orientation to new partners as they join the partnership	4.01 (0.93)	3.88 (1.20)	4.20 (0.92)
Evaluate the progress and impact of the partnership	3.83 (1.12)	3.63 (1.09)	4.00 (1.05)
Minimize the barriers to participation in the partnership's meetings and activities (i.e., holding meetings in convenient times and places)	3.85 (1.17)	1.29 (0.76)	4.17 (0.41)

Note. Response options range from *strongly disagree* (1) to *strongly agree* (5).

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Table C3.3. Collaboration Survey: Perceived Benefits and Drawbacks

Center staff and partners...	Total % (*n*)	Min %	Max %
Perceived benefits			
Enhanced ability to address an important issue	69.75 (83)	54.84	100.00
Development of new skills	50.42 (60)	42.86	68.75
Heightened public profile	50.42 (60)	14.29	60.00
Increased utilization of expertise or services	67.23 (80)	58.06	100.00
Acquisition of useful knowledge about services, programs, or people in the community	68.07 (81)	64.58	85.71
Enhanced ability to affect public policy	41.18 (49)	20.00	51.61
Development of valuable relationships	71.43 (85)	62.50	85.71
Enhanced ability to meet the needs of your constituency or clients	68.91 (82)	61.29	87.50
Ability to have a greater impact than you could have on your own	71.43 (85)	62.50	100.00
Ability to make a contribution to the community	68.07 (81)	62.50	85.71
Acquisition of additional financial support	31.93 (38)	0.00	50.00
Perceived Drawbacks			
Diversion of time and resources away from other priorities and obligations	16.81 (20)	0.00	18.75
Insufficient influence in partnership activities	11.76 (14)	0.00	16.13
Viewed negatively due to association with other partners or the partnership	14.29 (17)	9.68	25.00
Frustration or aggravation	26.05 (31)	0.00	35.48
Insufficient credit given for contributing to the accomplishments of the partnership	18.49 (22)	0.00	10.00
Conflict between job and partnership's work	17.65 (21)	0.00	25.81

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Table C3.4. Collaboration Survey: Knowledge about Partners and Confidence Making Referrals

Items	Total *M* (*SD*)	Min *M* (*SD*)	Max *M* (*SD*)
How knowledgeable are you about the services [this organization] provides to clients at the center?	3.82 (1.06)	3.68 (1.26)	4.61 (0.58)
How confident are you in your ability to make appropriate referrals to this partner organization at center?	3.94 (1.17)	3.68 (1.91)	4.87 (0.37)

Note. Response options range from *not at all* (1) to *extremely* (5).

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Table C3.5. Collaboration Survey: Communication, Guidance, and Trust

Items	Total *M* (*SD*)	Min *M* (*SD*)	Max *M* (*SD*)
Frequency of communication with partners [1]	2.29 (1.03)	2.17 (1.05)	2.52 (0.84)
Frequency of guidance received from partners [1]	2.08 (1.04)	1.94 (1.06)	2.52 (0.85)
Frequency of providing guidance to partner [1]	2.00 (1.00)	1.86 (0.94)	2.61 (0.73)
Self-reported trust that organization help clients feel supported [2]	4.99 (0.99)	4.71 (1.10)	5.40 (0.75)

Note. [1] Response options range from *monthly or less* (1) to *almost daily* (4). [2] Response options range from *completely untrue* (1) to *totally true* (6).

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Appendix C4: Adaptive Fidelity Self-Assessment Findings

Table C4.1. Adaptive Fidelity: Core Partners and Variation

Is the partner co-located?	Full-Time (*n*)	Part-Time (*n*)	None (*n*)	Center provided mixed response (*n*)
Rape crisis advocates	3	0	2	1
Domestic violence advocates	5	0	0	1
Human trafficking advocates	3	0	2	1
Police department personnel	5	0	1	0
Sheriff's office personnel	3	1	1	1
Medical personnel	2	0	4	0
District attorneys and city attorneys	1	0	3	2
Victim-witness program personnel	2	0	3	1
Domestic violence shelter staff	0	0	4	2
Social service agency staff members	2	0	2	2
Child welfare agency social workers	3	0	1	2
County health department staff	0	0	6	0
City or county public assistance workers	2	0	3	1
Mental health professionals	2	1	0	3
Civil legal service providers	1	1	2	2

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Table C4.2. Adaptive Fidelity: Essentialness of Partner Co-Location

	How essential is the partner's co-location in ensuring center effectiveness?						Do you think the way this organization partners with a co-located center can look differently in other communities and still be effective?			
Partners	**N**	**Extremely Essential (*n*)**	**Essential (*n*)**	**Moderately Essential (*n*)**	**Slightly Essential (*n*)**	**Not Essential (*n*)**	**N**	**Yes (*n*)**	**No (*n*)**	**I'm Not Sure (*n*)**
Domestic violence advocates	11	9	2	0	0	0	10	6	4	0
Mental health professionals	11	9	2	0	0	0	10	8	2	0
Civil legal service providers	11	9	1	1	0	0	10	7	3	0
Police department personnel	11	9	0	2	0	0	10	6	4	0
Sheriff's office personnel	11	7	3	0	1	0	10	7	3	0
Medical personnel	11	7	1	1	2	0	10	8	2	0
Rape crisis advocates	10	7	1	1	1	0	10	6	4	0
Child welfare agency social workers	11	6	3	2	0	0	10	7	1	2
Social service agency staff members	11	6	2	3	0	0	10	8	1	1
Human trafficking advocates	11	5	5	1	0	0	10	7	2	1
District attorneys and city attorneys	11	5	5	1	0	0	10	9	1	0
Victim-witness program personnel	10	5	4	0	0	1	10	8	1	1
Domestic violence shelter staff	10	4	2	0	2	1	10	9	0	1
County health department staff	10	3	1	3	3	0	10	8	0	2
City or county public assistance workers	10	1	4	3	2	0	10	9	0	1

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Table C4.3. Adaptive Fidelity: Core Services/Supports and Variation

Is this service or support co-located?	Yes (*n*)	No (*n*)	Center provided mixed response (*n*)
Information about Options and Resources	6	0	0
Danger Assessments and/ or Strangulation Assessment	6	0	0
Photo Documentation of Visible Injury	6	0	0
Permission for High-Risk Case Review	5	0	1
Case Coordination – Partner Follow Up	6	0	0
Safety Planning	6	0	0
Emergency Temporary Housing/Shelter Services	5	0	1
Assistance Completing a 50B Protective Orders	6	0	0
Assistance Completing 50Cs	6	0	0
Victim's Compensation Applications	6	0	0
Address Confidentiality Program	6	0	0
Violence Prevention Education and Outreach	6	0	0
Court Preparation – Civil or Criminal	6	0	0
Court Accompaniment – Civil or Criminal	6	0	0
Civil Legal Consultation	5	1	0
Criminal Legal Consultation	3	1	2
Protective Order Referral for Representation	6	0	0
Guardianship/Power of Attorney	2	2	2
Medical Care	1	3	2
Forensic Exams	3	1	2
Crisis Counseling/Emotional Support	6	0	0
Mental Health Counseling (for client and/ or children)	6	0	0
Peer Support or Support Groups	6	0	0
File New Police Report	5	0	1
Assistance Filing Private Warrant(s)	4	1	1
Economic Services	4	1	1
Housing Services	4	1	1
Childcare Assistance	5	0	1
Assistance with material goods	5	1	0
Care Management/Coordination – Aging Adults	3	1	2
Care Management/Coordination – Children/Families	4	1	1
FJC Specialized Youth Program	2	1	3
Parenting Support Resources	3	2	1
Immigration Services	1	4	1
Human Trafficking Services	3	2	1

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Table C4.4. Adaptive Fidelity: Essentialness of Services and Supports

	How essential is the service or support's co-location in ensuring center effectiveness?						Do you think the way this service or support is implemented can look differently in other communities and still be effective?			
Services and Supports	**N**	**Extremely Essential (*n*)**	**Essential (*n*)**	**Moderately Essential (*n*)**	**Slightly Essential (*n*)**	**Not Essential (*n*)**	**N**	**Yes (*n*)**	**No (*n*)**	**I'm Not Sure (*n*)**
Information about Options and Resources	11	10	1	0	0	0	9	4	5	0
Danger Assessments and/ or Strangulation Assessment	11	10	1	0	0	0	9	4	5	0
Safety Planning	11	10	1	0	0	0	9	4	5	0
Photo Documentation of Visible Injury	11	9	2	0	0	0	9	5	4	0
Case Coordination – Partner Follow Up	11	9	2	0	0	0	9	5	4	0
Mental Health Counseling (for client and/ or children)	11	9	2	0	0	0	9	6	2	1
Assistance Completing a 50B Protective Orders	11	9	1	1	0	0	9	5	4	0
Crisis Counseling/Emotional Support	11	9	1	1	0	0	9	5	3	1
Forensic Exams	11	9	0	2	0	0	9	5	3	1
Assistance with material goods	11	8	3	0	0	0	9	5	4	0
Peer Support or Support Groups	11	8	2	1	0	0	9	5	2	2
Court Preparation – Civil or Criminal	11	8	2	0	1	0	9	5	4	0
Care Management/Coordination – Children/Families	11	8	1	2	0	0	9	5	4	0
FJC Specialized Youth Program	11	8	1	2	0	0	9	5	3	1
Court Accompaniment – Civil or Criminal	11	8	1	1	1	0	8	5	3	0
Civil Legal Consultation	10	8	1	1	0	0	9	5	4	0
File New Police Report	10	8	1	1	0	0	9	5	4	0
Emergency Temporary Housing/Shelter Services	10	8	1	0	0	1	9	6	3	0
Protective Order Referral for Representation	10	8	1	0	1	0	9	5	4	0
Economic Services	11	8	0	3	0	0	9	6	3	0
Human Trafficking Services	11	7	4	0	0	0	9	7	2	0
Victim's Compensation Applications	10	7	3	0	0	0	9	4	4	1
Housing Services	10	7	3	0	0	0	9	6	3	0

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Permission for High-Risk Case Review	11	7	2	2	0	0	9	4	4	1
Violence Prevention Education and Outreach	11	7	2	1	1	0	9	6	3	0
Assistance Filing Private Warrant(s)	10	7	1	2	0	0	9	5	4	0
Childcare Assistance	10	7	1	2	0	0	9	4	5	0
Care Management/Coordination – Aging Adults	10	7	1	2	0	0	9	6	2	1
Assistance Completing 50Cs	10	6	3	1	0	0	9	5	3	1
Address Confidentiality Program	10	6	3	1	0	0	9	4	4	1
Criminal Legal Consultation	10	6	3	1	0	0	9	6	2	1
Immigration Services	10	6	2	2	0	0	9	7	2	0
Parenting Support Resources	10	6	1	3	0	0	9	8	1	0
Medical Care	10	5	2	1	2	0	9	7	1	1
Guardianship/Power of Attorney	10	5	1	3	1	0	9	7	2	0

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Table C4.5. Adaptive Fidelity: Core Infrastructure/Processes and Variation

Does the center implement the infrastructure or process?	Yes (*n*)	No (*n*)	Center provided mixed response (*n*)
Co-located center led by county government	5	0	1
Co-located center led by non-profit	1	3	2
Capacity building activities across partners (e.g., cross-agency trainings)	4	2	0
Centrally located center	5	1	0
Centralized intake process	5	1	0
Client navigation by a designated person	4	0	2
Collaborative infrastructure with cross-agency leaders	5	0	1
Confidentiality agreements between co-located partners	4	0	2
Memoranda of understanding (MOU) or memoranda of agreement (MOA)	6	0	0
High-risk lethality teams	4	1	1
Regular meetings across partners	5	0	1
Shared calendar	1	5	0
Shared database	1	4	1
VOICES committee	4	1	1

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Table C4.6. Adaptive Fidelity: Essentialness of Infrastructure and Processes

	How essential is this infrastructure or process in ensuring center effectiveness?						Do you think the way this infrastructure or process is implemented could look differently in other communities and still be effective?			
Infrastructure and Processes	**N**	**Extremely Essential (*n*)**	**Essential (*n*)**	**Moderately Essential (*n*)**	**Slightly Essential (*n*)**	**Not Essential (*n*)**	**N**	**Yes (*n*)**	**No (*n*)**	**I'm Not Sure (*n*)**
Co-located center led by county government	10	5	1	0	1	3	10	9	0	1
Co-located center led by non-profit	8	4	0	0	0	4	10	10	0	0
Capacity building activities across partners (e.g., cross-agency trainings)	10	7	3	0	0	0	10	8	2	0
Centrally located center	10	7	2	1	0	0	10	5	4	1
Centralized intake process	10	8	1	1	0	0	10	6	4	0
Client navigation by a designated person	10	8	1	1	0	0	10	6	3	1
Collaborative infrastructure with cross-agency leaders	10	9	1	0	0	0	10	6	4	0
Confidentiality agreements between co-located partners	9	7	2	0	0	0	10	6	4	0
Memoranda of understanding (MOU) or memoranda of agreement (MOA)	9	7	2	0	0	0	10	6	4	0
High-risk lethality teams	10	7	2	1	0	0	10	7	3	0
Regular meetings across partners	10	6	4	0	0	0	10	7	2	1
Shared calendar	9	3	0	1	2	3	10	9	0	1
Shared database	9	3	0	2	1	3	10	9	0	1
VOICES committee	10	8	1	0	0	1	10	7	2	1

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Appendix C5: Client Outcome Findings

Table C5.1. Client Outcomes: Client Service Needs

	TP1 and TP2 Comparison				TP 1 and TP 3 Comparison			
Individual Needs	***n***	**TP1 %**	**TP2 %**	**p-val**	***n***	**TP1 %**	**TP3 %**	**p-val**
Seasonally appropriate clothing and/or shoes	26	34.6	61.5	0.029	—	—	—	—
Personal hygiene items	25	32.0	60.0	0.015	—	—	—	—
Help filing criminal charges	25	28.0	8.0	0.037	—	—	—	—
Someone to come with me to court	24	45.8	8.3	0.007	—	—	—	—
Speak with an advocate or crisis counselor about my situation and available options/services	27	88.9	44.4	0.006	20	85.0	35.0	0.010
Personal safety	27	85.2	40.7	0.004	20	80.0	35.0	0.015
Safety of my child(ren)	25	64.0	36.0	0.048	20	65.0	30.0	0.033
Restraining order for self	26	65.4	19.2	0.007	20	55.0	15.0	0.022
Medical care	26	15.4	38.5	0.046	20	15.0	50.0	0.033
Dental care	—	—	—	—	19	10.5	47.4	0.018
Need Composites	***n***	**TP1 *M***	**TP2 *M***	**p-val**	***n***	**TP1 *M***	**TP3 *M***	**p-val**
IPV and SV needs	26	3.31	1.85	0.001	21	3.14	1.52	0.001
Law enforcement and legal needs	26	2.27	0.73	0.001	20	2.20	0.90	0.025
Medical needs	—	—	—	—	20	0.50	1.35	0.027

Note. TP = timepoint. Table presents only statistically significant findings. No significant differences between TP2 and TP3.

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Table C5.2. Client Outcomes: Perceptions of Center and Staff

	TP1 and TP2 Comparison				TP 1 and TP 3 Comparison			
Perceptions of Center and Staff	***n***	**TP1 *M***	**TP2 *M***	**p-val**	***n***	**TP1 *M***	**TP3 *M***	**p-val**
Staff offered choices	25	3.76	3.40	0.010	24	3.75	3.42	0.003
Staff believed that decisions about my life were mine to make	25	3.80	3.40	0.023	24	3.79	3.42	0.018
I was easily able to access services I needed	—	—	—	—	24	3.54	3.21	0.045
The services I received helped me make decisions about my next steps	—	—	—	—	24	3.63	3.17	0.009
I felt safe at the center	—	—	—	—	24	3.83	3.58	0.032
I felt respected by the staff	—	—	—	—	23	3.87	3.61	0.012
I feel like my confidentiality was honored by staff	—	—	—	—	24	3.83	3.58	0.032

Note. TP = timepoint. Table presents only statistically significant findings. No significant differences between TP2 and TP3. Response options: 1 = *Strongly Disagree*, 2 = *Disagree*, 3 = *Agree*, 4 = *Strongly Agree*.

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Table C5.3. Client Outcomes: Victimization

	TP1 and TP2 Comparison				TP 1 and TP 3 Comparison			
Experiences of Victimization	***n***	**TP1 *M***	**TP2 *M***	**p-val**	***n***	**TP1 *M***	**TP3 *M***	**p-val**
Physical IPV	—	—	—	—	24	3.21	0.50	0.025
Psychological IPV	28	11.14	2.07	0.000	24	10.38	1.92	0.000
Financial IPV	28	6.86	1.79	0.025	—	—	—	—
Stalking	28	8.18	1.64	0.003	24	8.29	1.38	0.004
Any IPV	28	33.29	9.21	0.000	24	31.88	9.13	0.000
Any IPV or SV	28	33.61	9.54	0.000	24	31.92	9.21	0.000

Note. TP = timepoint. Table presents only statistically significant findings. No significant differences between TP2 and TP3. Response options: 0 = *Never*, 1 = *Once*, 2 = *Twice*, 4 = *3-5 times*, 8 = *6-10 times*, 15 = *11-20 times*, 25 = *20+ times*.

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Table C5.4. Client Outcomes: Sense of Safety

	TP1 and TP3 Comparison				TP 2 and TP 3 Comparison			
Sense of Safety Items	***n***	**TP1 *M***	**TP3 *M***	**p-val**	***n***	**TP2 *M***	**TP3 *M***	**p-val**
I have a good idea about what kinds of support for safety that I can get from people in my community	24	2.58	2.00	0.021	22	2.64	1.95	0.005
Community programs and services provide support I need to keep safe	22	2.82	2.41	0.049	20	3.20	2.35	0.008
Overall, I feel safe	24	2.67	1.96	0.006	22	2.59	1.91	0.006
Sense of Safety Scales and Subscales	***n***	**TP1 *M***	**TP3 *M***	**p-val**	***n***	**TP2 *M***	**TP3 *M***	**p-val**
Internal tools subscale	24	2.57	2.24	0.005	22	2.53	2.18	0.024
Expectations of support subscale	24	2.59	2.24	0.026	22	2.69	2.15	0.012
Overall scale	24	2.56	2.24	0.002	22	2.50	2.19	0.016

Note. TP = timepoint. Table presents only statistically significant findings. No significant differences between TP1 and TP2. Response options: 1 = *Always True,* 2 = *Mostly True,* 3 = *Half the Time True,* 4 = *Sometimes True,* 5 = *Never True.*

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Table C5.5. Client Outcomes: Sense of Hope

	TP1 and TP3 Comparison				TP2 and TP3 Comparison			
Hope Items	***n***	**TP1 *M***	**TP3 *M***	**p-val**	***n***	**TP2 *M***	**TP3 *M***	**p-val**
I've been pretty successful in life	24	5.67	6.13	0.040	—	—	—	—
I meet the goals that I set for myself	24	5.58	6.21	0.042	22	5.45	6.27	0.017
There are lots of ways around any problem	—	—	—	—	22	5.68	6.45	0.043
Hope Scale and Subscales	***n***	**TP1 *M***	**TP3 *M***	**p-val**	***n***	**TP2 *M***	**TP3 *M***	**p-val**
Total Hope Scale	—	—	—	—	22	45.50	49.91	0.042

Note. TP = timepoint. Table presents only statistically significant findings. No significant differences between TP1 and TP2. Response options: 1 = *Definitely* False, 2 = *Mostly False*, 3 = *Somewhat False*, 4 = *Slightly False,* 5 = *Slightly True,* 6 = *Somewhat True,* 7 = *Mostly True,* 8 = *Definitely True.*

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